oregon**contraceptive**care

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

Demonstration Year 23
Fourth Quarter (October – December 2021)/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 was effective through December 31, 2021 and has been temporarily extended through June 30, 2022.

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) 23 for the waiver and associated report submission due dates.

TABLE 1.
Oregon Family Planning Waiver
Report Timeline Dates for CY 2021/DY 23

Quarter	Begin Date	End Date	Quarterly Report Due
1	January 1, 2021	March 31, 2021	May 31, 2021
2	April 1, 2021	June 30, 2021	August 31, 2021
3	July 1, 2021	September 30, 2021	November 30, 2021
4	October 1, 2021	December 31, 2021	March 31, 2022*

*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 23, 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 a full 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, throughout 2021 (DY 23), 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. Throughout the pandemic, clinics implemented 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. However, by the end 2021, all CCare agencies were offering the full scope of in-person visits again. Data regarding client enrollment trends for DY 23 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 early on in the pandemic 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).

While clinic staffing shortages have consistently been an issue, particularly among clinics in rural/frontier areas, COVID-19 has exacerbated this problem. Many of the CCare clinics in the eastern region of the state are local public health authorities (LPHAs) which have been heavily tasked with pandemic response and recovery efforts. In the past year, many of these LPHAs

have experienced significant staff turnover, particularly among nurses (both RNs and NPs). This has been proven to be a barrier to clients accessing services and supplies. Clinics have attempted to contract with clinicians working in local hospital districts and health systems on a part-time basis, but the widespread issue of health care staffing has made this difficult. The RH Program is exploring innovative solutions around establishing a telehealth network that could possibly alleviate some of these access issues, though it is likely that staffing shortages will continue to be a major problem both in the state and across the country.

Similarly, LPHAs have often been one of the few, or sometimes only, CCare provider in the county. Over the past few years, a handful of LPHAs have stopped providing clinical services, choosing instead to focus on more traditional public health surveillance and population-based prevention efforts. This has resulted in geographic gaps in access to high-quality reproductive health services provided by CCare. The RH Program has begun working with partners such as the Oregon Primary Care Association to identify other health care providers, including federally-qualified health centers (FQHCs), that may be interested in participating in CCare.

Enrollment

Annual Enrollment

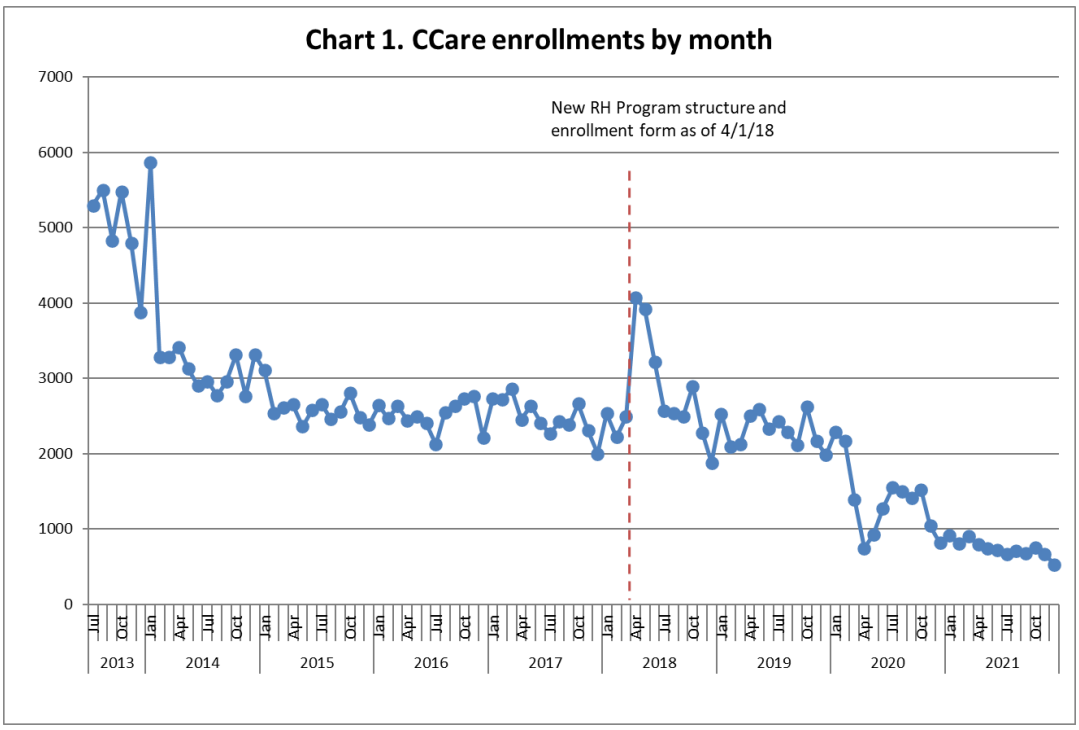
CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client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

During 2021, CCare enrollments and member months continued to be 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 2021. Finally, eligibility extensions were granted to clients each time the Public Health Emergency was extended. This resulted in an increase in the number of the member-months relative to the number of enrollees.

	TABLE 2. CY 2021/DY 23			
	Q1, January 1 - March 31	**Q2, April 1 – June 30**	**Q3, July 1 – September 30**	**Q4, October 1 – December 31**
# of Total Enrollees	2,634	2,258	2,060	1,955
# of Member Months	95,180	98,422	101,225	103,876

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 and were fairly stable until the COVID-19 pandemic. 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 health insurance coverage, significant coverage gaps remain for many individuals in need of family planning, and CCare is uniquely positioned to address these gaps.

[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.



Annual Enrollment by Race/Ethnicity

TABLE 3. Annual Enrollment by Race/Ethnicity, CY 2021/DY 23		
Race/Ethnicity	**% of Total**	**# Enrolled**
Hispanic	14.5%	1,293
White, Non-Hispanic	64.9%	5,781
Black, Non-Hispanic	2.1%	184
American Indian, Non-Hispanic	0.8%	72
Alaska Native, Non-Hispanic	0.1%	5
Asian, Non-Hispanic	4.7%	418
Hawaiian/PI, Non-Hispanic	0.5%	43
More than one race, Non-Hispanic	2.7%	240
Unknown/Not Reported	6.5%	579
Other	3.3%	292
Total	100.0%	8,908

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.

For the last two years, 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 have continued to be granted as a result of the Public Health Emergency, reducing the number of clients who needed to re-enroll in DY22 or DY23. See Table 4 below for enrollment retention figures.

TABLE 4. Annual Retention Rates	**CY 2016/ DY 18**	**CY 2017/ DY 19**	**CY 2018/ DY20**	**CY 2019/ DY21**	**CY 2020/ DY22**	**CY 2021/ DY23**
Total enrollments per demonstration year (includes clients who enrolled more than once in a single calendar year)	30,130	29,866	33,081	27,799	16,593	8,908
# clients who also enrolled the subsequent demonstration year	6,087	8,138	5,860	2,785	614	
% of clients retained from one year to the next	20.2%	27.2%	17.7%	10.0%	3.7%	

Service Providers

There are currently 45 agencies enrolled in CCare, representing a total of 149 clinic sites. Among these 45 agencies, 33 are certified to participate in the comprehensive RHCare program, affording them access to the RH Program's three sources of state and federal funding. Clinics are located in nearly every county across the state.

Between October and December 2021, the following provider training and education activities were provided to the RHCare/CCare provider network:

- Delivery of program news, policy updates, training opportunities, and other information to providers via the RH Newsletter.
- Two webinars, attended by approximately 30 staff from RHCare/CCare-enrolled clinics, about 2021 data and trends.

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 permanently to education and outreach activities directly related to Oregon's efforts to respond to COVID-19. New staff was brought on in the demonstration year to fill one position left from reassigned staff, and recruitment for outreach and education support continue. 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 23, the RH Program continued its partnership with eight separate organizations, including LPHAs, clinical partners, and community-based organizations, as part of its Reproductive Health Community Outreach Projects. 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.

In this coming year, the RH Program will be actively recruiting two more community-based organizations and will prioritize establishing partnerships with organizations serving Black and African American communities. This effort will support CCare priority populations not directly represented in the current iteration of the Community Outreach Projects.

The RH Program created an online materials ordering system that allows clinical and community partners to order educational and outreach materials created by our program. This ordering system has served to increase accessibility of program materials and has supported the ease with which community and clinical partners can engage in education and outreach activities. These materials describe services available at the network of CCare clinics and are translated into the 7 most commonly used languages in CCare clinics: English, Spanish, Vietnamese, Korean, Simplified Chinese, Traditional Chinese, and Chuukese.

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. Through our Community Outreach Projects, we have developed a model of collaborative leadership in the design and delivery of trainings that are best suited to the needs of community-based organization partners and the CCare priority communities the organizations serve. In the current calendar year, the RH Program will continue to develop partnerships and deliver trainings in response to the needs and interests of the CCare clinical network.

The RH Program is actively engaged in the creation of a brochure that provides information about vasectomies and serves as a tool to provide information about vasectomies and the ways clients can access vasectomy services. The creation of this brochure was in response to the identified needs of clinical partners. We will continue to create materials that are requested by clinical and community partners.

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 reviewed by a RH Program Nurse Consultant to ensure medical accuracy.

In the last year, the RH Program has hired new staff with dedicated FTE to increase our capacity to create social media content. Through this dedicated staff, we have also acquired increased capacity to create all social media content in both English and Spanish. This dedicated staff has proven beneficial to the overall reach and follower count for both social media platforms. We continue to utilize these platforms to prioritize information about CCare services, to promote CCare clinics and to provide trusted information about contraception and related reproductive health topics. Our platforms are also being increasingly used by community partners in their outreach and education activities.

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.

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. In the second calendar year of the pandemic, the RH Program's outreach and education activities continue to be impacted by the pandemic and continue to influence the ways and types of support that our clinical and community partners require in a COVID-changed world .

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. In 2021, minor changes to our website were made to ensure that the information we created remained accurate. In 2022, the RH Program will prioritize a more formal, dedicated update to our website, and will identify existing materials and begin to create materials to support clinical and community education.

Program Monitoring and Evaluation

Quality Assurance, Monitoring, Program Integrity, and Audit Activities

In response to the RH Program's structural changes implemented in 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

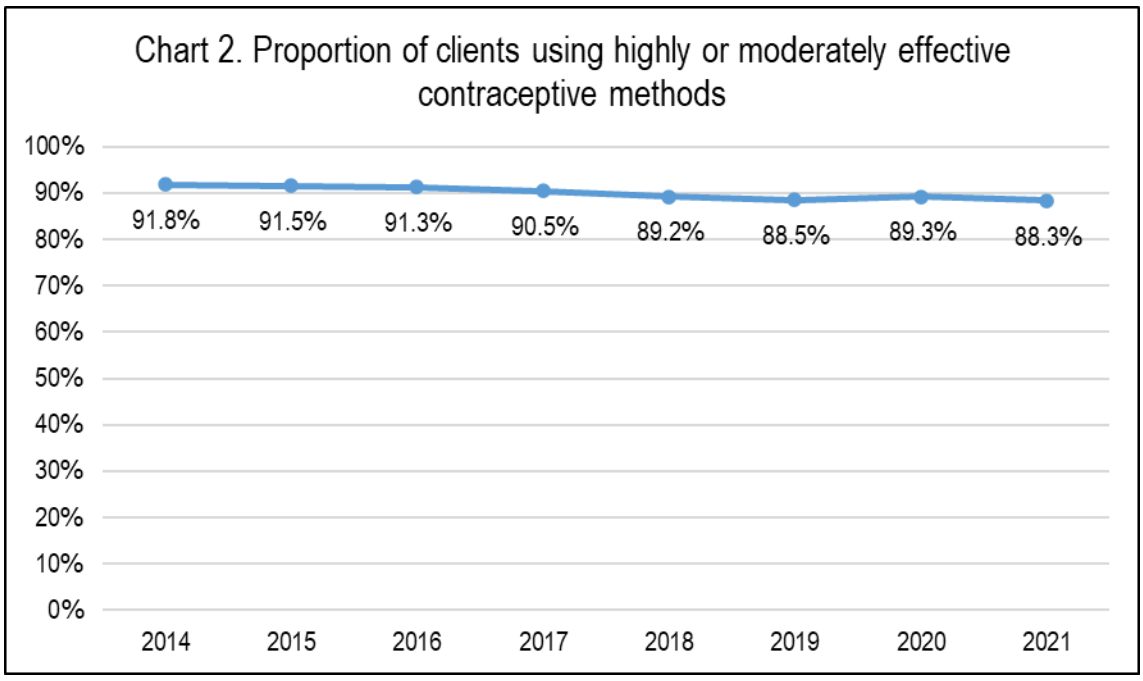
As a result of COVID-19, the RH Program suspended audit and program monitoring efforts in the second quarter of 2020 in acknowledgement of the additional burden and strain placed on clinics responding to the pandemic. As stated above, many CCare providers are LPHAs who are directly responsible for disease investigation and contact tracing related to COVID-19. The RH

Program intends to resume activities related to monitoring and compliance in March 2022. Staff developed a revised schedule to ensure that those agencies who were scheduled for review are prioritized.

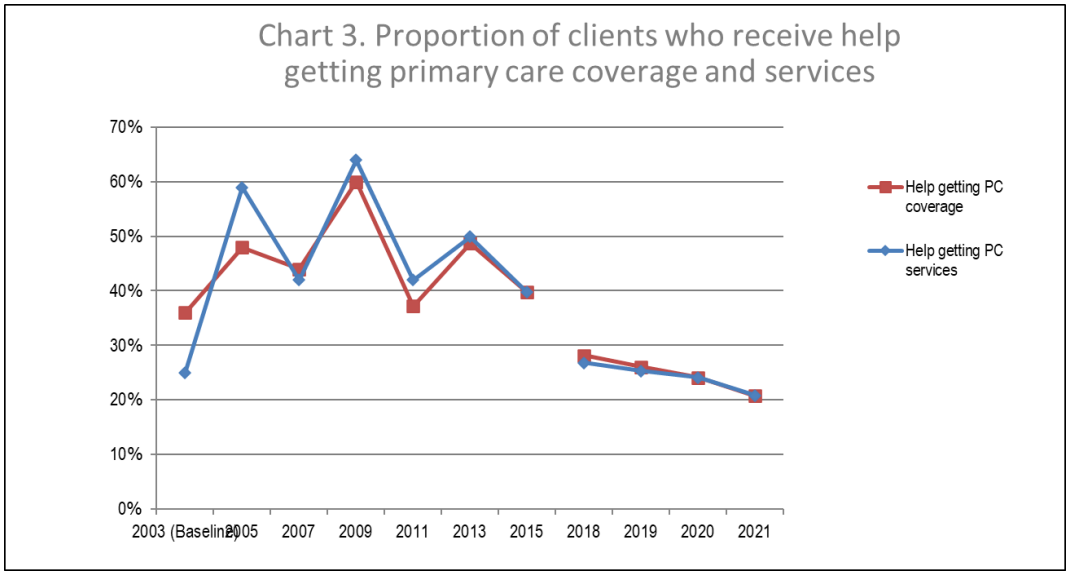
Evaluation of CCare Program Outcome Measures

(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 88.3% of all clients using a most or moderately effective method in 2020.

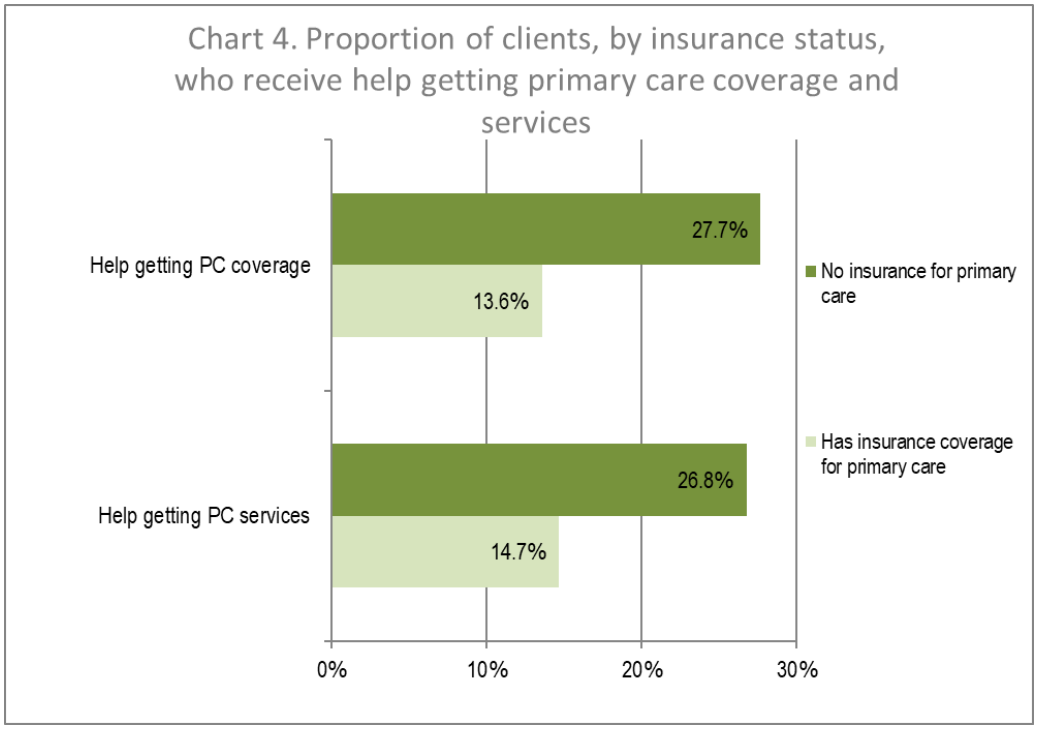


- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.
  Data source: RH Program Customer Satisfaction Survey (2003-2015), RH Program Enrollment Form (2018-present)
  Performance target: 50%
  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 2021, less than 30% of CCare enrollees indicated that they had received help getting primary care services and coverage. This represents a 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.



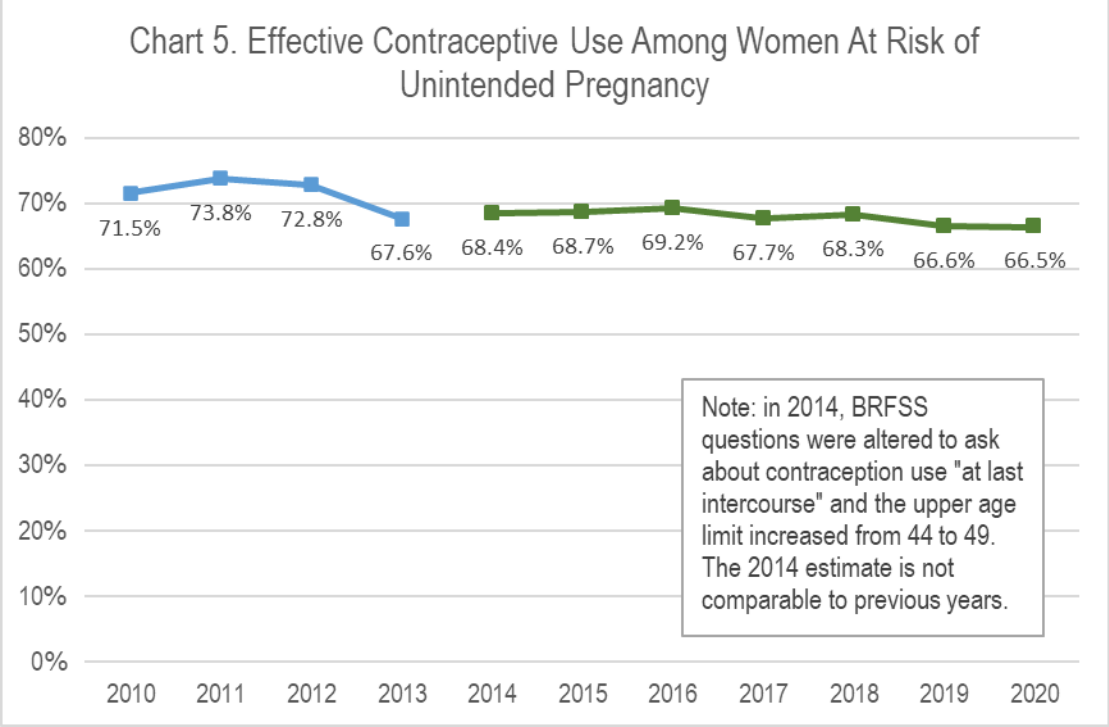
RH Program staff continue to conduct ongoing RH Program Enrollment Form audits on a random sample of medical records. These audits include a review of the primary care referral requirement to ensure that this objective is met. Furthermore, the primary care referral requirement continues to be a focus 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. In certain years, both female and male 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 had a hysterectomy, are currently pregnant, have a same sex partner, report being too old, report wanting to get pregnant, or who refuse to answer or respond "Don't Know" to the birth control use questions. This measure has remained relatively unchanged in the last several years.

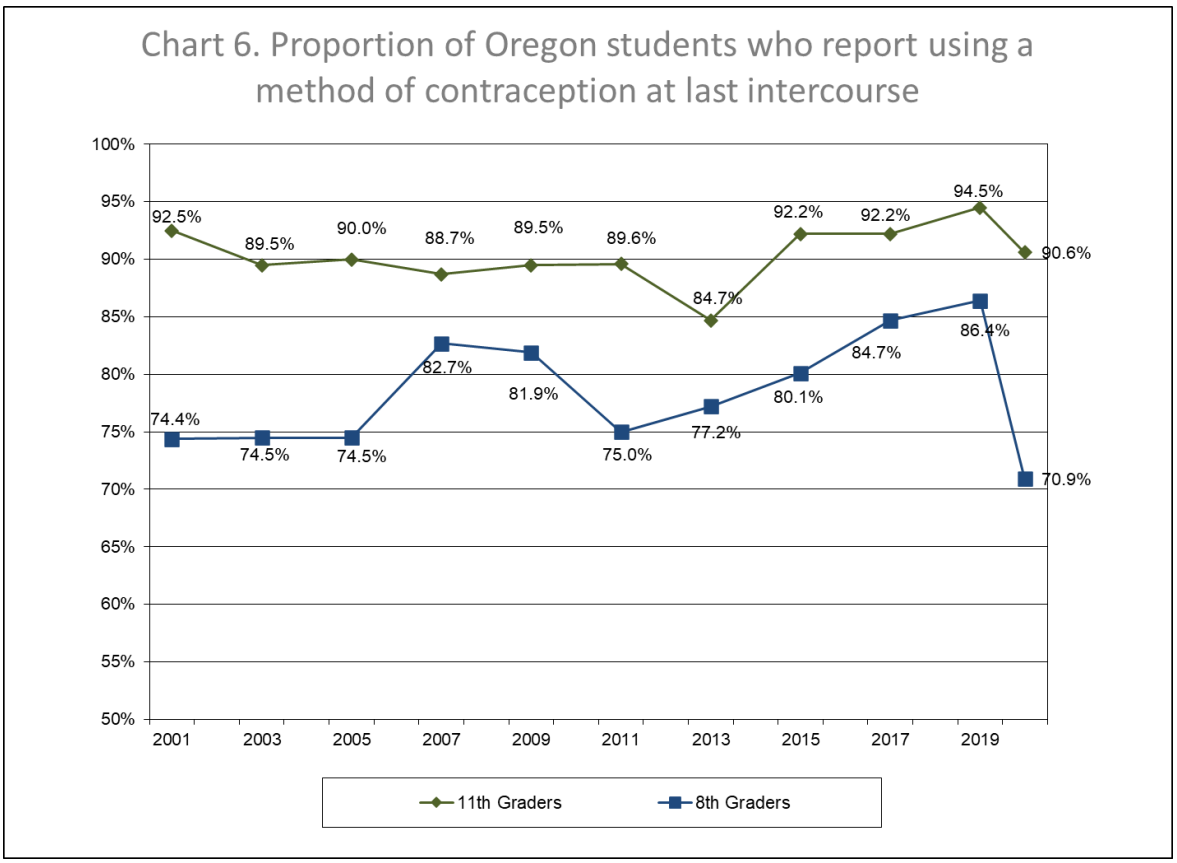


- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.

  Performance targets: 8th grade – 80.0% and 11th grade – 89.5%

Data source: Oregon Healthy Teens survey (OHT) 2001-2019; Student Health Survey (SHS) starting 2020

Progress: To determine whether expanded availability of subsidized birth control and contraceptive management services affects birth control use among teens, data from Oregon's school-based student health surveys are used. From 2001-2019 the survey was called Oregon Healthy Teens; starting 2020 the survey is called the Student Health Survey. Both surveys include 8th and 11th grade students. These surveys ask whether students have ever had sex, and if so, which method of contraception they used (if any) the last time they had sex. Those who responded that they didn't know or were not sure about the method used were counted among the "no method" group. Rates of contraceptive use among Oregon students increased steadily through 2019, although in 2020 these rates decreased: in 2020 90.6% of 11th graders and 70.9% of 8th graders reported using contraception at last intercourse (including only those students who reported ever having sex). It is possible that changes in survey methodology between Oregon Healthy Teens and the Student Health Survey impacted survey results. It is also possible that this decrease is due in part to the COVID-19 pandemic impacting access to contraception through School-Based Health Centers and other youth-friendly clinics, and we will be monitoring this data in the coming years to see if rates return to pre-pandemic levels.



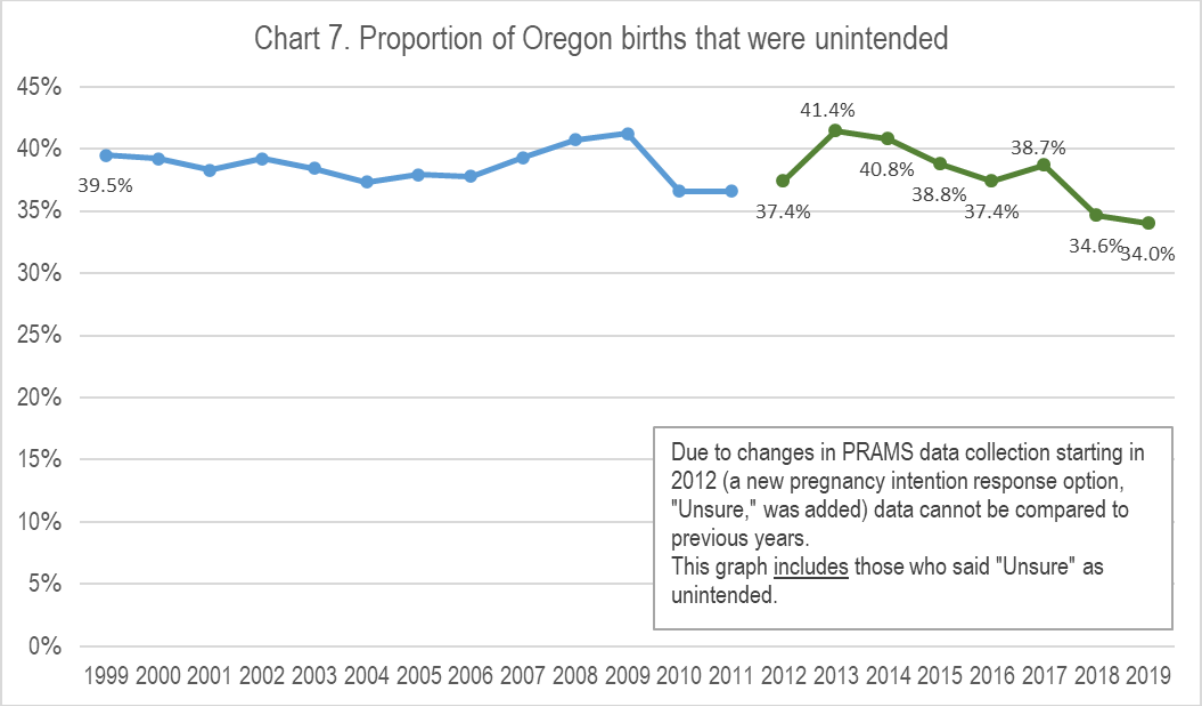
(C) Long-term Outcomes

- 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%

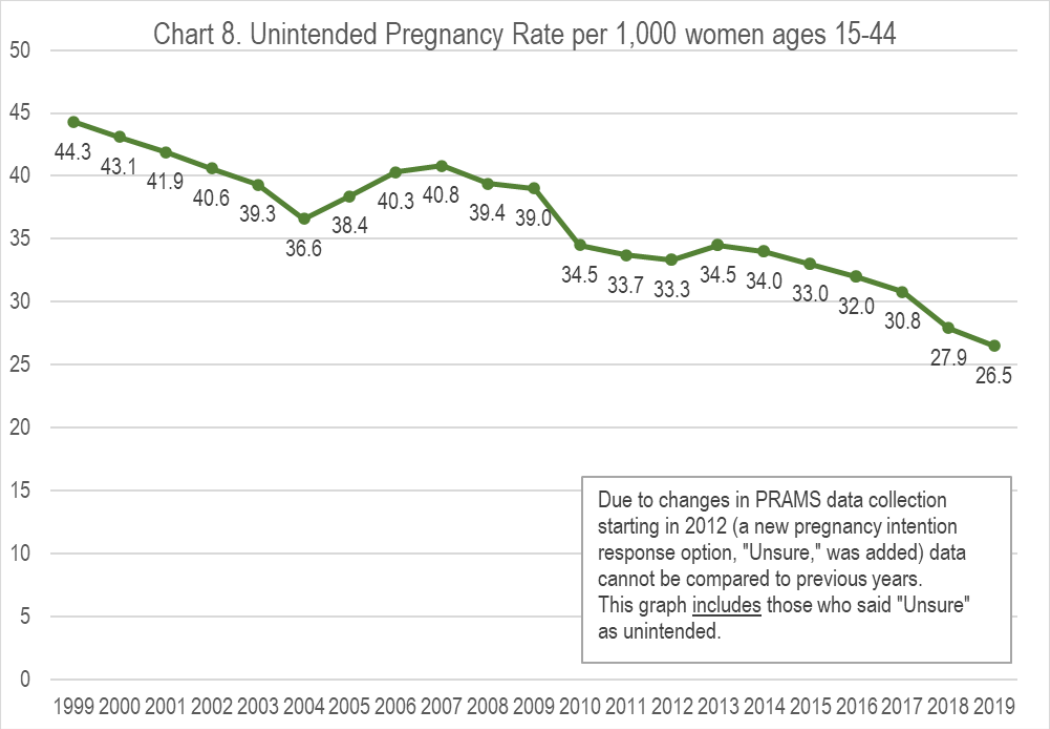
  Progress: National standard methodology is used to assess pregnancy intent: women are asked to think back before their recent pregnancy and report whether they had wanted to become pregnant at that time, sooner, later, or not at all. Pregnancies that occur too soon are classified as mistimed, those that 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, and has reached the performance target as of 2018.



- 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 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

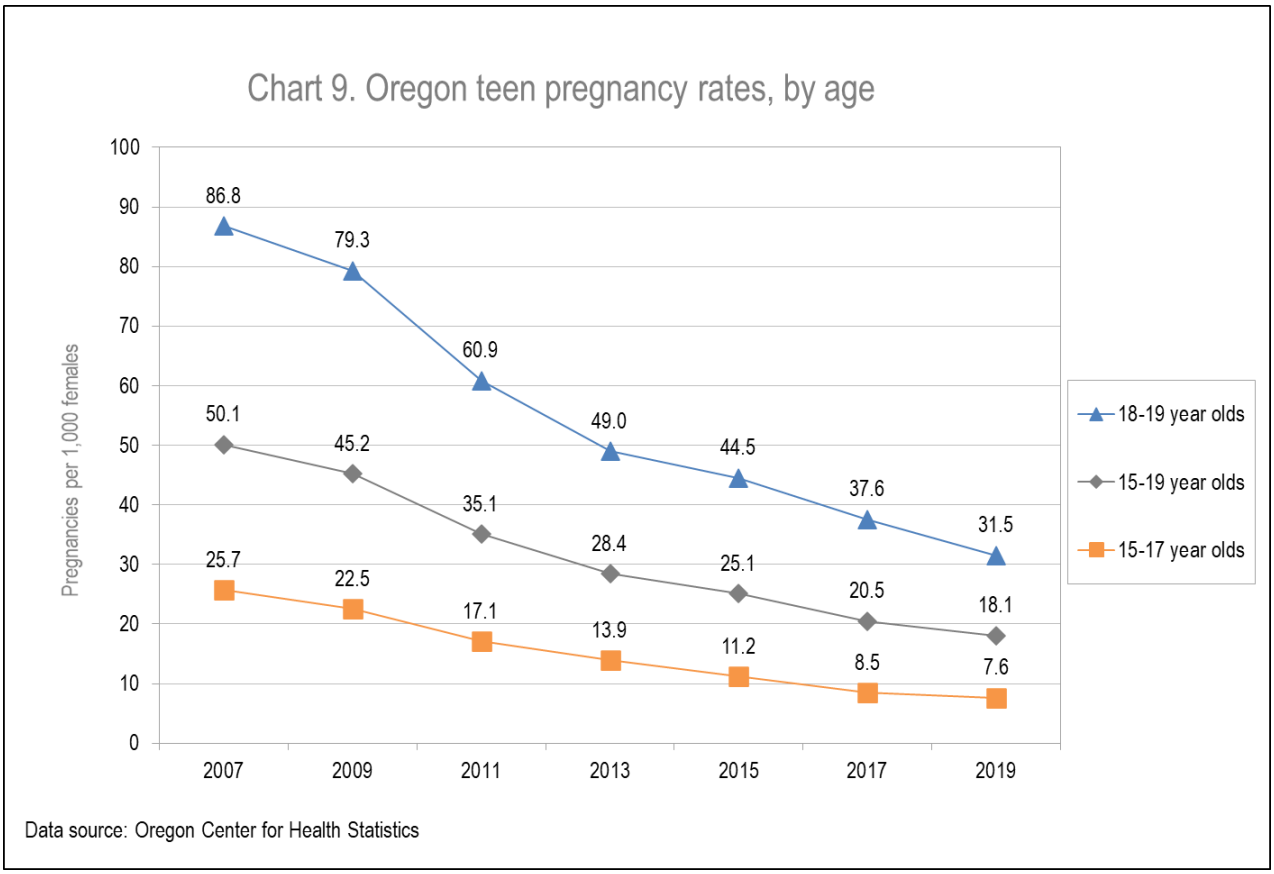
[2] Henshaw, S. (1998). Unintended Pregnancy in the United States. Family Planning Perspectives, 30(1), 24-29 & 46.
[3] Approximately 95% of abortions are estimated to result from unintended pregnancies. Personal communication: M. Zolna to R. Linz, 01/10/14.

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 has decreased since then. This decrease can be attributed both to the decline in the total number of pregnancies since 2007 and the drop in the proportion of births classified as unintended. 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, unintended pregnancies have continued to decrease, 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 2007 and 2019. As shown in the chart below, these rates are currently at their lowest rates ever since tracking began for this measure (7.6 per 1,000 per 15-17 year olds, 31.5 per 1,000 for 18-19 year olds; and 18.1 per 1,000 for 15-19 year olds).

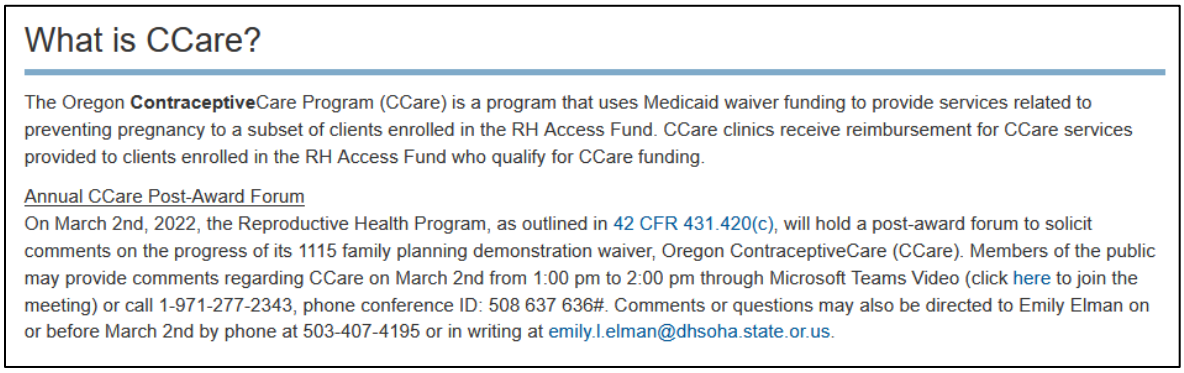


Annual Post-Award Forum

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 March 2, 2022. Information about the post-award forum was posted on the RH

[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

Program's website 30 days prior to the forum itself (see notice posted to program website below). No comments or issues were raised by the public.



What is CCare?

The Oregon **Contraceptive**Care Program (CCare) is a program that uses Medicaid waiver funding to provide services related to preventing pregnancy to a subset of clients enrolled in the RH Access Fund. CCare clinics receive reimbursement for CCare services provided to clients enrolled in the RH Access Fund who qualify for CCare funding.

Annual CCare Post-Award Forum

On March 2nd, 2022, the Reproductive Health Program, as outlined in 42 CFR 431.420(c), 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 March 2nd from 1:00 pm to 2:00 pm through Microsoft Teams Video (click here to join the meeting) or call 1-971-277-2343, phone conference ID: 508 637 636#. Comments or questions may also be directed to Emily Elman on or before March 2nd 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 23.

TABLE 5. Quarterly Expenditures for DY 23 January 1, 2021 – December 31, 2021	
Quarter	**Total Expenditures as Reported on the CMS-64**
1	$1,239,358
2	$1,119,048
3	$74,348
4	$1,007,341
Annual Total	$3,440,095

Budget Neutrality Annual Expenditure Limits

TABLE 6. Demonstration PMPM Ceilings						
Trend	**DY 18 (CY2016)**	**DY 19 (CY2017)**	**DY 20 (CY2018)**	**DY 21 (CY2019)**	**DY 22 (CY2020)**	**DY 23 (CY2021)**
.86%	$34.28	$34.57	$34.87	$35.17	$35.47	$35.78

Budget Limit Calculation:

$35.78 PMPM x 398,703 Member Months = $14,265,593

Plus 0.5% per STC 41 = $14,336,921

Multiply by 87% (composite federal share admin + direct) = $12,473,121

TABLE 7. DY 23 Budget Neutrality Annual Expenditure Limits	
DY 23 Budget Limit	**DY 23 Annual Expenditure**
$12,473,121	$3,440,095

Table 7 shows that actual expenditures for DY 23 are well within the budget limit. As noted in Table 2, in DY 23 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 DY 23. 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 2021/DY 23			
	Number of contraceptive methods dispensed	**Number of unique contraceptive users**	**Data source**
Male condom	1568	786	Claims data
Female condom	4	2	
Sponge	3	2	
Diaphragm	11	11	
Pill	4353	3938	
Patch	75	80	
Ring	578	488	
Injectable	2001	1060	
Implant	809	935	
IUD	1092	1488	
Emergency contraception	1915	0	
Sterilization	90 (vasectomy)	86	

TABLE 9. Contraceptive Care Quality Measures, CY 2021/DY 23						
	Ages 15-20			**Ages 21-44**		
	Percent	**Numerator**	**Denominator**	**Percent**	**Numerator**	**Denominator**
Most and Moderately Effective Methods	91.5%	2260	2469	87.1%	5528	6349
LARC Methods	30.0%	740	2469	25.7%	1630	6349

Activities for Next Quarter

Oregon's 2022 short legislative session begins on February 1st, 2022. 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, though generally budget-related questions do not arise during the state's short legislative session.

Oregon submitted its 1115 family planning Medicaid demonstration waiver renewal application in June 2022. The current waiver renewal period expired on December 31, 2021, and the RH Program, in collaboration with the Oregon Health Authority's Medicaid office, worked with CMS to receive a 6-month extension (through June 31, 2022) in order to work on outstanding questions about CCare policies and processes. Oregon will continue to collaborate with CMS in addressing these issues in order to successfully renew its waiver for another 5-year period.

APPENDIX A: CCare Certification Requirements

These requirements set forth minimum clinical and administrative services that an agency must offer in order to participate in CCare. The full certification packet can be found here.

CCare Certification Requirements, Version 1.0

Section A. Facility, Operations, & Staffing

A.1 Clinic Space

a. Clinics must make efforts to create a welcoming and inclusive environment whereby the clinic space and signage are reflective of all enrollees including but not limited to communities of color, teens, LGBTQ+ individuals, and people with disabilities.

A.2 Laboratory

a. Clinics must maintain the appropriate level of Clinical Laboratory Improvement Amendments (CLIA) certification.
b. Testing must be conducted on-site following CLIA rules and regulations.
c. Clinics must have the ability to collect specimens and samples. Specimens and samples may be sent off-site to a CLIA-certified laboratory.

A.3 Pharmacy and Contraceptive Methods

a. Contraceptive methods covered by CCare must be dispensed onsite following Oregon Board of Pharmacy rules and per appropriate licensure (OAR 855-043).
b. If a clinic utilizes RNs for dispensing:
    1. The quantity RNs may dispense under a standing order is subject to Oregon State Board of Nursing and Oregon Board of Pharmacy rules and regulations.
    2. An enrollee's ongoing use of a contraceptive method must be under a current written prescription.
    3. Clinics must establish procedures to ensure training and continued competencies in the dispensing of drugs by RNs.
c. Clinics must follow written policies and procedures for drug management, including security, acquisition, storage, dispensing and drug delivery, disposal, and record keeping.

A.4 Medical Emergencies

a. Clinics must maintain a current plan for medical emergencies.

A.5 Reproductive Health Coordinator

a. The agency must designate a staff person as a Reproductive Health Coordinator (RHC) to be the key point of contact in accordance with OAR 333-004-3040. The RHC is responsible for all the items listed in the RH Coordinator Competencies, including, but not limited to:

1. Ensuring program compliance at all clinic sites;
2. Being the agency's subject matter expert on all aspects of the CCare clinic certification requirements and how they are operationalized within clinic sites;
3. Acting as the primary contact with the Oregon RH Program; and
4. Managing the implementation and operationalization of CCare clinic certification requirements in all participating clinics.

b. If the agency's designated RHC does not comply with these responsibilities, the RH Program may require the agency to designate a different agency staff person.
c. When an RHC is designated, the designated RHC and a higher-ranking staff member (e.g. agency administrator, the RHC's supervisor) who understands the RHC's workload and job duties must sign the RH Coordinator Competencies.

A.6 Staffing and Workforce Development

a. Prior to implementing CCare, clinic staff must be trained on operationalizing CCare requirements, policies and processes, as applicable to their staff roles.
b. New staff must be trained on operationalizing CCare requirements, policies and processes, as applicable to their staff roles.
c. Clinics must provide staff ongoing opportunities to develop cultural responsiveness to ensure enrollees are treated with sensitivity to cultural context and with an awareness of implicit bias and stereotyping.

Section B. Equitable Access

B.1 Access to Care

a. Clinics must offer the same scope and quality of services to all enrollees regardless of race, national origin, religion, sex, sexual orientation, gender identity, age, or disability, in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964, section 1557 of the ACA, the Americans with Disabilities Act (ADA) of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A.
b. All CCare services must be provided without a referral requirement.
c. Enrollees must be offered information about:
    1. Where to access free or low-cost primary care services, and
    2. How to obtain full-benefit health insurance enrollment assistance, public or private, as needed.
d. Enrollees who cannot be provided services within two weeks must be offered information about other reproductive health providers in the area.

B.2 Cultural Responsiveness

a. Enrollees must be treated in a manner that is responsive to their identities, beliefs, communication styles, attitudes, languages, and behavior.

b. Clinics must communicate with enrollees in their preferred language and provide interpretation services in the enrollee's preferred language, at no cost to the enrollee.
    1. The agency must notify enrollees 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).
    2. All persons providing interpretation services must adhere to confidentiality guidelines.
    3. Family and friends shall not be used to provide interpretation services, unless requested by the enrollee.
    4. Individuals under age 18 shall never be used as interpreters for clinic encounters for enrollees with limited English proficiency or who otherwise need this level of assistance.
    5. When possible, the agency shall employ bilingual staff, personnel, or volunteers skilled or certified in the provision of medical and clinical interpretation that meets the needs of enrollees with limited English proficiency or who otherwise need this level of assistance during all clinic encounters.
c. Clinics must have materials and signage that are easily understandable and in languages commonly used by the populations in the service area.
    1. Culturally and linguistically appropriate health educational materials must be available for enrollees needing them.
    2. All print, electronic, and audiovisual materials shall be appropriate in terms of the enrollee's language and literacy level. An enrollee's need for alternate formats must be accommodated.

B.3 Fiscal Requirements

a. Prior to the visit and in a confidential manner, enrollees receiving services not covered by the RH Access Fund must informed that they may be expected to pay.

Section C. Enrollees' Rights & Safety

C.1 Confidentiality

a. Safeguards must be in place to ensure that confidentiality is maintained throughout the discussion of services, fees, and collection of payment.
b. Clinic space, staff practice, and the manner in which services are provided must protect enrollees' privacy and dignity.
c. Enrollees must be assured of the confidentiality of their services and medical and legal records.
d. Information obtained by staff may not be disclosed without written consent, except as required by law or as may be necessary to provide services to the individual.

e. All aspects of service provision must be compliant with the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and Health Information Technology for Economic and Clinical Health (HITECH) Act.
f. For services provided via telehealth, staff must comply with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (Authority/OHA) Confidentiality and Privacy Rules and security protections for the enrollee in connection with telemedicine technology, communication, and related records.
g. Minors (under 18 years)[5] & Confidentiality
    1. Clinic staff are prohibited from requiring written consent from parents or guardians for the provision of reproductive health services to minors.
    2. Clinic staff may not notify a parent or guardian before or after a minor has requested and/or received reproductive health services.

C.2 Informed Consent

a. All services must be voluntary
    1. Receipt of reproductive health services may not be a prerequisite for eligibility for, or receipt of services, assistance, or participation in any other program.
    2. Enrollees may not be coerced to accept services or to use a particular method of birth control.
    3. Upon establishing care, enrollees must sign an informed consent form for reproductive health services.
        i. Informed consent for reproductive health services may be incorporated into the clinic's general consent for services.
    4. The informed consent process, provided verbally and supplemented with written materials by the agency, must be presented in a language and style the enrollee understands.
b. Telehealth
    1. Clinics must obtain informed consent from the enrollee for the use of telehealth as an acceptable mode of delivering reproductive health services. The consent shall be documented in the enrollee's health record or in each telehealth visit note.

C.3 Mandatory Reporting

a. Clinics must have a policy that requires clinic staff to follow state and federal laws regarding mandatory reporting and assists staff to recognize and acknowledge their responsibility to report suspected abuse or neglect of a protected person pursuant to Federal and State law.

[5] Under Oregon law, anyone under the age of 18 is considered a minor (ORS 419B.550 [definition of minor] and ORS 109.510 [age of majority]).

Section D. Service Provision

D.1 Clinical Services

a. Clinics must offer the full scope of services as defined by CCare to all CCare-eligible enrollees. See Appendix A for the detailed list of services. The full scope of services includes:
    1. A broad range of contraceptives, including device insertion and removals;
    2. Core reproductive health services;
    3. Contraceptive services;
    4. Counseling and education services;
    5. Pregnancy testing in context of contraceptive management and counseling on all pregnancy options, including parenting, abortion, and adoption;
    6. Sexually transmitted infection (STI) screening, within the context of contraceptive management visit; and
    7. Breast and cervical cancer screening, within the context of contraceptive management visit.
b. The provision of services must be client-centered.
c. Clinics must offer the full range of contraceptive methods as listed in Appendix A.
d. Enrollees must be able to get their first choice of contraceptive method unless there are specific contraindications.
e. Clinics may offer enrollees the option of receiving their contraceptive methods by mail at no additional cost to the enrollee.
    1. Use of this option is at the discretion of the enrollee; it cannot be offered as the only way the enrollee can receive contraceptive methods.
    2. Clinics must package and mail supplies in a manner that ensures the integrity and confidentiality of the contraceptive packaging and effectiveness of the method upon delivery.
    3. Clinics must have the appropriate Board of Pharmacy licensure to mail contraceptive methods.
f. Limited exceptions to the clinical services and contraceptive supply requirements as described in D.1.a and D.1.c, may be considered. Please see Appendix B for more information.

D.2 Counseling and Education Services

a. Education and counseling services must be provided using a culturally-responsive, client-centered approach that helps the enrollee clarify their needs and wants, promotes personal choice and risk reduction, and takes into account the cultural and socioeconomic factors of the enrollee and psychosocial aspects of reproductive

health. See Appendix A for the list of counseling and education topics clients must be offered.

b. Pregnant people must be offered information and counseling regarding each of the options in a neutral, factual, and non-directive manner: parenting, abortion, and adoption.
c. Clinics must offer/provide a written brochure with all pregnancy options information and referrals to agencies that provide services in a factual and non-directive manner.

D.3 Referrals and Information Sharing

a. Clinics must provide closed-loop referrals[6] for clinical services within the scope of the CCare that require follow-up to ensure continuity of care.
b. Clinics must provide information to enrollees about resources available in the community to address barriers that might exist for enrollees, including but not limited to transportation, childcare, housing, and food insecurity, as appropriate.

D.4 Telehealth Services

a. Enrollees must be given the option to have an in-person visit and informed of the scheduling options, services available, and restrictions of both types of visits.[7]
b. Clinics should prioritize connecting at-risk and vulnerable populations to their health care providers via the client's preferred visit method (including telephone-based service delivery).

Section E. Data Collection & Reporting

E.1 Collection and Submission of Claims Data

a. Clinics must include all required visit/encounter data on the RH Program Clinic Visit Record (CVR) for the claim to be considered valid.

E.2 Other Data and Reporting Requirements

a. Clinics must submit annual updates on agency, clinic, and staff contact information to the RH Program.
    1. If any of this information changes, clinics must update the RH Program within 30 calendar days of when the change occurs.
b. Clinics must provide additional information as requested by the RH Program.

Section F. Reproductive Health Access Fund

F.1 Client Enrollment

a. The collection of all eligibility information from the enrollee must be conducted by the clinic in a manner that:
    1. Is responsive to the beliefs, interpersonal styles, attitudes, languages and behaviors of the client requesting services;
    2. Emphasizes no punitive action will be taken if a client is determined ineligible; and

[6] Closed-loop referral means a referral process in which the referring clinic or provider receives information from the entity to which a client was referred about the services they received. This excludes abortion care, as it is considered a self-referral.
[7] Exceptions to this requirement are permitted during a public health emergency.

3. Emphasizes that alternative programs may be available for clients ineligible for the Reproductive Health (RH) Access Fund.

b. Clinics must ensure that the RH Access Fund Enrollment Form is completed accurately and fully to the best of the enrollee's knowledge.
c. Clinics must ensure that all required enrollment data is collected using the Enrollment Form.
d. Clinics must ensure that each Enrollment Form is signed and dated appropriately. Enrollment Forms may not be backdated.
    1. If the Enrollment Form is completed remotely, either over the telephone or during a video visit, clinic staff must write the enrollee's name on the signature line and the day's date with a note that consent was obtained verbally.
e. All required enrollment data must be entered into the web-based RH Access Fund Eligibility Database.
f. As part of the enrollment process, clinics must comply with all relevant National Voter Registration Act (NVRA) rules. (OARs 165-005-0060 through 165-005-0070).

F.2 Billing and Payment

a. RH Access Fund enrollees who are eligible for CCare may not be charged for services covered by CCare. See OARs 333-004-3070(3) and 333-004-3090(1)(b) for CCare-covered services and client eligibility, respectively.
b. Clinics must submit claims to the RH Program claims processing vendor (currently Ahlers and Associates).
c. Clinics have a legal obligation to seek third party reimbursement, if applicable, prior to billing the RH Program. The agency:
    1. Must be enrolled with and bill the Oregon Health Plan (OHP);
    2. Must be credentialed with and bill private insurance companies; and
    3. Must provide assurance of confidentiality, when indicated.
d. Clinics may not request a deposit from an enrollee who is eligible for CCare in advance of services covered by CCare.
e. Enrollees can be billed for services that are outside of the CCare scope of services as defined in OAR 333-004-3070(3).
f. The clinic must notify enrollees prior to the visit that they may be billed for services not covered by CCare.
    1. Enrollees may not be billed for services that would normally be covered by CCare if not for an error on the part of clinic staff.
g. For services billed to the RH Access Fund, the clinic must accept RH Program reimbursement as payment in full and may not charge the enrollee additional fees for those services.

Appendix A. CCare Scope of Services

1. A broad range of contraceptive methods, as defined below:

Available onsite	Offer (must be available at clinic within 3 business days)	Refer for:
IUD and IUS	Internal condoms	Sterilization, both tubal and vasectomy
Sub-dermal implant	Diaphragm or cervical cap	
Hormonal injection	Spermicide	
Combination oral contraceptives (phasic and monophasic)	Ring or patch if not available onsite	
Progestin-only pill		
At least one non-oral combination contraception (ring or patch)		
Latex and non-latex external condoms		
Fertility Awareness Method (FAM)		
Information about abstinence and withdrawal		
Emergency contraception (Ella and Plan B)		

2. Core reproductive health services:

- Obtaining a medical history;
- Clarifying the client's reproductive needs and preferences;
- Performing a sexual health assessment;
- Screening for depression;
- Screening for Intimate Partner Violence (IPV)/contraceptive coercion, counseling, and referring for additional assistance when indicated;
- Screening for tobacco/illicit substance use, counseling, and referring for cessation assistance when indicated;
- Screening for immunization status and recommending/offering vaccination when indicated; and

- Screening for sexually transmitted infections (STIs) per national standards, and offering individualized risk reduction counseling;

3. **Contraceptive services:**
   - Identifying the client's contraceptive experiences and preferences;
   - Working with the client to select the most appropriate contraceptive method;
   - Conducting a physical assessment related to contraceptive use and per national standards when warranted;
   - Offering a broad range of contraceptive options and the ability to provide them;
   - Providing a contraceptive method with instructions, plan for using the method, follow-up schedule, and confirmation of client's understanding;
   - Follow-up and additional counseling as needed.

4. **Counseling and Education services:**
   - Contraception
   - Sterilization, vasectomy and tubal
   - STI risk reduction
   - Adult engagement
   - Relationship safety
   - Pregnancy options, including parenting, abortion, and adoption

5. **Pregnancy testing in the context of contraceptive management, and counseling services:**
   - Performing a pregnancy test.
     - If the test if positive:
       - Counseling on all pregnancy options, including parenting, abortion, and adoption;
       - Assessing for symptoms of and information regarding ectopic pregnancy;
       - Providing general information on pregnancy; and
       - Referring for services requested.
     - If the test is negative:
       - Contraceptive services if client doesn't wish to be pregnant; and
       - Referral for preconception and/or infertility services and information if seeking pregnancy.

6. **Sexually transmitted infection (STI) services, within the context of a contraceptive management visit:**
    - Screening for STIs per national standards, testing for STIs within the context of a contraceptive management visit based on individualized risk, and providing individualized risk reduction counseling;

7. **Breast and cervical cancer screening, within the context of a contraceptive management visit:**
    - Cervical Cytology services include:
        - Cervical cytology testing beginning at age 21, per national standards, when client lacks additional resources for the provision of this service or if timely access to care is an issue; and
        - Referral for abnormal results per national standards
        - Referral for additional procedures outside of scope (e.g. colposcopy).
    - Breast Cancer services include:
        - Providing a clinical breast exam only when clinically indicated and client lacks additional resources for the provision of this service or if timely access to care is an issue; and
        - Referral for abnormal results per national standards.
    - Mammography referrals include:
        - Recommending mammography per national standards; and
        - Referral for mammography.

REFERENCES:

Oregon Administrative Rules (OARs) 333-004-3000 through and 333-004-3240

Oregon Reproductive Health Program Certification Requirements for CCare Clinics, Version 1.

Centers for Disease Control and Prevention, 2013. U.S. Selected Practice Recommendations for Contraceptive Use. Retrieved from: http://www.cdc.gov/MMWr/preview/mmwrhtml/rr6205a1.htm

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Centers for Disease Control and Prevention, 2016. U.S. Medical Eligibility Criteria for Contraceptive Use. Retrieved from: https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm?s_cid=rr6503a1_w

Appendix B. CCare Clinic Exceptions

In limited circumstances, the Reproductive Health Program may grant clinics exceptions to the following certification requirements:

- D.1.a Clinics must offer the full scope of services as defined by CCare to all clients CCare-eligible clients enrolled in the RH Access Fund.
- D.1.c Clinics must offer the full range of contraceptive methods as defined by the RH Program.

In order for an exception to be considered, the site must meet the minimum criteria below:

- Services provided must follow national standards of care and be culturally-responsive and client-centered.
- Have a dedicated, private area for services to be conducted.
- Offer clinical services that meet the minimum scope of practice of an RN.
- Provide a referral for the clinical services and contraceptive supplies not available at the site.
- Offer written and verbal pregnancy options information and counseling about parenting, abortion, and adoption in a neutral, factual, and non-directive manner.

The RH Program will consider each request on a case-by-case basis.

To view and complete the CCare Clinic Exception Request Form go to:
https://app.smartsheet.com/b/form/f387cd6c88d7482a9862ec0ca3274e1c