DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

August 9, 2016

Lori Coyner
Medicaid Director
State of Oregon, Oregon Health Authority
500 Summer Street, NE., E-49
Salem, OR 97301

Dear Ms. Coyner:

We are pleased to inform you that Oregon's request for an extension of its section 1115 family planning demonstration, entitled "Oregon Contraceptive Care" (CCare) (formerly Oregon Family Planning Program) (project number 11-W-00142/0), has been approved. We congratulate Oregon on being the second state to use CMS' Fast Track extension application process and the first state to submit its application utilizing CMS' streamlined application templates.

Under this demonstration, the state will cover family planning services for men and women of childbearing age who are otherwise not eligible for Medicaid or the Children's Health Insurance Program (CHIP) and whose household income is at or below 250 percent of the Federal poverty level. Approval of this demonstration extension is granted under the authority of section 1115(a) of the Social Security Act and is effective as of the date of this letter through December 31, 2021.

Our approval of this demonstration project is subject to the limitations specified in the approved Special Terms and Conditions (STCs), expenditure authorities, and list of non-applicable title XIX requirements accompanying this award letter. All Medicaid title XIX requirements as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in these approval documents shall apply to the Oregon CCare demonstration. The state's authority to deviate from Medicaid requirements is limited to the specific expenditure authorities and non-applicables described in the enclosed approval documents, and to the purpose(s) indicated.

CMS' approval of this demonstration extension is also conditioned upon the state's continued compliance with the enclosed STCs defining the nature, character, and extent of federal involvement in this project. This award letter is subject to our receipt of your written acceptance of the award, including the STCs and associated authorities, within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Patricia Hansen, who can be contacted to answer any questions concerning the implementation of this demonstration at (410) 786-4252 or at patricia.hansen1@cms.hhs.gov. Official communications regarding program matters and correspondence concerning the demonstration should be submitted to her at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244-1850

Official communications regarding program matters should be submitted simultaneously to Ms. Hansen and to Mr. David Meacham, Associate Regional Administrator, in our Seattle Regional Office. Mr. Meacham's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
701 Fifth Avenue, Suite 1600 - MS/RX-200
Seattle, WA 98104

We extend our congratulations to you on this award and look forward to working with you during the course of the demonstration extension.

Sincerely,

/s/

Vikki Wachino
Director

Enclosures

cc: David Meacham, Associate Regional Administrator, CMS Region X
Janice Adams, State Representative, CMS Region X

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00142/0**

TITLE: **Oregon Contraceptive Care (CCare) (formerly Oregon Family Planning Program)**

AWARDEE: **Oregon Health Authority**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Oregon for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities, except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as "not applicable" enable Oregon to operate this section 1115 Medicaid family planning demonstration effective August 9, 2016 through December 31, 2021. CMS is specifically approving expenditure authority to extend Medicaid eligibility for family planning services to men and women of child bearing age who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and whose household income is at or below 250 percent of the Federal poverty level.

These expenditure authorities promote the objectives of title XIX in the following ways:

- increases and strengthens overall coverage of low-income individuals in the state; and,
- improves health outcomes for Medicaid and other low-income populations in the state.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Amount, Duration, and Scope of Services (Comparability) **Section 1902(a)(10)(B)**

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of approved family planning services.

2. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics **Section 1902(a)(15)**

The state will establish reimbursement levels to these clinics that will compensate them solely for family planning services.

3. Eligibility Procedures **Section 1902(a)(17)**

Parental income will not be included when determining a minor's (individual under age 18) eligibility for the family planning demonstration.

4. Retroactive Coverage **Section 1902(a)(34)**

Individuals enrolled in the family planning demonstration will not be retroactively eligible.

5. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) **Section 1902(a)(43)(A)**

The state will not furnish or arrange for EPSDT services to the demonstration population.

Centers for Medicare & Medicaid Services

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00142/0**

TITLE: **Oregon Contraceptive Care (CCare) (formerly Oregon Family Planning Program)**

AWARDEE: **Oregon Health Authority**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Oregon's section 1115(a) Medicaid family planning demonstration entitled, "Contraceptive Care (CCare)" (formerly Oregon Family Planning Program) (hereinafter "Demonstration"). The parties to this agreement are the Oregon Health Authority (OHA) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These STCs are effective August 9, 2016 through December 31, 2021. All previously CMS approved STCs, waivers, expenditure authorities, and/or non-applicable title XIX requirements are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

Effective through December 31, 2021, the Oregon CCare section 1115(a) Medicaid demonstration expands the provision of family planning services to men and women of child bearing age who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and whose household income is at or below 250 percent of the Federal Poverty Level (FPL).

Historical Context and Objectives

On October 14, 1998, CMS approved the precursor to this Medicaid section 1115(a) demonstration proposal titled "Oregon Family Planning Expansion Project" (now known as "Oregon ContraceptiveCare" or "CCare"), designed to expand the availability of Medicaid-supported contraceptive management services to a wider population base. The program was implemented on January 1, 1999 and has been consistently extended by CMS since that date. The current extension of this demonstration program is being granted for an additional five years beyond the current demonstration approval period, i.e., through December 31, 2021.

The goal of the Oregon ContraceptiveCare (CCare) demonstration 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 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. Services are provided through a statewide public network of family planning providers that consists of clinics, County Health Departments, Federally Qualified Health Centers and Rural Health Clinics, college/university health services and School-Based Health Centers as well as private providers.

CMS and Oregon expects this demonstration program will promote Medicaid program objectives by:

- Increasing the proportion of clients who use a highly effective or moderately effective contraceptive method;
- Increasing the proportion of clients who receive help to access primary care services and comprehensive health coverage;
- Increasing the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method;
- Increasing the proportion of sexually experienced high school students who report using a method of contraception at last intercourse;
- Decreasing the proportion of Oregon births classified as unintended;
- Decreasing the unintended pregnancy rate in Oregon; and,
- Decreasing teen pregnancy rates in Oregon.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration .

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occurs during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

    a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

    b) If mandated changes in federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process.** Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below. The state will notify CMS of proposed demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs including, but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the state consistent with the requirements of STC 13 to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;

   c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and,

   d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration**. No later than 12 months prior to the expiration date of the demonstration, the Governor of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR 431.412(c) or a phase-out plan consistent with the requirements of STC 8.

8. **Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, at any time prior to the date of expiration.

   a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six (6) months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty (30) day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the received comments into the transition and phase-out plan submitted to CMS.

   b) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices including information on the beneficiary's appeal rights, the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected

beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities and community resources that are available.

c) Phase-out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of phase-out activities. Implementation of phase-out activities must be no sooner than fourteen (14) days after CMS approval of the phase-out plan.

d) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as found in 42 CFR 435.916.

e) Exemption from Public Notice Procedures 42.CFR 431.416(g): CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of titles XIX or XXI would be served or under circumstances described in 42 CFR 431.416(g).

f) Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration as described in STC 7, during the last six (6) months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. **CMS Right to Amend, Terminate or Suspend.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

10. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply with the terms of this agreement.

11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the

withdrawal, together with the effective date, and must afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other demonstration components.

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR 431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6 are proposed by the state.

    a) *Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations*. In states with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    b) *Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals, and Amendments*. In states with Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.

14. **Federal Financial Participation (FFP).** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

15. **Use of Modified Adjusted Gross Income (MAGI) Based Methodologies.** The state must use the state's CMS-approved MAGI standard for determination of eligibility for the

demonstration. Any other Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, or any future CMS-approved revisions to the state's MAGI standard taking place during this approval period, will apply to this demonstration.

16. **Eligibility Requirements.** Family planning services are provided to eligible individuals, provided the individual is redetermined eligible for the program on an annual basis. Additionally, the state will provide twelve (12) month continuous eligibility, and not require reporting of changes in income or household size for this twelve (12) month period, for an individual found to be income-eligible for this demonstration upon initial application or annual redetermination.

    Effective through December 31, 2021, eligibility for this demonstration is limited to men and women of child bearing age who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and whose household income is at or below 250 percent of the FPL.

17. **Redeterminations.** The state must ensure that redeterminations of eligibility for the demonstration are conducted at least every twelve (12) months. At the state's option, redeterminations may be administrative in nature.

18. **Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the demonstration, she may be determined eligible for Medicaid under the state plan. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid state plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from this demonstration.

III. BENEFITS AND DELIVERY SYSTEMS

19. **Family Planning Benefits.** Individuals eligible under this demonstration will receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act, which are reimbursable at the 90 percent Federal matching rate. The specific family planning services provided under this demonstration are as follows:

    a) FDA-approved methods of contraception;

    b) Laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception;

    c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements, subject to the national drug rebate program requirements;

d) Contraceptive management, patient education, and counseling; and,

e) Vasectomies for men over the age of 21.

20. Minimum Essential Coverage (MEC). The CCare demonstration is limited to the provision of family planning services as described in STC 19 and 20; thereby, the demonstration is not recognized as MEC as communicated by CMS in its February 12, 2016 correspondence to the state regarding our designation of MEC for the state's section 1115 demonstrations.

21. Primary Care Referrals. Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.

22. Delivery of Services. Services under this demonstration are provided through a fee-for-service (FFS) delivery system.

VI. GENERAL REPORTING REQUIREMENTS

23. General Financial Requirements. The state must comply with all general financial requirements under title XIX set forth in section VII.

24. Reporting Requirements Relating to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.

25. Monitoring Calls. CMS and the state will participate in quarterly conference calls following the receipt of the quarterly reports, unless CMS determines that more frequent calls are necessary to adequately monitor the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, anticipated or proposed changes in payment rates, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, state legislative developments, and any demonstration amendments the state is considering submitting. The state and CMS will discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS will update the state on any amendments under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

26. Quarterly Operational Reports. The state must submit quarterly operation reports for the first three quarters in a DY. The fourth quarter report should be submitted as part of the annual report. The state must submit progress reports no later than sixty (60) days following

the end of each quarter for every demonstration year (DY) using the format outlined in Attachment A. The state must submit the quarterly report through CMS' designated system. The intent of these reports is to present the state's data along with an analysis of the status of the various operational areas under the demonstration. The Quarterly Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section. These quarterly reports must include, but are not limited to:

a) A summary of current notable program activity. This includes highlights of activity occurring during the quarter, or anticipated to occur in the near future, pertaining to provider participation, health care delivery, benefits, eligibility, enrollment, beneficiary complaints, grievances, and/or appeals, quality of care, access, payment rates, pertinent legislative activity, and other operational issues;

b) Quarterly enrollment and member month counts (per STC 33) for demonstration enrollees (defined as any individual who obtains a covered family planning service through the demonstration) as required to evaluate compliance with the budget neutral agreement;

c) Notification of any changes in enrollment and/or participation that fluctuate ten (10) percent or more in relation to the previous quarter; and,

d) Quarterly expenditures for the demonstration population as reported on the CMS-64 (per STC 30) as required to evaluate compliance with the budget neutral agreement;

27. Annual Report. The state must submit annual reports that, at a minimum, include the requirements outlined below using the format outlined in Attachment A. The state's fourth quarter progress report for each demonstration year (DY) may serve as the state's annual report. The state must submit the annual report through CMS' designated system. The fourth quarter/annual report shall include an end of year summary of the program elements as reported in each quarterly report for the DY. The annual report is due ninety (90) days following the end of the fourth quarter of each DY. The Annual Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section

a) All program items included in the quarterly report pursuant to STC 26 must be summarized to reflect activities throughout the DY;

b) Total annual expenditures for the demonstration population;

c) Total annual member month count for demonstration enrollees as required to evaluate compliance with the budget neutral agreement as specified in STC 39;

d) Annual budget neutrality target calculation;

e) Annual enrollment counts for the demonstration population by race/ethnicity;

f) Annual disenrollment/retention figures;

g) Summary of program outreach activities that occurred during the DY;

h) Summary of program evaluation activities and any interim evaluation findings;

i) End-of-year report on the utilization of contraceptive methods dispensed during the DY and percentage of usage by women between ages 15-44;

j) A summary of the annual post award public forum conducted by the state as required by 42 CFR 431.420(c) and,

k) Summary of program integrity and related audit activities for the demonstration.

28. Final Demonstration Report. The state must submit a final demonstration report to CMS to describe the impact of the demonstration, including the extent to which the state met the goals of the demonstration. The draft report will be due to CMS 120 days after the expiration of the demonstration. CMS must provide comments within sixty (60) days of receipt of the draft final demonstration report. The state must submit a final demonstration report within sixty (60) days of receipt of CMS comments.

VII. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

29. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports to report total expenditures for services provided under this Medicaid section 1115(a) demonstration following routine CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined cost limits specified in STC 39.

30. Reporting Expenditures Subject to the title XIX Budget Neutrality Agreement. The following describes the reporting of expenditures subject to the budget neutrality limit:

a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES). All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project

number extension, which indicates the DY in which services were rendered or for which capitation payments were made.

b) Use of Waiver Forms. The state must report demonstration expenditures on separate forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report title XIX expenditures for demonstration services. The state will use the waiver name "Family Planning Dem." to report expenditures in the MBES/CBES system.

c) MBES/CBES Schedule C Reporting Adjustments. The state must submit prior period adjustments subsequent to the routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual to report actual expenditures incurred for demonstration services in DY13 (CY2011) through DY17 (CY2015). The state must complete similar adjustments to separately report administrative costs that are directly attributable to the demonstration for DY13 through DY17. The state shall complete these reporting adjustments within twelve (12) months of the date of CMS' approval of this extension and provide written certification of the accuracy of the adjusted expenditures upon completion. The state must provide an update on the progress of these adjustments during the CMS monitoring calls described in STC 26.

d) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C.

31. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on Form CMS-64.10.

32. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two (2) years after the conclusion or termination of the demonstration. During the latter two (2) year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

33. Reporting Member Months. The following describes the reporting of member months for the demonstration:

a) For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the quarterly and annual reports as required under STC 27 and 28 respectively, the actual number of eligible member months for all demonstration

enrollees. The state must submit a statement accompanying the quarterly and annual reports, certifying the accuracy of this information.

b) The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two (2) months, each contribute two eligible member months, for a total of four eligible member months.

34. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

35. Extent of Federal Financial Participation (FFP) for the Demonstration. CMS shall provide FFP for family planning services at the applicable federal matching rates as described in STC 19, subject to the limits and processes described below:

a) For family planning services, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

b) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in STC 19, should be entered in Column (D) on Form CMS-64.9 Waiver.

c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the ninety (90) percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

d) Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and

furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

36. Sources of Non-Federal Share. The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a) CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

b) Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

37. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of

the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

VIII. MONITORING BUDGET NEUTRALITY

The following is the method by which budget neutrality will be monitored for the Oregon Contraceptive Care (CCare) section 1115(a) Medicaid demonstration.

38. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding it may receive on approved demonstration service expenditures incurred during the period of demonstration approval. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the approved demonstration period. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 30.

39. Budget Neutrality Annual Expenditure Limits. For each DY, an annual budget limit will be calculated for the demonstration. This program's annual demonstration cycle is calendar year (i.e., January 1 - December 31). The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share.

PMPM Cost. The following table provides the approved demonstration cost trend (based on the state's historical rate of growth) and the PMPM (total computable) ceiling for each DY.

	Trend	DY 18 (CY2016)	DY 19 (CY2017)	DY 20 (CY 2018)	DY 21 (CY 2019)	DY 22 (CY2020)	DY 23 (CY 2021)
Demonstration PMPM Ceilings	.86%	$34.28	$34.57	$34.87	$35.17	$35.47	$35.78

a) Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC 30 above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the approval period (see STCs 8 and 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

b) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures reported by the state on the CMS-64 forms. If at the end of

the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS. If the costs of the demonstration services do not exceed the budget limit, the state may not derive or utilize any such savings.

40. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

41. Enforcement of Budget Neutrality. CMS will enforce budget neutrality over the life of this demonstration approval period. However, no later than six (6) months after the end of each DY or as soon thereafter as the data are available, the state will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the state exceeds these targets, it will submit a corrective action plan to CMS for approval as outlined in STC 42.

Demo Year	Cumulative Target Definition	Percentage
DY 18 (CY 2016)	DY 18 budget limit amount plus:	2.0 percent
DY 19 (CY 2017)	DYs 18 through 19 combined budget limit amount plus:	1.5 percent
DY 20 (CY 2018)	DYs 18 through 20 combined budget limit amount plus:	1.0 percent
DY 21 (CY 2019)	DYs 18 through 21 combined budget limit amount plus:	1.0 percent
DY 22 (CY 2020)	DYs 18 through 22 combined budget limit amount plus:	0.5 percent
DY 23 (CY 2021)	DYs 18 through 23 combined budget limit amount plus:	0 percent

42. Budget Neutrality Corrective Actions. The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which must include submitting a corrective action plan to CMS within twenty-one (21) days of the date the state is informed of the problem. While CMS will pursue corrective actions with the state, CMS will work with the state to set reasonable goals that will ensure that the state is in compliance.

IX. EVALUATION

43. Evaluation Design. The CMS approved state evaluation design for this demonstration program is incorporated in these STCs as Attachment B. Should the state choose to change the evaluation design (such as changes to research hypotheses, objectives, or research

methodologies), it must submit an amendment request as set forth in STC 6. The Evaluation Design must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section

44. Final Evaluation Plan and Implementation. CMS shall provide comments on a proposed revised design within sixty (60) days of receipt, and the state must submit a final plan for the overall evaluation of the demonstration outlined in STC 43 within sixty (60) days of receipt of CMS comments.

45. Interim Evaluation Report. The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration as required by 42 CFR 431.412(c)(2)(vi). The interim evaluation report will discuss evaluation progress and present findings to date based on the approved evaluation plan. The Interim Evaluation Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section

46. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by CMS; including submission of any required data to CMS or its contractor.

47. Final Evaluation Report. The state must submit to CMS a draft of the final evaluation report within 120 days following the expiration of the demonstration. The Final Evaluation report shall include items as required in the approved Evaluation Design. The state will present to and participate in a discussion with CMS on the interim and final evaluations. The state must take into consideration CMS' comments for incorporation into the final report. CMS will provide any comments within sixty (60) days of the submission of the draft final evaluation report. The final evaluation report is due to CMS no later than sixty (60) days after receipt of CMS' comments. The Evaluation Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Quarterly Report	Within 60 days following the end of each quarter	STC 26
Annual Report	Within 90 days following the end of the 4th quarter for each DY	STC 27
Draft Final Report	Within 120 days after the expiration of the demonstration	STC 28
Final Report	Within 60 days receipt of CMS comments	STC 28

ATTACHMENT A: Template for Quarterly and Annual Operational Reports

Oregon CCare
Section 1115 Quarterly Report
Demonstration Year X, Quarter X
Federal Fiscal Quarter X
Date Submitted

Introduction

Provide a brief historical background and overview of the demonstration (e.g., populations served, benefits provided, overall goals/objectives of the demonstration, etc.).

Executive Summary

- *Current Trends or Significant Program Changes*
  - Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes).
  - Narrative on any noteworthy demonstration changes, such as changes in enrollment, service utilization, and provider participation. Discussion of any action plan if applicable.

- *Policy Issues and Challenges*
  - Narrative of any operational challenges or issues the state has experienced.
  - Narrative of any policy issues the state is considering, including pertinent legislative/budget activity and potential demonstration amendments.
  - Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable.

Enrollment

- Include a narrative of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter.

- Please utilize the chart below to provide data on the number of individuals enrolled in the demonstration as of the end of the quarter and associated eligible member months (as defined in STC 33).

	Quarter 1 (fill in quarter dates)	**Quarter 2 (fill in quarter dates)**	**Quarter 3 (fill in quarter dates)**	**Quarter 4 (fill in quarter dates)**
# of Total Enrollees				
# of Member Months				

Service Providers

- Provide a narrative on current provider participation; highlighting any current or expected changes in provider participation, planned eligibility provider outreach and the implication for health care delivery.

Program Monitoring

- Identify any quality monitoring activities in current quarter.

- Provide a narrative of any feedback and grievances made by beneficiaries, providers, or the public; including any public hearings or other notice procedures, with a summary of the state's response or planned response.

Expenditures

- As outlined in Section VII of these STCs, the state is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration. Please also include those CMS-64 reported expenditures in the chart below.

Demonstration Year XX [fill in start & end dates]	**Service Expenditures as Reported on the CMS-64 (Total Computable)**
Quarter 1 - CMS 64 Service Expenditures	
Quarter 2 - CMS 64 Service Expenditures	
Quarter 3 - CMS 64 Service Expenditures	
Quarter 4 - CMS 64 Service Expenditures	
Total DY Annual Expenditures	

Activities for Next Quarter

- Report on any anticipated activities for next quarter.

Additional Information to Provide in Fourth Quarter/Annual Reports:

In addition to the information outlined above for quarterly reports, the state's fourth quarter/end-of-year report shall also include information on the below program elements:

Expenditures

- End-of-year calculation of total quarterly expenditures claimed for the demonstration year and a comparison against the budget neutrality target as outlined in STC 41. The state

will also provide a narrative on any budget neutrality issues the state has identified. If the state has exceeded the defined cumulative target for the demonstration year, please include a description of the state's intended corrective action plan.

Enrollment

- Annual enrollment for the demonstration year and end-of year enrollment for the most recent five (5) years of the demonstration (including the current demonstration year). Provide narrative on any observed trends and explanation of data.
- Annual enrollment by race/ethnicity for the current demonstration year.
- Annual disenrollment and Retention figures
    - Discuss the current demonstration year's retention and disenrollment figures; including top reasons for disenrollment, trends observed throughout the demonstration year, and comparison to previous demonstration years.

Program Outreach and Education

- *General Outreach and Awareness*
    - Provide information on the public outreach and education activities conducted this demonstration year; and,
    - Provide a brief assessment on the effectiveness of these outreach and education activities.
- *Target Outreach Campaign(s) (if applicable)*
    - Provide a narrative on the populations targeted for outreach and education campaigns and reasons for targeting; and,
    - Provide a brief assessment on the effectiveness of these targeted outreach and education activities.

Program Evaluation and Monitoring

- Identify an overall summary of quality assurance and monitoring activities conducted in the demonstration year; including a discussion of program evaluation activities, how the state is progressing on meeting its stated goals/performance targets, and any interim evaluation findings.
- Provide a summary of the annual post award public forum conducted by the state as required by 42 CFR 431.420(c) that includes a report of any issues raised by the public and how the state is considering such comments in its continued operation of the demonstration.
- Provide a summary of any program integrity and related audit activities for the demonstration that occurred in the demonstration year.

Contraceptive Methods

- Using the below chart, indicate the *number of each contraceptive method dispensed* in the demonstration year. If the state did not receive any claims for a specific contraceptive method in the current year, enter a zero ("0"). If the state does not cover a specific method under its demonstration, enter not applicable ("N/A"). The *number of unique contraceptive users* should identify the number of unique beneficiaries who received a given method in the demonstration year. The *data source* column should specify the type

of data used to describe the specified contraceptive method (i.e., MMIS data, claims data, chart review, etc.).

Oregon Family Planning Demonstration – Contraceptive Methods			
Demonstration Year X (mm/dd/yy – mm/dd/yy)			
	Number of contraceptive method dispensed	Number of unique contraceptive users	Data source
Male Condom			
Female Condom			
Sponge			
Diaphragm			
Pill			
Patch			
Ring			
Injectable			
Implant			
IUD			
Emergency Contraception			
Sterilization			

- Using the below chart, provide information on the CMS measure "Contraceptive Utilization by Women." This measure assesses the percentage of women ages 15–44 that:
    - Adopted or continued use of the most effective or moderately effective FDA-approved methods of contraception.
    - Adopted or continued use of a long-acting reversible method of contraception (LARC).

  Two rates are reported for each measure, one for ages 15–20 and one for ages 21–44. Specifications may be found on CMS' Maternal and Infant Health Care Quality page, under the "Data and Measurement" tab. See webpage at: (https://www.medicaid.gov/medicaid chip-program-information/by-topics/quality-of-care/maternal-and-infant-health-care quality.html).

	Ages 15-20			Ages 21-44		
	Rate	Numerator	Denominator	Rate	Numerator	Denominator
Most and Moderately Effective Methods						
LARC Methods						

ATTACHMENT B: CMS Approved Evaluation Design

The state has developed revised outcome measures for this demonstration extension period that reflect the current healthcare landscape and goals of the program. The program's outcomes can be grouped into three categories: (A) immediate outcomes for CCare clients; (B) intermediate outcomes for both CCare clients and the demonstration's target population; and, (C) long-term outcomes for Oregon's reproductive-age population as a whole. These proximal, intermediate, and longer-term outcomes are related to the program's overall goal of improving the well-being of children and families by reducing unintended pregnancies and providing assistance in accessing primary health care services and comprehensive health care coverage. Performance targets have been set for each outcome and will be monitored annually to measure progress toward these goals.

(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.**

  Performance target: 92.5%
  Current rate (2014): 91.7%

  Data Source/Research Methodology: RH Program Data System, Clinic Visit Record (CVR) data. A CVR is completed for each CCare encounter and includes a unique client identifier, demographics, contraceptive methods used, and services received. The program tracks utilization of effective contraceptive methods, including all Tier 1 and Tier 2 methods, among unduplicated female clients of all ages who are at risk of unintended pregnancy. The denominator, women at risk of unintended pregnancy, excludes clients who are using no method because they are pregnant, seeking pregnancy, or not currently sexually active.

- **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.**

  Performance target: 50%
  Current rate (2015): 40%

  Data Source/Research Methodology: RH Program Customer Satisfaction Survey. The RH Customer Satisfaction Survey (CSS) is 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. It is not possible to distinguish between clients with CCare and other sources of pay in the CSS data. Therefore, we are unable to assess whether those who did not report receiving assistance are non-CCare clients, and to whom the requirement does not apply, which is why the performance target is set at a low rate.

(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.**

  Performance target: 76.0%
  Current rate (2013): 68.7%

  Data Source/Research Methodology: Oregon Behavior Risk Factor Surveillance System (BRFSS). The Oregon Reproductive Health Program sponsors a Family Planning Module in the Oregon BRFSS annually. This Module is asked of women ages 18-44 (and males 18-59, but male respondents are not included in this outcome) and includes questions regarding contraceptive use and reasons for non-use of contraception. This objective assesses use of effective contraceptive methods, including all Tier 1 and Tier 2 methods, among women 18-44 at risk of unintended pregnancy. The denominator, women at risk of unintended pregnancy, excludes respondents who have a same sex partner, don't know their birth control use, refuse to answer any of the Family Planning Module questions, have had a hysterectomy, are currently pregnant, report 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%
  Current rates (2013): 8th grade – 77.2% and 11th grade – 84.7%

  Data Source/Research Methodology: Oregon Healthy Teens survey (OHT). The OHT survey is administered biennially to students in 8^{th} and 11^{th} grade. OHT includes questions regarding whether students have ever engaged in sexual activity, whether they are currently sexually active, and what contraceptive method(s) they used at last intercourse. This outcome measures the proportion of sexually experienced, defined as those who have ever had intercourse, 8^{th} and 11^{th} graders who indicated using birth control pills, Depo Provera, condoms, or an "unspecified method".

(C) Long-term Outcomes

- **Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.**

  Performance target: 36.0%
  Current rate (2012): 37.2%

Data Source/Research Methodology: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS). The PRAMS survey is administered to women who have had a live birth approximately 3 months after their delivery. The survey includes questions regarding pregnancy intention. This outcome measures the proportion of respondents who reported that their most recent birth was either mistimed or unwanted are classified as unintended.

- **Outcome 6: The program will result in a decrease in the unintended pregnancy rate in Oregon.**

  Performance target: 32.0 per 1,000 women 15-44
  Current rate (2012): 33.1 per 1,000 women 15-44

  Data Source/Research Methodology: Oregon PRAMS and Oregon Center for Health Statistics. The unintended pregnancy rate is derived from a multi-step procedure in which the proportion of births that are unintended (from PRAMS, see Outcome 5) is multiplied by the actual number of birth in each year (obtained from the Oregon Center for Health Statistics) to produce an annual number of unintended births in the state. Next, the annual number of abortions in the state is multiplied by .95 (research suggests that approximately 95% of abortions are thought to result from unintended pregnancies) to estimate the number of unintended abortions in the state. The unintended birth and abortion numbers are added together and divided by state population figures to produce an unintended pregnancy rate per 1,000 women 15-44.

- **Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.**

  Performance target: 15-17 year olds – 11.0 and 18-19 year olds – 43.5
  Current rate (2014): 15-17 year olds – 12.4 and 18-19 year olds – 45.4

  Data Source/Research Methodology: Oregon Center for Health Statistics. Teen pregnancy estimates are based upon the estimated number of teen births and induced terminations reported among Oregon teens; they do not include the number of fetal deaths or miscarriages (spontaneous abortions) which occur.