oregon**contraceptive**care

Oregon Family Planning Medicaid Waiver
Section 1115, Waiver No. 11-W-00142/0

Demonstration Year 22
Fourth Quarter (October – December 2020)/Annual Report

Oregon Health Authority

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Introduction

Oregon's 1115 family planning Medicaid demonstration waiver, entitled Oregon ContraceptiveCare or "CCare" (Project Number 11-W-00142/0), is administered by the Reproductive Health (RH) Program within the Public Health Division of the Oregon Health Authority. First approved in October 1998 by the Centers for Medicare and Medicaid Services (CMS) (previously the Health Care Financing Administration), the program began providing services in January of 1999. The current waiver renewal period is effective through December 31, 2021.

CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). The goal of the program is to improve the well-being of children and families by reducing unintended pregnancies and improving access to primary health care services. Clients are enrolled in CCare at the point of service (clinic site) but final determinations of eligibility are made by state staff. CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client has lost CCare eligibility for some reason (e.g., acquired and then lost regular Medicaid coverage) and is seeking to reestablish it. CCare covers office visits for contraceptive management services, limited laboratory services, contraceptive devices, and pharmaceutical supplies. There is no cost-sharing for coverage and services are provided through a statewide network of providers. Participating providers abide by the program's Standards of Care (Appendix A). One of these is the requirement to provide all clients with information and resources to help them access primary care services and health coverage on an ongoing basis.

The overall outcomes of CCare can grouped into three categories: (A) immediate outcomes for CCare clients; (B) intermediate outcomes for both CCare clients and the waiver's target population; and, (C) long-term outcomes for Oregon's reproductive-age population as a whole.

(A) Immediate Outcomes

- Outcome 1: The program will result in an increase in the proportion of clients who use a highly effective or moderately effective contraceptive method.
- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.
  Data source: RH Program Data System

(B) Intermediate Outcomes

- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.
- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.

(C) Long-term Outcomes

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.
- Outcome 6: The program will result in a decrease in the unintended pregnancy rate in Oregon.
- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.

Table 1 shows the quarters for demonstration year (DY) 22 for the waiver and associated report submission due dates.

TABLE 1.
Oregon Family Planning Waiver
Report Timeline Dates for CY 2020/DY 22

Quarter	Begin Date	End Date	Quarterly Report Due
1	January 1, 2020	March 31, 2020	May 31, 2020
2	April 1, 2020	June 30, 2020	August 31, 2020
3	July 1, 2020	September 30, 2020	November 30, 2020
4	October 1, 2020	December 31, 2020	March 31, 2021*

*Per STC 27, the state's fourth quarter progress report for each DY serves as the state's annual report. The annual report is due ninety (90) days following the end of the fourth quarter of each DY.

Executive Summary

Current Trends or Significant Program Changes

CCare continues to provide the same services as in the previous demonstration period. For the most part, there have been no noteworthy changes in administration/operations or provider participation. The RH Program has maintained its integrated program structure through DY 22, using its three sources of funding (Reproductive Health Equity Act or 'REHA', state general RH funds or 'RH GF', and CCare) to reimburse agencies for services rendered. As described in prior years' annual evaluation reports, the RH Program uses a set of system rules based on each

funding source's client eligibility and service coverage requirements to determine the appropriate fund source to draw from. The RH Program uses a single, streamlined client application that allows individuals to enroll in the RH Program and receive covered benefits based on their eligibility (i.e., U.S. citizens that meet all other CCare eligibility requirements will be eligible for CCare and RH GF, while those who do not qualify for Medicaid because of their immigration status are eligible for RHEA and RH GF). The RH Program continues to closely monitor monthly claims processing, both to track CCare payments and to assure appropriate use of funds, including adherence to all CCare requirements.

CCare agencies are able to apply and become certified as a fully integrated RH Program provider. Agencies that decline to become certified as RH Program providers, may be certified as CCare-only. Clients seeking services at CCare-only clinics complete the integrated RH Program Enrollment Form but are only eligible for CCare-covered services unless they seek services at an RH Program certified agency.

Policy Issues and Challenges

The COVID-19 pandemic has impacted both CCare enrollment and service utilization as clinics reduced in-person clinic access to ensure the health and safety of both clinic staff and clients. However, during the second half of DY 22, clinics began to offer more in-person visits as PPE supplies became more widely available and clinics were able to institute greater physical safety precautions. Clinics have been able to implement changes to clinic workflows and service provision including strategies such as delaying routine well woman visits, providing Depo injections in the clinic parking lot, and offering appointments via telehealth. By the end of DY 22, nearly all CCare agencies were offering the full scope of in-person visits again. Data regarding client enrollment trends for DY 22 are included in the section below.

Clinics have continued to increase their capacity in their use of telemedicine/telehealth during COVID-19. In order to facilitate client access, the RH Program developed guidance in the spring of 2020 to support the provision of telehealth services and remote enrollment (i.e., completion of RH Program Enrollment Form via telephone or video conference and obtaining verbal consent).

Enrollment

Annual Enrollment

CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client has lost CCare eligibility for some reason (e.g., acquired and then lost regular Medicaid coverage) and is seeking to reestablish it.

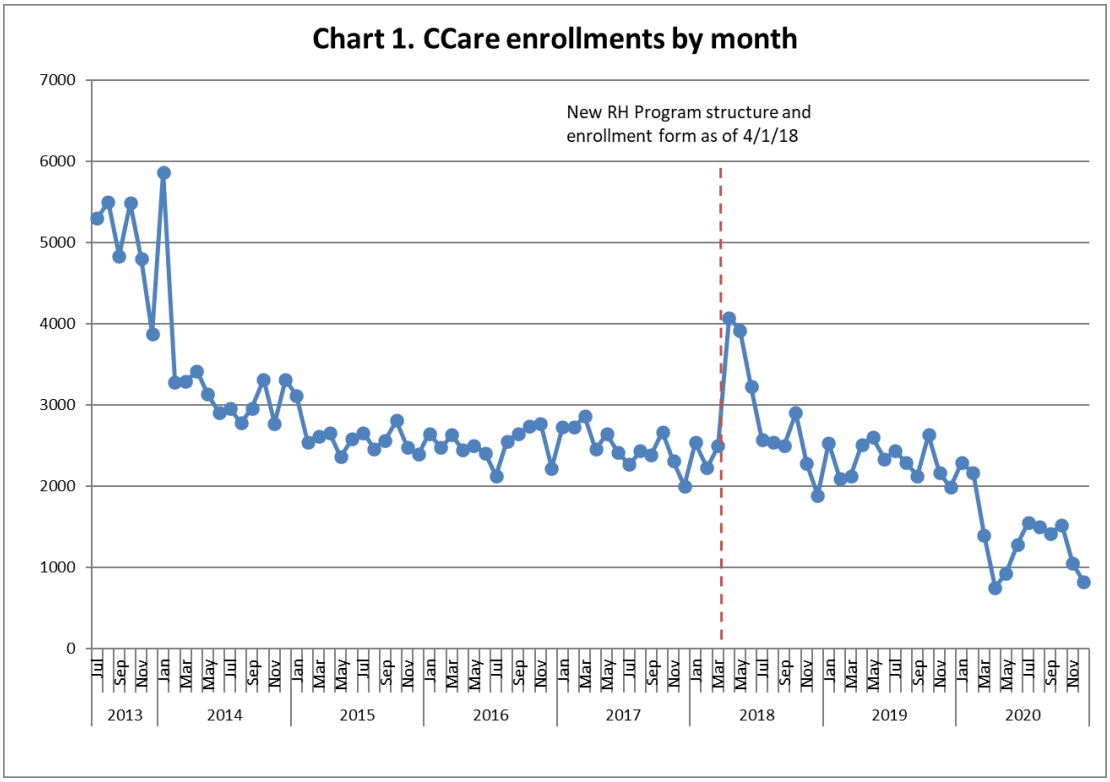
During 2020, CCare enrollments and member months were greatly impacted by the COVID-19 pandemic. Early on in the pandemic, many clinics limited hours and reduced appointment availability in order to preserve limited PPE and protect the health and safety of clinic staff and clients. Furthermore, many individuals previously not eligible for full Medicaid coverage were able to enroll because of lost employment and income. This resulted in fewer CCare enrollments in 2020. Finally, eligibility extensions were granted to clients whose eligibility was reaching its one-year end point. This resulted in an increase in the number of the member-months relative to the number of enrollees.

	TABLE 2. CY 2020/DY 22			
	Q1, January 1 - March 31	**Q2, April 1 – June 30**	**Q3, July 1 – September 30**	**Q4, October 1 – December 31**
# of Total Enrollees	5,842	2,945	4,461	3,382
# of Member Months	78,922	76,783	64,054	92,362

Prior to 2020, CCare enrollments were impacted by the implementation of the Affordable Care Act. This included Medicaid expansion and the creation of the health insurance marketplace which effectively provided coverage to thousands of Oregonians who were previously uninsured. Enrollment into CCare decreased significantly following ACA implementation efforts in 2014. As expected, many previously enrolled CCare clients shifted to the state's full-benefit Medicaid program, the Oregon Health Plan (OHP). As demonstrated by Chart 1 below, CCare monthly enrollments declined sharply starting in 2014, although enrollment numbers began to level off by mid-2015. The ongoing need for CCare coverage is supported by research from the health reform experience of Massachusetts[1] that showed that even with greatly expanded

[1] Leighton Ku, et al., "Safety-Net Providers After Health Care Reform: Lessons from Massachusetts," *Archives of Internal Medicine*, August 8, 2011, Vol 171, Number 15.

health insurance coverage, significant coverage gaps remain for many individuals in need of family planning, and CCare is uniquely positioned to address these gaps.



Annual Enrollment by Race/Ethnicity

TABLE 3. Annual Enrollment by Race/Ethnicity, CY 2020/DY 22		
Race/Ethnicity	**% of Total**	**# Enrolled**
Hispanic	12.0%	1,995
White, Non-Hispanic	67.4%	11,183
Black, Non-Hispanic	2.6%	425
American Indian, Non-Hispanic	0.8%	132
Alaska Native, Non-Hispanic	0.0%	8
Asian, Non-Hispanic	4.8%	792
Hawaiian/PI, Non-Hispanic	0.6%	101
More than one race, Non-Hispanic	2.1%	343

TABLE 3. Annual Enrollment by Race/Ethnicity, CY 2020/DY 22		
Race/Ethnicity	**% of Total**	**# Enrolled**
Unknown/Not Reported	6.0%	993
Other	3.7%	621
Total	100.0%	16,593

Annual Disenrollment and Retention Figures

Although the RH Program is unable to track reasons for disenrollment, it is assumed that the majority of disenrollments occur because clients obtained full-benefit insurance coverage either through OHP or through the state's health insurance marketplace. Every CCare claim received is matched against the OHP eligibility file to ensure that no claims are paid for clients who are eligible for family planning services or supplies under a different Medicaid program. In cases where a match is found, claims are denied and returned to the provider and CCare eligibility is terminated.

Another reason for disenrollment may be attributed to lapses in coverage due to changing standards of care. For instance, national guidelines regarding the frequency of cervical cancer screenings and increases in LARC uptake may mean that clients are not seeking care each year. Instead, they may delay returning to the clinic for services until the following year, resulting in a temporary lapse in enrollment.

This year, it is likely that the lower client retention rate is due in large part to the COVID-19 pandemic, which resulted in limitations in clinic hours as well as increased enrollment in OHP. Eligibility extensions were also granted as a result of the Public Health Emergency, reducing the number of clients who needed to re-enroll in DY22. See Table 4 below for enrollment retention figures.

TABLE 4. Annual Retention Rates	CY 2015/ DY 17	CY 2016/ DY 18	CY 2017/ DY 19	CY 2018/ DY20	CY 2019/ DY21	CY 2020/ DY22
Total enrollments per demonstration year (includes clients who enrolled more than once in a single calendar year)	31,266	30,130	29,866	33,081	27,799	16,593

# clients who also enrolled the subsequent demonstration year	6,668	6,087	8,138	5,860	2,785	
% of clients retained from one year to the next	21.3%	20.2%	27.2%	17.7%	10.0%	

Service Providers

There are currently 46 provider agencies enrolled in CCare, representing a total of 153 clinic sites. Among these 46 agencies, 33 are certified to participate in the full RH Program (RHCare), affording them access to the RH Program's three sources of funding (CCare, RH GF, and HB 3391). Clinics are located in 33 of the 36 counties across the state.

Between October and December 2020, the following provider training and education activities were provided to the RH Program/CCare provider network:

- Delivery of program news, policy updates, training opportunities, and other information to providers via the RH Newsletter.
- Two webinars, attended by a total of 53 Reproductive Health Program/CCare-enrolled providers, about the new RHCare and CCare Certification Requirements.

Due to COVID-19, the RH Program was unable to conduct its usual in-person Reproductive Health Coordinators' meeting.

Program Outreach and Education

The COVID-19 pandemic has greatly impacted the RH Program's ability to engage in typical outreach and education activities. A number of program staff were reassigned to education and outreach activities directly related to Oregon's efforts to respond to COVID-19. Despite these changes, throughout this demonstration year, the RH Program was able to engage in and support education and outreach activities to CCare priority populations as well as community and clinical partners throughout the state.

Outreach and Awareness Activities

During DY 22, the RH Program partnered with eight separate agencies, both clinical partners and community-based organizations, on a Reproductive Health Outreach and Education Project. The purpose of these partnerships is to build on the strengths and relationships of the community-based organizations to increase access to reproductive and sexual health services, increase education and decrease stigma about sexual and reproductive health, and support CCare clinics to strengthen their capacity to provide culturally responsive services. In this

project, the RH Program is facilitating monthly trainings for partners in topics related to the RH Program's function, clinical services, reproductive health education and outreach, and to share best practices between all eight project partners. These projects represent a significant shift in the RH Program's work in engaging with community. All projects received digital and print RH outreach and promotional materials to provide when doing virtual or in person community engagement.

RH Program staff have continued to participate in the Oregon Youth Sexual Health Partnership (OYSHP) and remain engaged in statewide sexual health education policies and events.
The RH Program continues to provide RH Program brochures and other outreach and education materials to community and clinical partners. These materials describe services available at the network of CCare clinics and are translated into 6 languages besides English, including Spanish, Vietnamese, Korean, Simplified Chinese, Traditional Chinese, and Chuukese. RH Program staff continued to meet with key partners in the Black/African-American community in the Portland area to advance collaboration through the Healthy Birth Initiative (HBI) to reduce reproductive health disparities and promote access to and utilization of contraceptive services among participants.

Educational Activities
The RH Program continues to provide training and resources for its provider network and community partners including trainings to promote client-centered counseling and comprehensive sexual education. Other RH Program educational activities included: a three-part series on Open Adoption and a five-part series working with the LGBTQ+ community in culturally responsive ways. Each of these trainings was delivered virtually to clinical staff throughout the state by community partners who are directly engaged in Open Adoption and LGBTQ+ education and outreach. The RH Program will continue to develop partnerships and deliver trainings in response to the needs and interests of the CCare clinical network.

Targeted Outreach Campaign
The RH Program manages both Facebook and Instagram social media pages designed to provide outreach and education about accessing services in Oregon to individuals between the ages of 18 and 33. The RH Program contracts with a graphic designer to ensure that our posts are engaging and presented in a way that invites easy comprehension of information. Content on both platforms continues to focus on topics related to pregnancy prevention and contraception as well as a broad range of sexual and reproductive health topics. All posts are written in planning language and are vetted by a RH Program Nurse Consultant to ensure medical accuracy.

Overall, both Facebook and Instagram campaigns have been successful. Posts from both mediums reached individuals with information about services, contraception, and related reproductive health topics.

COVID-19 Response Activities

The COVID-19 pandemic shifted large bodies of work as program staff stepped into roles to support the state's educational and outreach needs to mitigate the impact of COVID-19. RH Program staff served dedicated and ongoing roles to support Oregon's response to the COVID-19 pandemic. One staff person transitioned into a full-time leadership role to create and lead a team dedicated to working with community-based organizations to support communities. Another staff member served as a lead educator in designing and delivering trainings for contact tracers working statewide. A number of staff also served as contact tracers and engaged in activities related to outreach, monitoring and collaboration with Local Public Health Authorities. The RH Program's outreach and education activities shifted in several ways, including the examples below.

In June, the RH Program conducted a survey of clinical providers to assess the clinical services they were providing, the manner in which they were serving clients, and their plans for the provision of services and contraception during the restrictions imposed by state orders and in efforts to protect client health. Through this survey, the RH Program was able to understand the capacity of its clinical network, provide support as needed, and to ensure that communications to community partners and clients were accurate and consistent. Throughout the COVID-19 pandemic, the CCare clinical network has provided sexual and reproductive health services, often in innovative ways. Many clinics shifted a substantial portion of their work to telehealth, providing screenings, health education, and prescriptions through various telehealth modes.

Throughout the pandemic, CCare clinics have maintained reproductive health as a vital service. The RH Program continues to work with clinical partners to deliver timely information and access as innovative approaches become standard practice even as COVID-19 restrictions are lifted.

Outreach and Education Activities Evaluation

Indicators that the RH Program's outreach and education efforts have met with success include high scoring and positive responses on surveys and training evaluations, social media engagement and responses, successful project reports, and feedback from RH Program providers, partners, and clients.

Materials Evaluation
The RH Program began a process to review and revise all RH Program educational materials on a three-year basis. This new process began in 2020.

Program Monitoring and Evaluation

Quality Assurance, Monitoring, Program Integrity, and Audit Activities
In response to the program changes implemented in April 1, 2018, the RH Program updated its program integrity and monitoring processes and revised its review. The existing audit and compliance components related to CCare were maintained and enhanced as part of the integration with the RH Program's other funding sources.

Program integrity and monitoring activities include:

1. Monthly desk-audits, including review of data and claims to identify potential improper billing practices.
2. Random-sample chart audits to verify documentation supporting contraceptive management services, billed at the appropriate visit level.
3. Enrollment form audits to assess for completeness and accuracy and verified against eligibility database processes.
4. Chart reviews during onsite clinic reviews where reviewers follow a checklist of components to review charts with visits billed to CCare.
5. Visit frequency audits to help identify clients with a high number of visits within the year, which may indicate the need for a chart audit.
6. Monthly duplicate claims audit process to identify and correct any duplicate claims inadvertently submitted to and paid by CCare.
7. Monthly RH Program Monitoring and Quality Assurance Workgroup to review processes, troubleshoot problems, and share information related to program monitoring

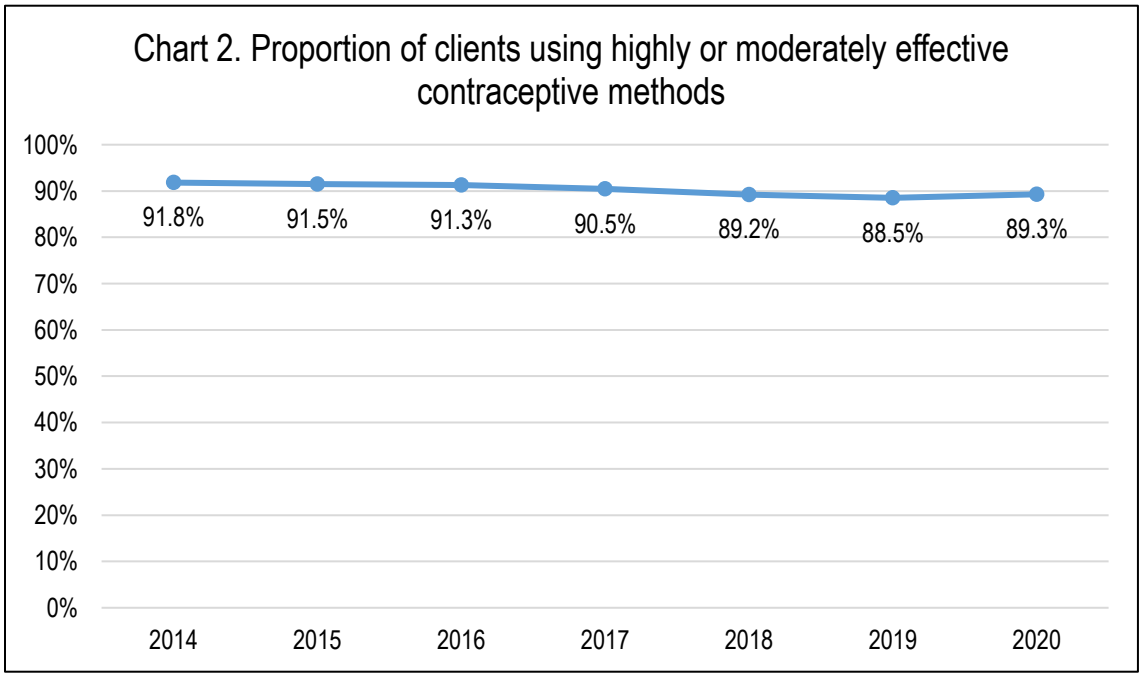
A total of 10 agencies were reviewed in 2020 using the audit processes noted above. As a result of COVID-19, the RH Program suspended audit and program monitoring efforts in the second quarter of 2020 in acknowledgement of the additional burden and strain placed on clinics responding to the pandemic. Many CCare providers are local public health departments who are directly responsible for disease investigation and contact tracing related to COVID-19. The RH Program intends to resume activities related to monitoring and compliance in the second

half of 2021. Staff will develop a revised schedule to ensure that those agencies who were scheduled for review are prioritized.

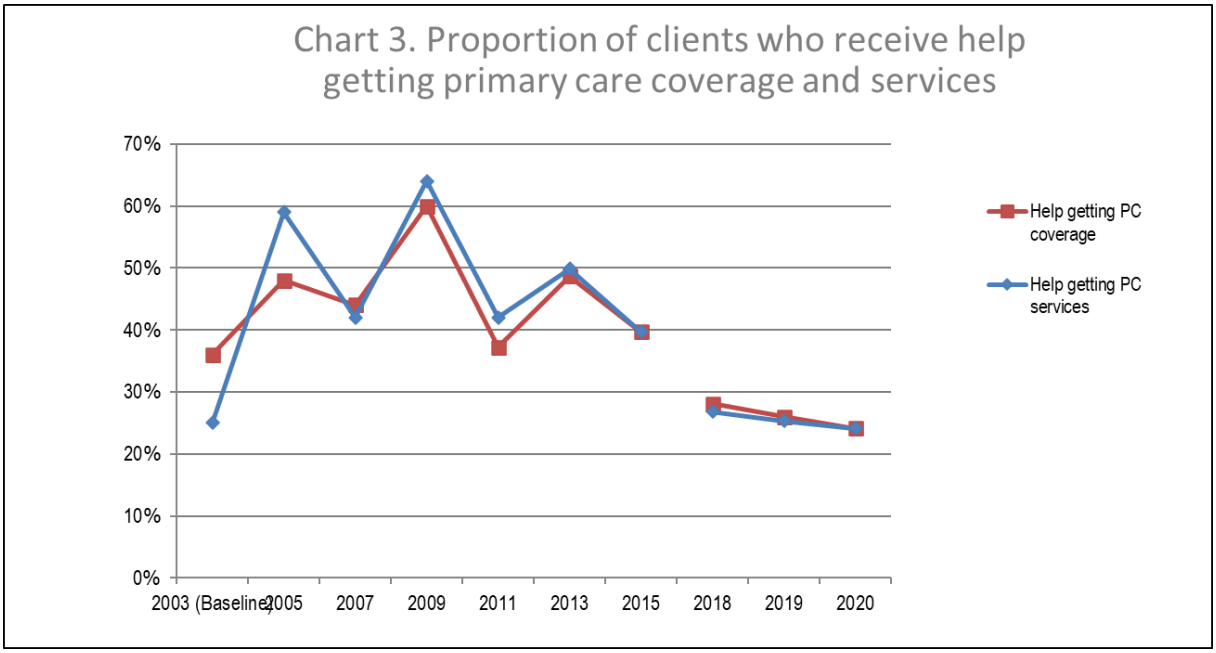
Evaluation of CCare Program Outcome Measures

(A) Immediate Outcomes:

- Outcome 1: The program will result in an increase in the proportion of clients who use a highly effective or moderately effective contraceptive method.
  Data source: RH Program Data System, Clinic Visit Record (CVR) data
  Performance target: 92.5%
  Progress: This outcome measure uses encounter data for clients with CCare source of coverage served within publicly supported family planning clinics. Effective contraceptive use is defined as all Tier 1 and Tier 2 contraceptive methods among unduplicated female clients of all ages at risk of unintended pregnancy. Women at risk of unintended pregnancy excludes clients who are using no method because they are pregnant, seeking pregnancy, or not currently sexually active. In 2014, when this measure was first tracked, 91.8% of all clients used a most or moderately effective method. This rate has declined slightly since 2014, with 89.3% of all clients using a most or moderately effective method in 2020.

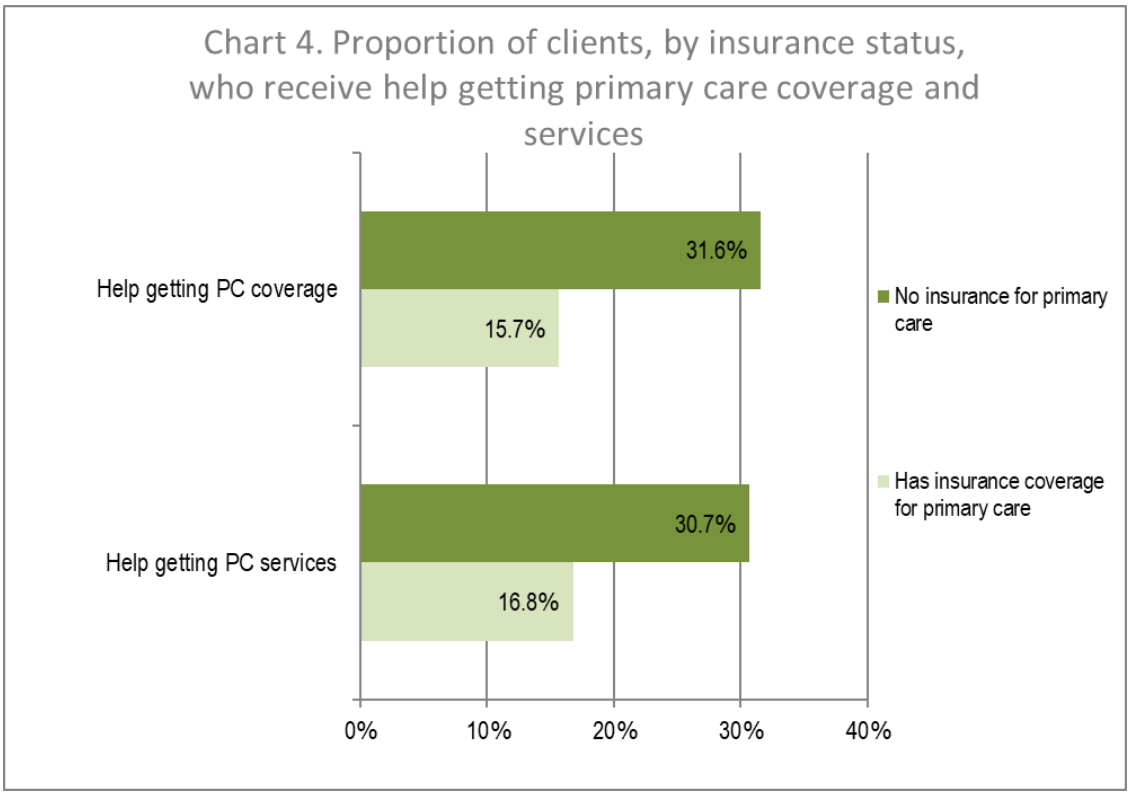


- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.
  Data source: RH Program Customer Satisfaction Survey (2003-2015), RH Program Enrollment Form (2018-present)
  Performance target: 50%
  Progress: This outcome was established at the time of CCare's first renewal to monitor progress toward the newly added goal of ensuring that clients received assistance with access to primary care services and coverage. To track this outcome, we use data from our own Customer Satisfaction Survey (CSS), a system-wide, self-administered client exit survey conducted approximately every other year. Sample selection for the CSS takes place at the clinic level and is typically designed to ensure representation of all but the very smallest volume clinics (those with less than 10 visits per week). Both CCare and non-CCare clients participate at the sampled clinics. The most recent data available come from the CSS administered in the fall of 2015. Results from 2003 (baseline) through 2015 are shown in Chart 3. Beginning in 2018, this information is collected on the RH Program Enrollment Form rather than the CSS, so the 2018 figures cannot be compared to previous years. Because this is a new data source, we will be tracking this moving forward to reestablish trends.



In 2020, less than 30% of CCare enrollees indicated that they had received help getting primary care services and coverage. This represents a substantial decline compared to

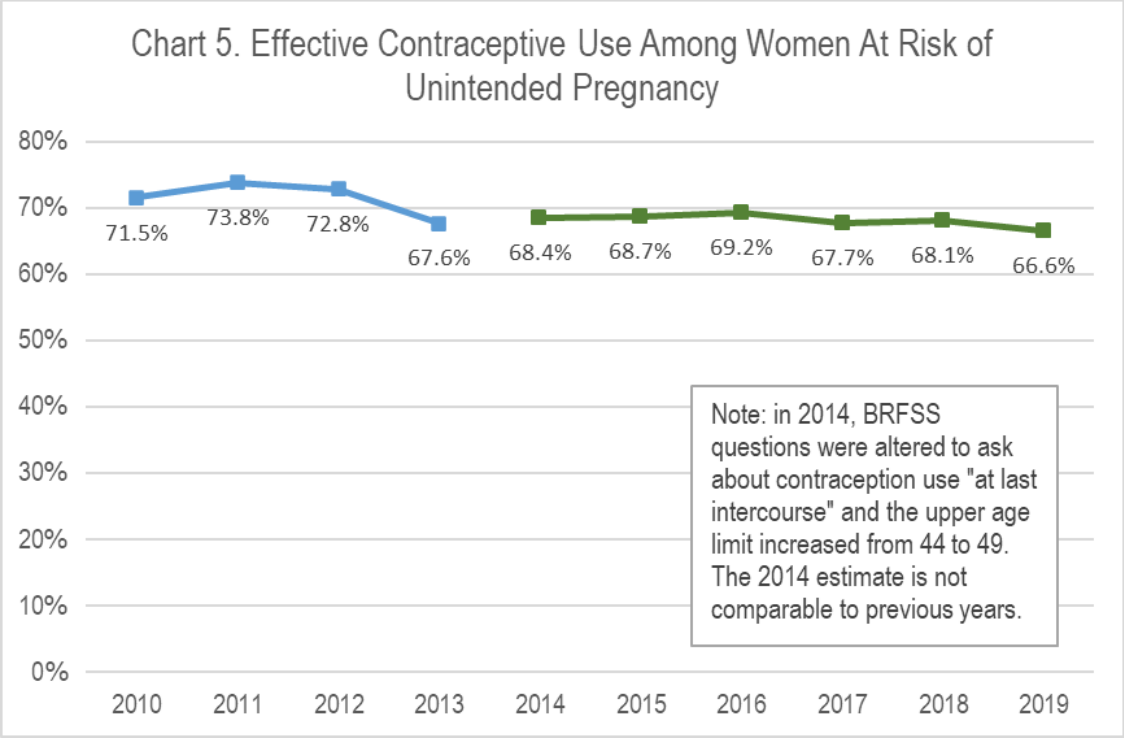
the client survey results, which can be attributed to two factors. First, the wording of these questions has changed from how it was collected in our client survey, highlighting the need to review the phrasing of these questions and possibly reword them in future iterations of the RH Program Enrollment Form. Second, as more individuals gain comprehensive insurance coverage and access to primary care services through ACA and Medicaid expansion, it is possible that clinic staff are not offering assistance to individuals to get primary care coverage or services if there is no need (i.e. the client already has both coverage and access to services). As shown in Chart 4, those without insurance for primary care were much more likely to have received information about both public health insurance and accessing general health services than those with insurance.



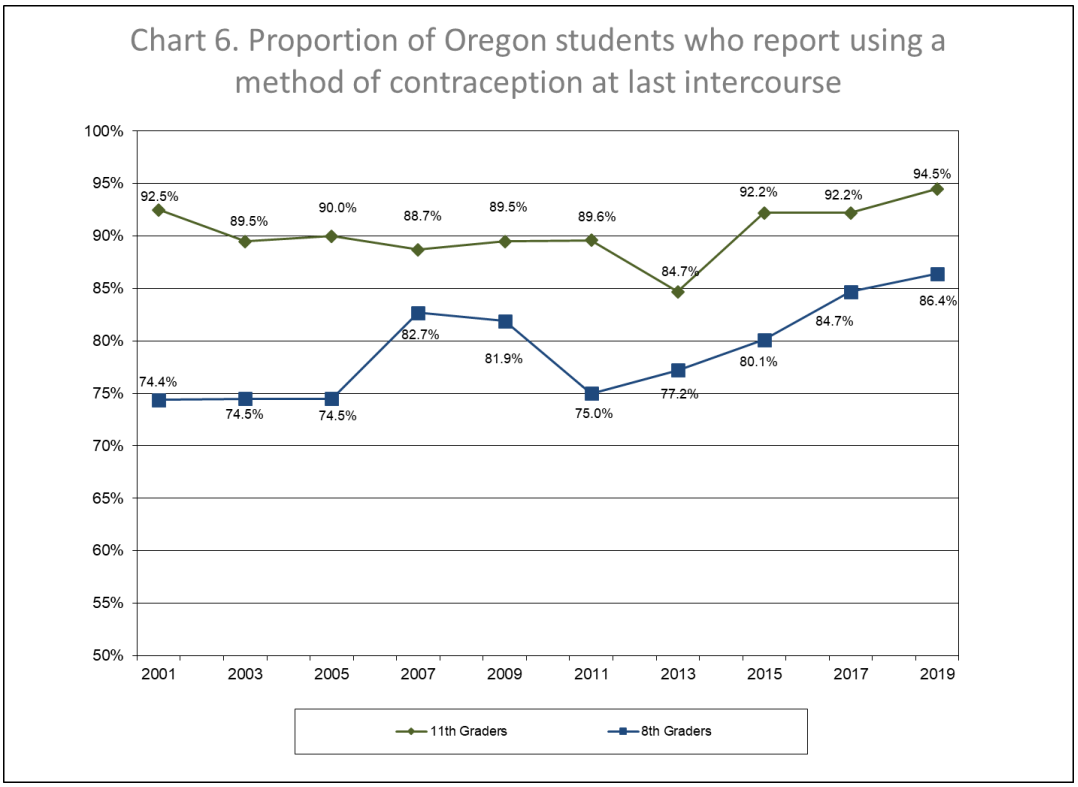
RH Program staff continue to conduct ongoing RH Program Enrollment Form audits on a random sample of medical records. These audits include a review of the primary care referral requirement to ensure that this objective is met. Furthermore, the primary care referral requirement continues to be a focus for provider trainings.

(B) Intermediate Outcomes

- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.
  Data source: Oregon Behavior Risk Factor Surveillance System (BRFSS)
  Performance target: 76.0%
  Progress: To monitor this outcome, we use data from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a CDC-sponsored, population-based, telephone survey of non-institutionalized adults in the state. The specific BRFSS item used to track this outcome first appeared on the questionnaire in 1998 and asks respondents what method they and/or their partners currently use to prevent pregnancy. Beginning in 2002, both male and female respondents answered this item but we restrict our analysis to female respondents to facilitate year-to-year comparisons. Effective contraceptive use is defined as use of all Tier 1 and Tier 2 methods among women 18-49 at risk of unintended pregnancy. Women at risk of unintended pregnancy excludes respondents who have a same sex partner, don't know their birth control use, refuse birth control use, have had a hysterectomy, are currently pregnant, reporting being too old, want to get pregnant, and/or don't care if they get pregnant.



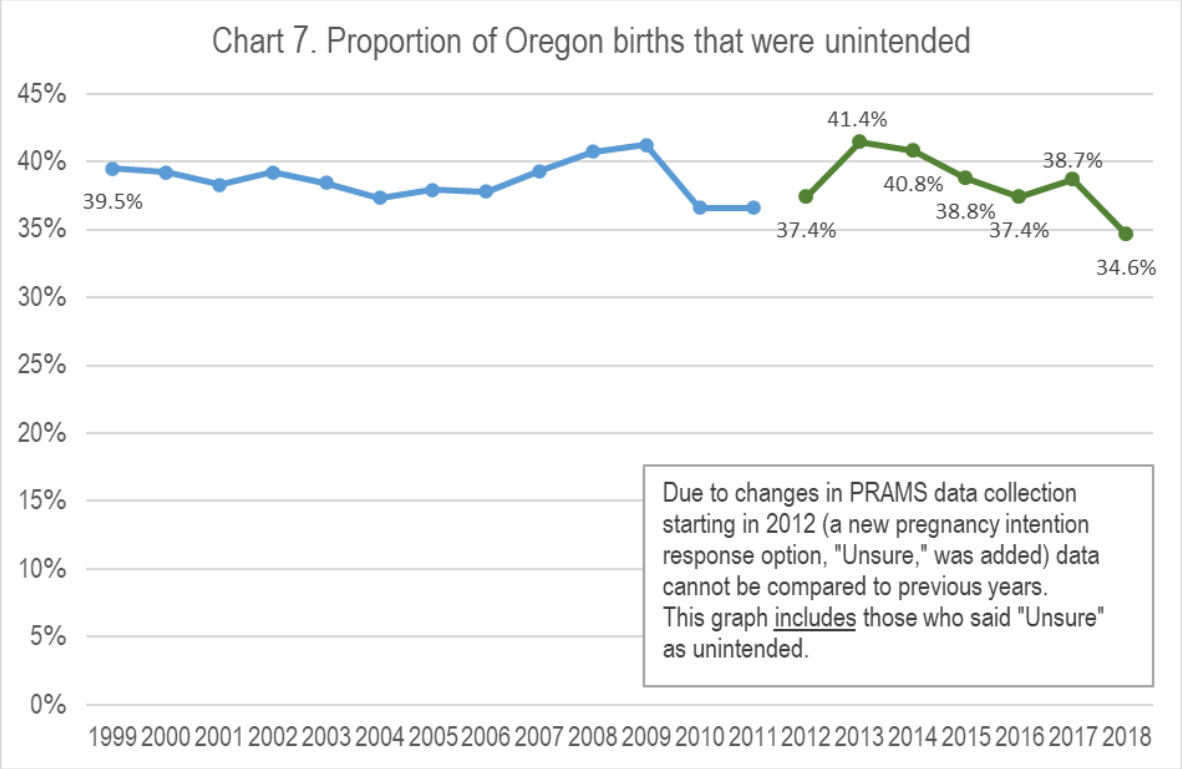
- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.
  Performance targets: 8th grade – 80.0% and 11th grade – 89.5%
  Data source: Oregon Healthy Teens survey (OHT)
  Progress: To determine whether expanded availability of subsidized birth control and contraceptive management services affects birth control use among teens, data from the Oregon Healthy Teens Survey (OHT), a school-based survey, is used. OHT focuses on 8th and 11th grade students. Between 2001 and 2009, OHT was conducted annually; it is now administered every odd year. The OHT questionnaire includes an item asking participants what *one* method of contraception they used to prevent pregnancy at last intercourse. For the purposes of this analysis, students who responded as never having had sex were excluded. Students who said they used a highly effective method (IUD and implant), moderately effective method (Depo, pills, patch, and ring), less effective method (condoms and withdrawal), or an unspecified "other" method were counted among contraceptive method users. Those who responded that they didn't know or were not sure about the method used were counted among the "no method" group. It should be noted that starting in 2017, students were asked to mark "all that apply" so each response was calculated individually, though those who responded that they didn't know or were not sure about the method used were still counted among the "no method" group. Rates of contraceptive use among Oregon students continues to increase; in 2019 94.5% of 11th graders and 86.4% of 8th graders reported using contraception at last intercourse (including only those students who reported ever having sex).



(C) Long-term Outcomes

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.
  Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS)
  Performance target: 36.0%
  Progress: National standard methodology is used to assess pregnancy intent: women are asked to think back before their recent pregnancy and report whether they had wanted to become pregnant at that time, sooner, later, or not at all. Pregnancies that occur too soon are classified as mistimed, those that are not wanted at all are labeled unwanted, and those two categories together form the unintended group. Pregnancies that occur too late or "at about the right time" are considered intended. In 2012, an additional response option was included to the question assessing pregnancy intent: "unsure". Based on analysis of previous years' response breakdowns, the unsure responses have been grouped as part of the unintended category. Because of this change, results for 2012 and after cannot be compared with data from prior years. Chart 7 below details the proportion of Oregon births that were unintended, starting in 1999.

The proportion of births classified as unintended has been declining over the last few years.

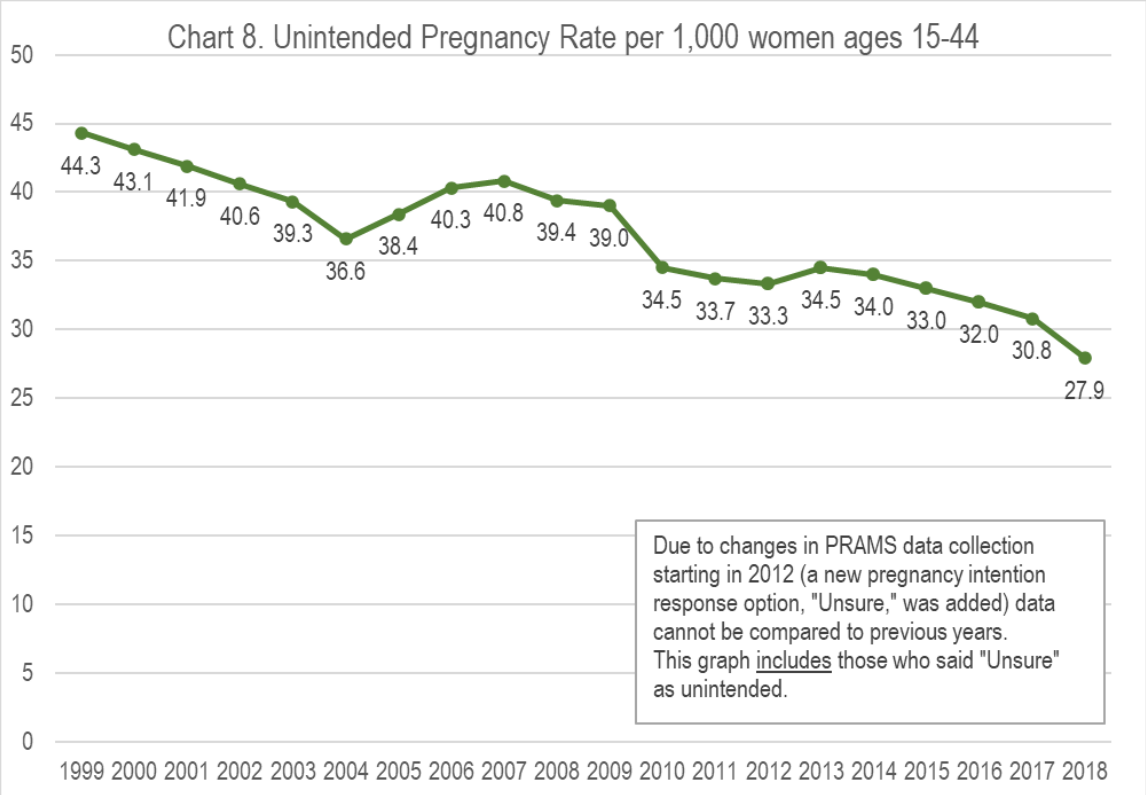


- Outcome 6: The program will result in a decrease in the unintended pregnancy rate in Oregon.
  Data source: Oregon PRAMS and Oregon Center for Health Statistics
  Performance target: 32.0 per 1,000 women 15-44
  Progress: To estimate the unintended pregnancy *rate*, we use a three-step procedure very similar to the one outlined by Stanley Henshaw in his well-known article "Unintended Pregnancy in the United States."[2] In the first step, we estimate the proportion of Oregon's births (not pregnancies) that are unintended using PRAMS data. We then multiply the actual number of births in each year (obtained from the Center for Health Statistics, or CHS) by the unintended proportion to produce an annual number of unintended births in the state. Next, we multiply the annual number of abortions in the state by approximately 0.95 to derive an annual estimate of the number of unintended abortions in the state.[3] Finally, we add the unintended birth and abortion numbers

[2] Henshaw, S. (1998). Unintended Pregnancy in the United States. Family Planning Perspectives, 30(1), 24-29 & 46.

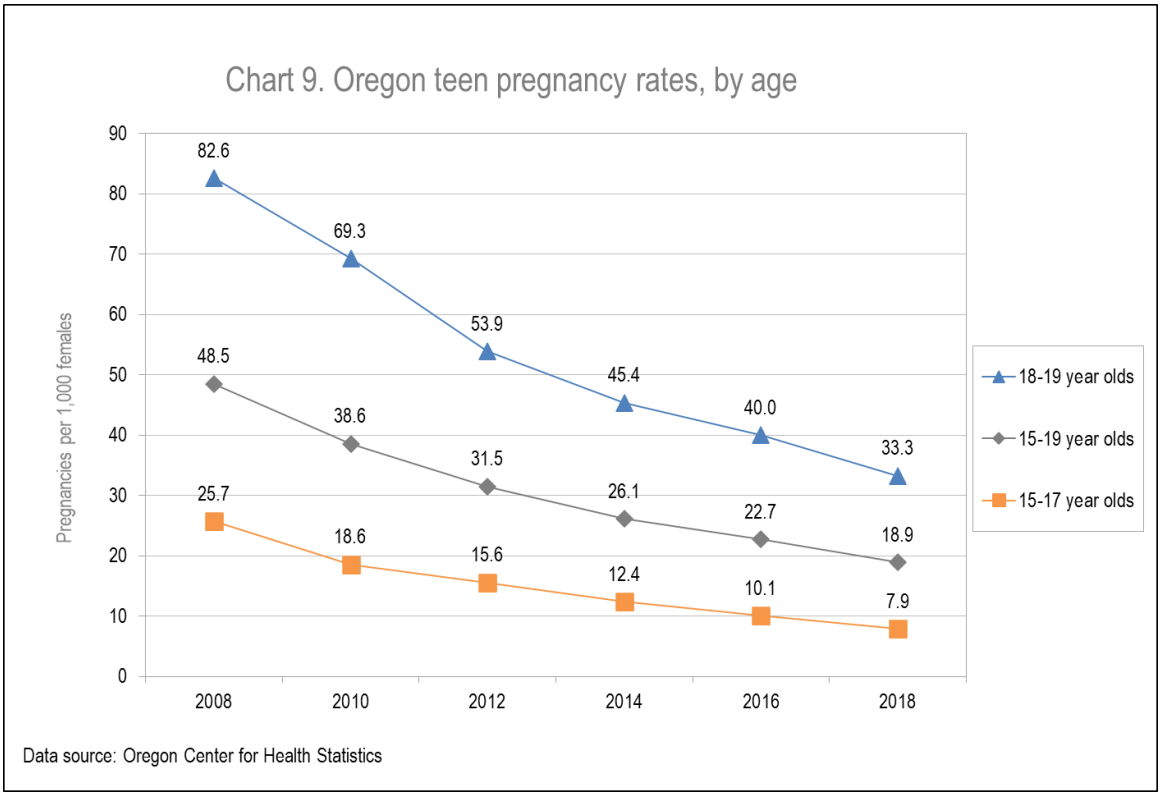
[3] Approximately 95% of abortions are estimated to result from unintended pregnancies. Personal communication: M. Zolna to R. Linz, 01/10/14.

together and divide the result by state population figures to produce an estimated unintended pregnancy rate per 1,000 women aged 15-44. The results of this analysis are shown in Chart 8. Between 2005 and 2007, the unintended pregnancy rate increased slightly to 40.8 per 1,000 women in 2007, but decreased to 33.1 per 1,000 women in 2012. This recent decrease can be attributed largely to the decline in the total number of pregnancies since 2007 and the drop in the unintended birth rate in 2010 and 2011. As with the measure above, data for 2012 and after cannot be compared with data from prior years because of the addition of the new response option "unsure" used to calculate the unintended pregnancy rate. However, it appears that unintended pregnancies have been declining in the last few years, with current rates below the target of 32.0 per 1,000 women age 15-44.



- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.
  Data source: Oregon Center for Health Statistics
  Performance target: 15-17 year olds – 11.0 and 18-19 year olds – 43.5
  Progress: Teen pregnancy has declined dramatically over the last 20 years. In all three age groups, the drop that occurred in the three years following CCare implementation (1999-2002) was greater than the decline experienced in the previous three-year period

(1996 to 1999). Starting in 2005, Oregon teen pregnancy rates increased for the first time in about 10 years, depending on the age group. This trend was reflected nationally, where both teen birth and pregnancy rates rose in 2006, for the first time since 1991.[4] This increase has since reversed, however, with Oregon teen pregnancy rates among all age groups continuing to dramatically decline between 2008 and 2018. As shown in the chart below, these rates are currently at their lowest rates ever since tracking began for this measure (7.9 per 1,000 per 15-17 year olds, 33.3 per 1,000 for 18-19 year olds; and 18.9 per 1,000 for 15-19 year olds).



[4] Guttmacher Institute data report. "U.S. Teenage Pregnancies, Births, and Abortions: National and State Trends and Trends by Race and Ethnicity." January 2010. Accessible at: http://www.guttmacher.org/pubs/USTPtrends.pdf

Annual Post-Award Forum

Per the federal requirements outlined in the Special Terms and Conditions for the current waiver renewal period (42 CFR 431.420(c)), the RH Program conducted a post-award forum for CCare on Friday, March 12, 2021. Information about the post-award forum was posted on the RH Program's website 30 days prior to the forum itself (see notice posted to program website below). Notice of the forum was also included in the February 18, 2021 edition of the RH Update Newsletter, sent to approximately 480 recipients via email. No comments or issues were raised by the public.

Annual CCare Post-Award Forum

In March 2021, the Reproductive Health Program (RH Program), as outlined in 42 CFR 431.420, will hold a post-award forum to solicit comments on the progress of its 1115 family planning demonstration waiver, Oregon ContraceptiveCare (CCare). Members of the public may provide comments regarding CCare on Friday, March 12th from 1:00 pm to 2:00 pm by phone at 877-336-1828, code 829579#. Comments or questions may also be directed to Emily Elman on or before March 12th by phone at 503-407-4195 or in writing at emily.l.elman@dhsoha.state.or.us.

Expenditures

The below table show the quarterly expenditures through the 4th quarter of DY 22.

TABLE 5.
Quarterly Expenditures for DY 22
January 1, 2020 – December 31, 2020

Quarter	Total Expenditures as Reported on the CMS-64
1	$2,490,059
2	$1,639,120
3	$1,557,212
4	$1,346,250
Annual Total	$4,542,582

Budget Neutrality Annual Expenditure Limits

TABLE 6. Demonstration PMPM Ceilings						
Trend	**DY18 (CY2016)**	**DY19 (CY2017)**	**DY20 (CY2018)**	**DY21 (CY2019)**	**DY22 (CY2020)**	**DY23 (CY2021)**
.86%	$34.28	$34.57	$34.87	$35.17	$35.47	$35.78

Budget Limit Calculation:

$35.47 PMPM x 312,121 Member Months = $11,070,931.87

Plus 0.5% per STC 41 = $11,126,286.53

Multiply by 87% (composite federal share admin + direct) = $9,679,869.28

TABLE 7. DY 22 Budget Neutrality Annual Expenditure Limits	
DY 22 Budget Limit	**DY 22 Annual Expenditure**
$9,679,869.28	$4,542,582

Table 7 shows that actual expenditures for DY22 are well within the budget limit. As noted in Table 2, in DY22 CCare experienced a decrease in the number of new enrollments, but an increase in total member-months due to the eligibility extensions that were granted as a result of the Public Health Emergency. Decreased enrollment and decreased utilization of services as a result of the COVID-19 pandemic resulted in lower expenditures for DY22. We expect expenditures to return to pre-COVID levels in the coming years.

Contraceptive Methods

TABLE 8. Number of Contraceptive Methods and Contraceptive Users, CY 2020/DY 22			
	Number of contraceptive methods dispensed	**Number of unique contraceptive users**	**Data source**
Male condom	2,900	1,212	Claims data
Female condom	6	1	
Sponge	2	2	
Diaphragm	33	19	
Pill	8,027	6,976	
Patch	141	137	
Ring	961	799	
Injectable	3,267	1,731	
Implant	1,122	1,418	
IUD	1,439	2,119	
Emergency contraception	3,550	0	
Sterilization	125 (vasectomy)	74	

TABLE 9. Contraceptive Care Quality Measures, CY 2020/DY 22						
	Ages 15-20			**Ages 21-44**		
	Percent	**Numerator**	**Denominator**	**Percent**	**Numerator**	**Denominator**
Most and Moderately Effective Methods	92.2%	4,005	4,344	88.3%	8,930	10,118
LARC Methods	26.0%	1,129	4,344	23.3%	2,359	10,118

Activities for Next Quarter

Oregon's 2021 legislative session begins on January 19th. RH Program staff will track all bills related to reproductive health and provide bill analyses and fiscal impact statements, as appropriate. RH Program staff will also respond to any questions from legislators and the legislative fiscal office related to state general funding of CCare.

Oregon's 1115 family planning Medicaid demonstration waiver is due to expire on December 31, 2021. As such, the RH Program, in collaboration with the Oregon Health Authority's Medicaid office, will work on drafting the CCare waiver renewal application (using the fast track application process) for submission in June 2021 in order to renew the program by the end of the year. The RH Program intends to request a 5-year waiver renewal period with no major changes to waiver or expenditure authorities. As required by state and federal law, the RH Program will engage in all necessary public notice and comment activities as well as tribal consultation.

APPENDIX A: Standards of Care

These standards set forth minimum clinical and administrative services that an agency must offer in order to participate in CCare.

SECTION	DESCRIPTION
(1) Informed Consent The client's decision to participate in and consent to receive family planning services must be voluntary and without bias or coercion.	(a) The informed consent process, provided verbally and supplemented with written materials, must be presented in a language and style the client understands. (b) A signed consent must be obtained from the client before receiving family planning services.
(2) Confidentiality Services must be provided in a manner that respects the client's privacy and dignity in accordance with OAR 333-004-0060(7)(b)(B).	(a) Clients must be assured of the confidentiality of services and of their medical and legal records. (b) Records cannot be released without written client consent, except as may be required by law, or otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).
(3) Availability of Contraceptive Services A broad range of Federal Drug Administration (FDA)-approved contraceptive methods and their applications, consistent with recognized medical practice standards, as well as fertility awareness methods must be available on-site at the clinic for dispensing to the client at the time of the visit.	(a) Clients shall be able to get their first choice of contraceptive method during their visits unless there are specific contraindications. (b) Contraceptive methods, including emergency contraception, must be available at the clinic site and available to the client at the time of service, except as provided in OAR 333-004-0060(8)(a). (c) If the agency's clinical staff lack the specialized skills to provide vasectomies, intrauterine devices or intrauterine contraceptive systems (IUDs/IUSs) or subdermal implants, or if there is insufficient volume to ensure and maintain high skill level for these procedures, clients must be

SECTION	DESCRIPTION
	referred to another qualified provider for these procedures.
(4) Linguistic and Cultural Competence All services, support and other assistance must be provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, languages and behaviors of the client receiving services, and in a manner that has the greatest likelihood of ensuring maximum program participation.	(a) The agency must make interpretation services available to all clients needing or requesting such assistance at no cost to the client. The agency must notify clients in need of interpretation services of the availability of such services in accordance with the Civil Rights Act of 1964 and sections 1557, 1331 and 1001 of the Affordable Care Act (ACA). (A) All persons providing interpretation services must adhere to confidentiality guidelines. (B) Family and friends shall not be used to provide interpretation services, unless requested by the client. (C) Individuals under age 18 shall never be used as interpreters for clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance. (D) The agency should employ bilingual staff, personnel or volunteers skilled or certified in the provision of medical and clinical interpretation that meets the needs of the client during all clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance. (b) The agency must assure the competency of language assistance provided to limited English proficiency clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services, unless requested by the client.

SECTION	DESCRIPTION
Linguistic and Cultural Competence (cont.)	(c) The agency must make interpretation services available to all clients needing or requesting such assistance at no cost to the client. The agency must notify clients in need of interpretation services of the availability of such services in accordance with the Civil Rights Act of 1964. (d) The agency shall make easily understandable print materials available to clients and post signage in the languages of groups represented or commonly encountered in the service area. (e) All print, electronic and audiovisual materials shall be appropriate in terms of the client's language and literacy level. A client's need for alternate formats must be accommodated.
(5) Access to Care Services covered by CCare must be provided without cost to eligible clients. Clients must be informed of the scope of services available through the program.	(a) Appointments for established clients shall be available within a reasonable time period, generally less than two weeks. New clients who cannot be seen within this time period shall be given the option to be referred to other qualified provider agencies in the area. (b) Clinics may offer established clients the option of receiving their contraceptive methods by mail. (A) Use of this option is at the discretion of the client; it cannot be offered as the only way in which to receive contraceptive methods. (B) Contraceptive methods that require a written prescription may only be mailed to established clients who have been using the

SECTION	DESCRIPTION
Access to Care (cont.)	method(s) with no problems or contraindications. (C) Non-prescription methods may be mailed to any established client, regardless of the client's previous use of the method(s). (D) Clients must not incur any cost for the option of receiving contraceptive methods through the mail. (E) Clinics must package and mail supplies in a manner that ensures the integrity of the contraceptive packaging and effectiveness of the method upon delivery. (c) Although not covered by CCare, treatment and supplies for sexually transmitted infections must be available at the clinic site, or by referral. (d) Clients in need of additional medical or psychosocial services beyond the scope of the agency must be provided with information about available local resources, including domestic violence and substance abuse related services. (e) Clients must be offered information about where to access free or low cost primary care services. (f) Clients in need of full-benefit health insurance coverage, private or public, must be given information about how to obtain health insurance enrollment assistance. (g) All services must be provided to eligible clients without regard to race, color, national origin, religion, sex, sexual orientation, gender identity, marital status, age, parity or disability in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A. (h) All counseling and referral-to-care options appropriate to a pregnancy test result during an authorized CCare visit must be provided in a client-centered, unbiased manner, allowing the client full freedom of choice between prenatal

SECTION	DESCRIPTION
	care, adoption counseling or pregnancy termination services.
(6) Clinical and Preventive Services	(a) The scope of services available to clients at each CCare clinic site must include: (A) A comprehensive health history, including health risk behaviors and a complete contraceptive, personal, sexual health, and family medical history; and reproductive health assessment in conjunction with contraceptive counseling; (B) Routine laboratory tests, which may include a Pap test, blood count, and pregnancy test, and health screenings related to the decision-making process for contraceptive choices; (C) Provision of a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception; (D) Vasectomy counseling, including a comprehensive health history that includes health risk behaviors, a complete contraceptive, personal and family medical history, and a sexual health history; (E) Vasectomy or referral for vasectomy; (F) Follow-up care for maintenance of a client's current contraceptive method or to change their method, including removal of a method; (G) Information about providers available for meeting primary care needs and direct

SECTION	DESCRIPTION
Clinical and Preventive Services (cont.)	referral for medical services not covered by CCare, including management of high-risk conditions and specialty consultation if needed; and (H) Preventive services for communicable diseases, provided within the context of a CCare visit, including: (i) Screening tests for sexually transmitted infections (STIs) as indicated; and (ii) Reporting of STIs, as required, to appropriate public health agencies for contact management, prevention, and control. (b) All services must be documented in the client's medical record.

SECTION	DESCRIPTION
(7) Education and Counseling Services	(a) All education and counseling services must be provided using a client-centered approach to help the client clarify their needs and wants, promote personal choice and risk reduction. (b) The following elements comprise the required client-centered education and counseling services that must be provided to all family planning clients: (A) Initial clinical assessment and re-assessment as needed, of the client's educational needs and knowledge about reproductive health, including: (i) Relevant reproductive anatomy and physiology; (ii) Counseling and education about a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception; (iii) A description of services and clinic procedures; (iv) Preventive health care, nutrition, preconception health, pregnancy intention, and STI and HIV prevention; (v) Psychosocial issues, such as partner relationship and communication, risk-taking, and decision-making; and (vi) An explanation of how to locate and access primary care services not covered by CCare. (B) Initial and all subsequent education and counseling sessions must be provided in a way that is understandable to the client and conducted in a manner that respects the dignity and privacy of the client and facilitates the client's ability to make informed decisions about reproductive health behaviors and goals, and must include:

SECTION	DESCRIPTION
Education and Counseling Services (cont.)	(i) An explanation of the results of the physical examination and the laboratory tests; (ii) Information on where to obtain 24-hour emergency care services; (iii) The option of including a client's partner in an education and counseling session, and other services at the client's discretion; and (iv) Effective educational information that takes into account diverse cultural and socioeconomic factors of the client and the psychosocial aspects of reproductive health. (C) Using a client-centered approach, each client must be provided with adequate information to make an informed choice about contraceptive methods, including: (i) A general verbal or written review of all FDA-approved contraceptive methods, including sterilizations and emergency contraception, along with the opportunity for the client to ask questions. Documentation of this method education must be maintained in the client record; (ii) A description of the implications and consequences of sterilization procedures, if provided; (iii) The opportunity for questions concerning procedures or methods; and (iv) Written information about how to obtain services for contraceptive-related complications or emergencies. (D) Specific instructions for care, use, and possible danger signs for the selected method each time the method is dispensed. (E) Clinicians and other agency staff persons providing education and counseling must be

SECTION	DESCRIPTION
Education and Counseling Services (cont.)	knowledgeable about the psychosocial and medical aspects of reproductive health, and trained in client-centered counseling techniques. Agency staff must make referrals for more intensive counseling as indicated.

SECTION	DESCRIPTION
(8) Exceptions	(a) School-Based Health Centers are exempt from the requirement to make contraceptive methods available for on-site dispensing described in section (3) and subsection (5)(b) of this rule. School-Based Health Centers may offer contraceptive methods to clients either on-site or by referral. When offered by referral, School-Based Health Centers must have an established referral agreement in place, preferably with another CCare clinic. RH must be notified of the parties involved in order to ensure proper billing and audit practices. When the referral clinic participates in CCare, that clinic may submit claims directly to CCare for reimbursement of the dispensed supplies. When referral clinics do not participate in CCare, payment arrangements must be made between the referring and receiving clinics. Dispensing by any provider must not result in a charge to the client. (b) Non-School-Based Health Center sites: (A) Agencies may bill CCare for family planning services conducted and contraceptive supplies dispensed at a school site, grade 12 and under, if the site meets the following criteria: (i) The school site must be within a RH-approved distance from the enrolled CCare agency to ensure adequate access to client contraceptive method of choice; and (ii) The school site must have a dedicated, private room for services to be conducted. (B) Agencies that wish to bill CCare for client counseling and education services conducted at school sites must adhere to the following standards: (i) The agency must notify RH of the school site to be enrolled and must request from RH a unique site number for the school site;

SECTION	DESCRIPTION
Exceptions (cont.)	(ii) The agency must receive written approval from the school site to conduct services; (iii) For newly enrolling clients, the agency must ensure that clients meet all eligibility criteria described in OAR 333-004-0020 and are enrolled according to OAR 333-004-0030 at the school site; (iv) For clients already enrolled in CCare, the agency must ensure that clients have active eligibility; (v) The agency must follow all standards of care for family planning services described in OAR 333-004-0060 with the exception of OAR 333-004-0060(3) (supplies dispensed on-site) and OAR 333-004-0060(6) (clinical and preventive services); (vi) The agency must offer clients a written referral to an enrolled CCare clinic for supply pick-up, if not dispensed on-site, and full array of clinical services; and (vii) The agency must submit claims for services conducted at the school site using the assigned project and site number of the school site.