oregon**contraceptive**care

Oregon Family Planning Medicaid Waiver

Section 1115, Waiver No. 11-W-00142/0

Demonstration Year 26

CY 24 Annual Monitoring Report

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Introduction

The Oregon Health Authority (OHA), Public Health Division, Reproductive Health (RH) Program administers Oregon's 1115 family planning Medicaid demonstration waiver entitled Oregon ContraceptiveCare or "CCare" (Project Number 11-W-00142/0). First approved in October 1998 by the Centers for Medicare and Medicaid Services (CMS), the program began providing services in January of 1999. The current waiver renewal period is January 2024 through December 2028.

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. 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 agencies. Participating agencies abide by the program's Certification Requirements (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 RH Program utilizes an integrated funding structure whereby its three primary sources of funding – CCare, federal Title X grant, and Reproductive Health Equity Act state funds – are braided to form one coverage program, the Reproductive Health Access Fund (RHAF). Individuals complete a RHAF application to receive reproductive health benefits and are assigned to the appropriate funding source (CCare, RHEA, and/or Title X) based on their eligibility for each source. The RH Program uses a set of system rules based on each funding source's eligibility and service coverage requirements to determine the appropriate fund source to draw from.

Executive Summary

Current Trends or Significant Program Changes

As part of its most recent waiver renewal, the RH Program will be implementing a number of new requirements outlined in its Special Terms and Conditions (STCs). Most notably, the updated STCs include a number of requirements related to streamlined application and eligibility determination processes that the state was not in alignment with the Code of Federal Regulations (CFRs). In April 2024, the RH Program submitted for CMS review a workplan describing the changes the state will make to its demonstration application and enrollment processes in order to meet the intent of section 1943 of the Act and regulations at 42 CFR part

435 and the timeline for implementing these mitigations. These changes include migrating CCare's current standalone eligibility and claims processing systems to the state's Integrated Eligibility ONE system and Medicaid Management Information System (MMIS) claims processing system. Starting in May 2023, RH Program staff, in conjunction with eligibility policy specialists in OHA's Medicaid Division and the Oregon Department of Human Services, meet twice per month to discuss and plan for systems migration. The state anticipates compliance with all relevant federal requirements related to application and eligibility determination processes by January 1, 2027.

In addition to the above requirements, the updated STCs for the current waiver renewal period include coverage for non-emergent medical transportation services effective January 2025. The RH Program will amend existing contracts OHA has with the state's transportation brokerages to establish coverage for all RHAF enrollees (not just those with CCare eligibility). Until systems migration to the ONE system and MMIS occurs, the RH Program will use alternate processes to implement coverage, including the development of a manual invoice and payment processing system. Oregon Administrative Rules (OARs), made effective January 1, 2025, outline transportation brokerage requirements related to coverage for RHAF enrollees (OARS 410-136). Lastly, the updated STCs provide for 24-month continuous eligibility which the RH Program implemented June 1, 2024.

The RH Program conducted a post-award forum for CCare on May 14, 2024. Notice of the forum was posted on the OHA website and published in the RH Program monthly newsletter 30 days prior. No public comments were received.

Policy Issues and Challenges

Over the past few years, Oregon has remained committed to ensuring broad access to full benefit coverage through the state's Oregon Health Plan (OHP). This includes the implementation of the Healthier Oregon Program which expands OHP eligibility to people of all ages who meet income and other criteria qualify for full OHP benefits and other services and supports, no matter their immigration status. This also includes the creation of OHP Bridge which expands eligibility to people with incomes 138 – 200% of the federal poverty level (FPL) at no cost to the enrollee.

These coverage expansions have resulted in a decrease in enrollment into CCare. More information about fluctuations in enrollment can be found in the following section.

As described in previous years' reports, local public health authorities (LPHAs) are one of the few, or sometimes only, CCare agencies in the county (particularly in the eastern region of the

state) and increasing numbers of LPHAs have stopped providing clinical services. This has resulted in geographic gaps in access to high-quality reproductive health services provided by CCare. In conversations with LPHAs that have continued as CCare agencies, but are considering stopping clinical services, low OHP reimbursement rates have been cited as a major concern. In response to this, the RH Program worked with an evaluation contractor to conduct a statewide needs assessment to better understand decreases in client enrollment and service utilization, and how to best support CCare agencies in maintaining financial sustainability. Additionally, the RH Program will be working with its partners in the Medicaid Division and Office of Actuarial and Financial Services in 2025 to reassess and revise both OHP and CCare reimbursement rates for reproductive health services to ensure they better reflect current costs to providers.

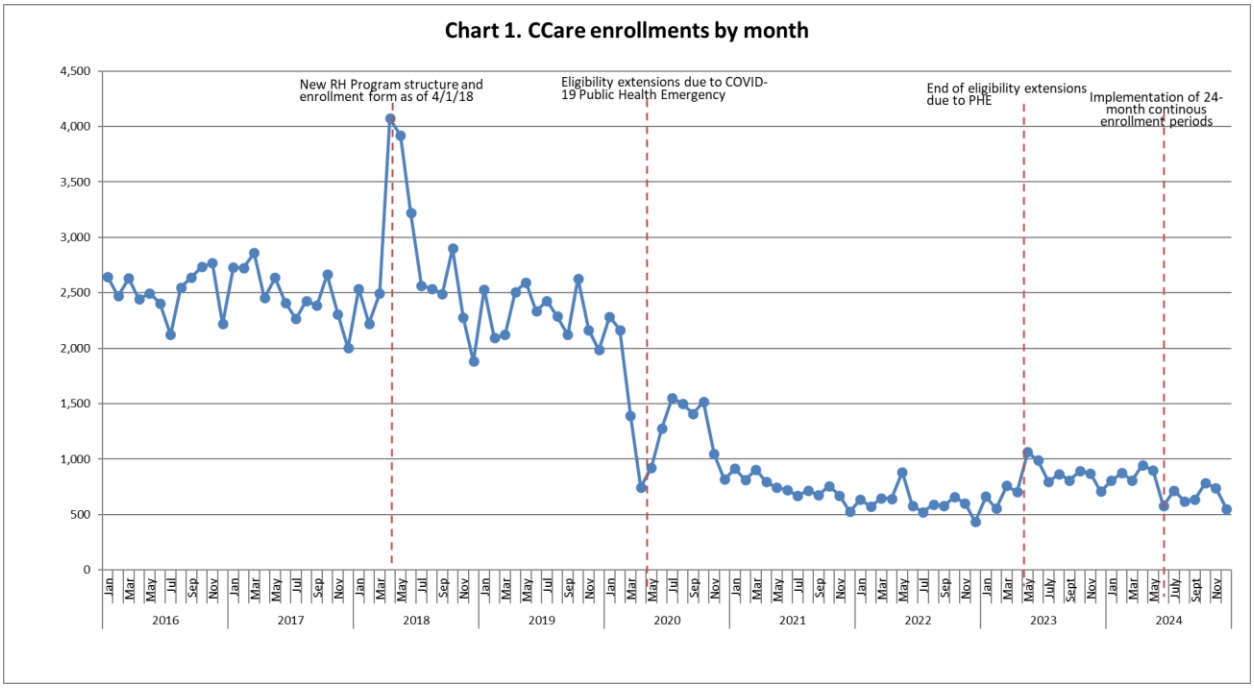
Enrollment

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). Prior to June 2024, CCare eligibility was effective for one year once established. Eligibility re-determination occurred 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.

In 2024, CCare enrollments and member months continued to recover but have not yet returned to pre-COVID-19 levels. As of June 2024, CCare has implemented 24-month continuous eligibility periods, which has contributed to maintaining enrollment stability and ensuring consistent access to care. This change is also resulting in an increase in the number of member months relative to the number of enrollees.

	TABLE 2. CY 2024/DY 26			
	Q1. January 1 - March 31	**Q2. April 1 – June 30**	**Q3. July 1 – September 30**	**Q4. October 1 – December 31**
# of Total Enrollees	2,490	2,423	1,974	2,075
# of Member Months	32,599	48,527	50,630	52,469



Annual Enrollment by Race/Ethnicity

TABLE 3. Annual Enrollment by Race/Ethnicity, CY 2024/DY 26		
Race/Ethnicity	**% of Total**	**# Enrolled**
Hispanic	17.3%	1554
White, Non-Hispanic	60.9%	5462
Black, Non-Hispanic	2.8%	248
American Indian, Non-Hispanic	0.6%	51
Alaska Native, Non-Hispanic	0.1%	10
Asian, Non-Hispanic	2.5%	224
Hawaiian/Pacific Islander, Non-Hispanic	0.6%	54
More than one race, Non-Hispanic	2.8%	250
Unknown/Not Reported	10.4%	930
Other	2.0%	179
Total	100.0%	8962

Annual Disenrollment and Retention Figures

Although the RH Program is unable to track reasons for disenrollment, we assume 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.

In June 2024, 24-month continuous eligibility was implemented for CCare clients, where previously clients had a 12-month eligibility period. Because of this change, the majority of clients will most likely not need to re-enroll two years in a row, and the client retention percentages as calculated below are likely to remain low.

TABLE 4. Annual Retention Rates	CY 2023/ DY 25	CY 2024/ DY 26	CY 2025/ DY 27	CY 2026/ DY 28	CY 2027/ DY 29	CY 2028/ DY 30
Total enrollments per demonstration year (includes clients who enrolled more than once in a single calendar year)	9,672	8,962				
# clients who also enrolled the subsequent demonstration year	324					
% of clients retained from one year to the next	3.3%					

Service Providers

In 2024, there were 41 agencies enrolled in CCare, representing a total of 135 clinic sites. Among these agencies, 33 were certified to participate in the comprehensive RHCare program, affording them access to the RH Program's three sources of state and federal funding. Clinics were located in nearly every county across the state.

Throughout 2024, the following training and education activities were provided to the RHCare/CCare provider network:

- Delivery of program news, policy updates, training opportunities, and other information to agencies via the RH Newsletter.
- Hosted virtual office hours for clinic staff to provide support and technical assistance.
- Webinars attended by staff from RHCare/CCare-enrolled clinics about CCare/RHCare orientation, enrollment processes, billing and data, adolescent friendly health services, trauma informed pelvic care, and nurse-initiate contraception.

Program Outreach and Education

The RH Program now has a fully staffed outreach and education team that is responsible for creating and leading many of the RH Program's outreach and education activities. 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. In the coming year we will continue to take advantage of increased staffing to provide expanded educational and outreach activities and trainings for CCare clinics and other community partners.

Outreach and Awareness Activities

During 2024, the RH Program increased its community partnership work by funding twelve separate organizations, including Local Public Health Authorities (LPHAs), clinical partners, and community-based organizations, as part of its Community Outreach Project grants. We continued deepening our relationships with Black/African American and Native American serving organizations. We will continue these projects and are eager to create educational opportunities that improve reproductive health outcomes in CCare populations.

Through these Community Outreach Project grants, our program continues to build on the strengths and relationships of the community-based organizations to increase access to reproductive and sexual health services, increase education, and to decrease stigma about sexual and reproductive health. These partnerships also allow us to support CCare clinics to strengthen their capacity to provide culturally responsive services. In this project, the RH Program facilitates 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 eleven project partners. These projects continue to support a significant shift in the RH Program's work in engaging with community and in supporting improved services in our CCare clinics. All projects receive digital and print reproductive health outreach and promotional materials to provide when doing virtual or in-person community engagement.

The RH Program's online materials ordering system continues to be used by 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.

We began a complete update of our program brochure to more accurately reflect services and eligibility for CCare populations. This updated brochure will describe services available at the network of CCare clinics and translated into the 7 most commonly used languages in CCare clinics: English, Spanish, Vietnamese, Korean, Simplified Chinese, Traditional Chinese, and Chuukese.

The RH Program continues to convene a quarterly meeting of community members and partners around the state who serve Spanish-speaking populations with varying social and medical services. This meeting is facilitated entirely in Spanish and serves to provide a unique opportunity for Spanish-speaking people interested in learning and sharing more about sexual and reproductive health needs of Spanish-speaking communities throughout the state. In the last year this group spoke about topics including: breast and cervical cancer screenings, services available in CCare clinics, and asking questions about and responding to commonly asked and misunderstood questions about sexual and reproductive health.

Educational Activities

The RH Program continues to provide training and resources for its clinical network and community partners including trainings to promote client-centered counseling and comprehensive sexual education. Through the 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 brochure the RH Program created related to pregnancy options counseling will be finalized and made available to all CCare clinical partners this within the next calendar year. 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 plain language and are reviewed by a RH Program Nurse Consultant to ensure medical accuracy.

RH Program has staff with dedicated FTE which allows us to increase our capacity to create timely social media content. We continue 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.

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 agencies, partners, and clients. A formal evaluation of Outreach Projects will be created in 2024 to be administered to partners beginning in 2025.

Materials Evaluation

The RH Program continues to identify and review materials created by outside organizations related to reproductive health topics. These materials are identified based on community and clinical partner input, and are reviewed for accuracy and accessibility by those same partners. We continue to make our webpage a resource for accessing and ordering materials, and newly identified resources are posted there for community to access. In 2025, the RH Program will continue to update our website, and will identify existing materials and begin to create materials to support clinical and community education.

Program Monitoring

The RH Program uses established program integrity and monitoring processes to assure adherence to program requirements and ensure the provision of high-quality care across all of its three funding sources. Audit and compliance components related to CCare continue to be an integral part of the program audit processes.

Typically, RH Program staff conduct several CCare audit activities each month to assure compliance with program, state, and federal requirements, including:

1. Monthly desk-audits, including reviews 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. The Enrollment Forms are checked against information entered into the eligibility database.
4. Chart reviews during onsite clinic reviews where reviewers follow a checklist of components to review charts with visits billed to CCare.
5. Monthly duplicate claims audit process to identify and correct any duplicate claims inadvertently submitted to and paid by CCare.

For DY26, a total of 31 agencies were reviewed. The audit results showed common issues related to enrollment form completion and storage as well as billing at the wrong visit level. Issues are addressed through Corrective Action Plans (CAPs) and/or by correcting claims.

The RH Program Data and Operations teams meet on a monthly basis to review processes, troubleshoot problems, and share information related to clinical operations and program monitoring.

Program Evaluation

The RH Program has contracted with an external evaluator, the Center for Outcomes Research and Education (CORE), to develop the evaluation design for CCare and to implement the approved evaluation design. To select an independent evaluator, OHA released a Request For Proposals (RFP) outlining the requirements in the Special Terms and Conditions. Proposals were reviewed and scored by a team of OHA staff using criteria that prioritize OHA's goals for health equity, and CORE's proposal received the top score. CORE has a longstanding, established relationship with OHA, which enables CORE to begin work on the family planning waiver evaluation design in a timely manner and meet the deliverables.

The draft evaluation design was submitted to CMS in November 2024, and comments were received in January 2025. The RH Program has worked with CORE to address CMS' comments and CORE has provided a revised evaluation design, which we are submitting along with this annual monitoring report. Once the evaluation design is approved, evaluation activities will continue such as the beneficiary survey.

Expenditures and Budget Neutrality

The Budget Neutrality Workbook for DY 26 is being submitted along with this Annual Monitoring Report. The number of member months has increased following implementation of 24-month Continuous Eligibility in June 2024.

The below table show the quarterly expenditures through the 4th quarter of DY 26.

Quarter	MAP Expenditures	ADM Expenditures	Total Expenditures as Reported on the CMS-64
1	$743,315	$367,258	$1,110,573
2	$893,645	$402,420	$1,296,065
3	$803,715	$356,515	$1,160,230
4	$664,462	$411,161	$1,075,623
Annual Total	$3,105,137	$1,537,354	$4,462,491

Contraceptive Methods

TABLE 8. Number of Contraceptive Methods and Contraceptive Users, CY 2024/DY 26			
	Number of contraceptive methods dispensed	**Number of unique contraceptive users**	**Data source**
Male condom	880	751	Claims data
Female condom	3	4	
Sponge	0	0	
Diaphragm	5	9	
Pill	3026	2639	
Patch	166	162	
Ring	342	282	
Injectable	1484	768	
Implant	611	723	
IUD	765	1266	
Emergency contraception	1674	0	
Sterilization	108 (vasectomy)	56	

TABLE 9. Contraceptive Care Quality Measures, CY 2024/DY 26						
	Ages 15-20			**Ages 21-44**		
	Percent	**Numerator**	**Denominator**	**Percent**	**Numerator**	**Denominator**
Most and Moderately Effective Methods	86.2%	2209	2355	79.4%	3566	4491
LARC Methods	29.3%	690	2355	26.7%	1197	4491

Activities for Next Quarter

Legislative session: Oregon's 2025 legislative session begins on January 21, 2025. As always, 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.

NEMT coverage: Oregon Administrative Rules (OARs) related to the coverage of NEMT for CCare/RHAF enrollees were made effective January 1, 2025: OAR 333-004-3070 (Reproductive Health Access Fund Covered Services by Funding Source) and OAR 410-136 (Medical Transportation Services). Work will continue throughout the quarter to onboard and provide technical assistance to the state's contracted transportation brokerages and troubleshoot any implementation issues.

Reimbursement rate review project: As mentioned in the Executive Summary, the RH Program is working with its partners in the Medicaid Division and Office of Actuarial and Financial Services in 2025 to reassess and revise both OHP and CCare reimbursement rates for reproductive health services to ensure they better reflect current costs to providers. As part of this work, the RH Program will execute a contract with one of the Office of Actuarial and Financial Services' vendors to assess OHP and RHAF's current reimbursement methodologies and rates, study alternate payment methodology models, engage external partners, and develop recommendations for the adoption of aligned payment methodologies and increased reimbursement rates. The contract is expected to begin in March 2025 and end in August 2025.

Eligibility and claims systems migration: RH Program staff will continue to work with eligibility policy specialists in OHA's Medicaid Division and the Oregon Department of Human Services to develop systems requirements and processes in preparation for systems migration to the ONE integrated eligibility system and MMIS claims processing system. This includes meeting with each systems' respective vendors, Deloitte and Gainwell, to finalize the Level of Effort (LOE) documents and to prepare for the Joint Application Design (JAD) meetings in which detailed systems requirements are determined.

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.

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.
b. The agency's clinic facility(s) must be compliant with ADA requirements.

A.2 Infection Control

a. Clinics must utilize Standard Precautions for infection control, following CDC guidelines.

A.3 Laboratory

a. Clinics must maintain the appropriate level of Clinical Laboratory Improvement Amendments (CLIA) certification, and must have written policies that align with CLIA rules and regulations. Staff competency assessment must be included in the policies.
b. Clinics must have the ability to collect specimens and samples. Specimens and samples may be sent off-site to a CLIA-certified laboratory.

A.4 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. 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.

A.5 Medical Emergencies

a. Clinics must maintain a written plan for medical emergencies, including:
    a. Anaphylaxis/Shock;
    b. Vaso-vagal reaction/Syncope;
    c. Cardiac Arrest/Respiratory Difficulty (if the clinic has an automated external defibrillator (AED) include protocol on how to use); and
    d. Hemorrhage.
b. Clinics must maintain a written after-hours emergency policy management plan.

A.6 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 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 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.
d. The agency must notify the RH Program within 10 business days of when the designated RHC leaves the agency, takes a leave of absence longer than one month, or if a different staff member is being assigned the role of RHC.
    1. In the case of a leave of absence longer than one month, an interim RHC must be assigned.

A.7 Staff Training Requirements

a. Upon CCare clinic certification or new hire, clinic staff must receive training on the following topics:
    1. CCare certification requirements, policies, and processes (as applicable to staff roles);
    2. Client-centered, nondirective pregnancy options counseling (staff who provide pregnancy options counseling to CCare enrollees); and
    3. Reproductive Justice in the clinical setting (staff who interact with CCare enrollees).
b. Annually, clinic staff must receive one training focused on equity, including topics related to racism, health equity, cultural-responsiveness[1], and/or trauma-informed[2] care in providing sexual and reproductive health clinical services (staff who interact with CCare enrollees).

[1] Culturally responsive means paying particular attention to social and cultural factors in managing medical encounters with patients from different social and cultural backgrounds. The word "responsiveness" places emphasis on the capacity to respond. In practice this boils down to utilizing a set of tools – questions and skills for negotiation based on cultural knowledge – which they can incorporate into their interactions with patients from diverse cultural backgrounds. Examples include finding out about the patient's history of present illness, their health beliefs and use of alternative treatments, expectations of care, linguistic challenges, and culturally based family dynamics that guide decision-making processes. (Culturally Responsive Care by Marcia Carteret, M.Ed. https://www.dimensionsofculture.com/2010/10/576/)

[2] Trauma-informed means an approach, based on knowledge of the impact of trauma, aimed at ensuring that environments and services are welcoming and engaging for recipients and staff. (Trauma Informed Oregon: traumainformedoregon.org)

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, skin color, national origin, religion, sex, sex characteristics, sexual orientation, gender identity, age, number of pregnancies, marital status, 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 who cannot be provided services within two weeks must be offered information about other reproductive health providers in the area, including whether or not they are RHCare or CCare providers.

B.2 Cultural Responsiveness

a. Agencies must implement a written, ongoing comprehensive strategy to provide equitable, trauma-informed, culturally responsive services. The strategy should include an assessment, action plan, and evaluation.
b. Clinics must ensure that clinical services are provided in a way that makes it easy and comfortable for youth to seek and receive the services they need.
c. Enrollees must be treated in a trauma-informed manner that is responsive to their identities, beliefs, communication styles, attitudes, languages, and behavior.

B.3 Linguistic Responsiveness

a. 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 clinic must inform enrollees, in their preferred language, both verbally and in writing, that language services are readily available at no cost to them, 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 may not be used to provide interpretation services, unless requested by the enrollee.
    4. Individuals under age 18 should never be used as interpreters for clinic encounters for enrollees with limited English proficiency or who otherwise need this level of assistance.
b. Clinics must have materials and signage that are easily understandable and in languages commonly used by the populations in the service area.
    1. Medically accurate, culturally, and linguistically responsive, inclusive[3], and trauma-informed appropriate health educational materials must be available for enrollees needing them.

[3] Inclusive means all people are included and can actively participate in reproductive health decision making, including, but not limited to people who belong to communities that have been historically marginalized such

2. All print, electronic, and audiovisual materials must use plain language[4] and be easy to understand. An enrollee's need for alternate formats must be accommodated.

Section C. Enrollees' Rights & Safety

C.1 Confidentiality

a. Safeguards must be in place to ensure confidentiality, and to protect enrollees' privacy and dignity throughout the clinic space, during clinic interactions, and in record keeping.
b. 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.
c. 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.
d. 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.
e. A copy of a patients' bill of rights must be posted in a public area of the clinic in the languages most commonly used by enrollees.
f. 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 Noncoercion

a. All services must be voluntary
    1. Clients may not be coerced to accept services or to use a particular method of birth control.
    2. Receipt of reproductive health services may not be a prerequisite for eligibility for, or receipt of services, assistance, or participation in any other program.

C.3 Informed Consent

a. Upon establishing care, enrollees must sign an informed consent form for reproductive health services.

Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. (42 CFR § 59.2)

[4] A communication is in plain language if its wording, structure, and design are so clear that the intended readers can easily find what they need, understand what they find, and use that information. (Plain Language Association International: https://plainlanguagenetwork.org/)

[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]).

1. Informed consent for reproductive health services may be incorporated into the clinic's general consent for services.

b. The informed consent process, provided verbally and supplemented with written materials by the clinic, must be presented in plain language.
c. 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 must be documented in the enrollee's health record or in each telehealth visit note.

C.4 Mandatory Reporting

a. Agencies must maintain a written 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. The policy must:
    1. Address mandatory reporting obligations regarding sexual abuse, and
    2. Be updated when applicable laws change.

Section D. Services

D.1 Service Delivery

a. Services must be provided using a trauma-informed, inclusive, culturally responsive, and client-driven[6] approach that helps the client clarify their needs and wants, promotes personal choice and risk reduction, and takes into account the cultural and socioeconomic factors of the client and psychosocial aspects of reproductive health.

D.2 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 a contraceptive management visit; and
    7. Breast and cervical cancer screening, within the context of a contraceptive management visit.
b. Clinics must notify the RH Program within 10 business days if they are unable to provide the full scope of services (e.g. loss of clinical provider) for one month or longer.
c. Enrollees must be able to get their first choice of contraceptive method unless there are specific contraindications.

[6] Client-driven means the client's preferences and needs are prioritized, and their values guide all decision-making.

d. Limited exceptions to the clinical services and contraceptive supply requirements as described in D.2.a may be considered. Please see Appendix B for more information.

D.3 Counseling and Education Services

a. Clinics must offer the list of counseling and education topics as detailed in Appendix A.
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 written information about all pregnancy options. It must be written in a factual and non-directive manner and include contact information for agencies that give medically accurate, unbiased information about the option(s) for which they are being listed.

D.4 Referrals and Information Sharing

a. Enrollees must be offered information about:
    1. Where to access free or low-cost primary care services,
    2. How to obtain full-benefit health insurance enrollment assistance, public or private, as needed, and
    3. 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.
b. Clinics must provide closed-loop referrals[7] for clinical services within the scope of CCare that require follow-up to ensure continuity of care.

D.5 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.[8]

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

[7] 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.

[8] Exceptions to this requirement are permitted during a public health emergency.

Section F. Reproductive Health Access Fund

F.1 Client Enrollment

a. Clinics must emphasize that alternative programs may be available for clients ineligible for the Reproductive Health (RH) Access Fund.
b. Clinic staff must support clients in completing the RH Access Fund Enrollment Form accurately and to the best of the client's knowledge.
c. Clinics must ensure that all required client enrollment data is collected using the RH Access Fund Enrollment Form, that all fields are completed, and the form is signed and dated appropriately, unless they receive written approval from the RH Program to enter client enrollment data directly into the RH Access Fund Eligibility Database. 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, unless the clinic receives written approval from the RH Program to enter client enrollment data directly into the RH Access Fund Eligibility Database.
d. All required enrollment data must be entered into the web-based RH Access Fund Eligibility Database.
e. 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. 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.
c. Enrollees may be billed for services that are outside of the CCare scope of services as defined in OAR 333-004-3070(3).
d. Prior to the visit and in a confidential manner, enrollees receiving services not covered by CCare must be informed that they may be expected to pay. See OARs 333-004-3070(3) for CCare-covered services.
e. Clinics may not request a deposit from an enrollee who is eligible for CCare in advance of services covered by CCare.
f. Clinics must submit claims to the RH Program or its claims processing vendor, as directed.
g. Clinics have a legal obligation to seek third party reimbursement, if applicable, prior to billing the RH Access Fund. The clinic:
    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 assure confidentiality, when indicated.
        i. Including not seeking third party reimbursement if the enrollee requested confidentiality.

h. 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.

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

Available onsite (i.e. stock onsite)	**Offer** (must be available at clinic within 7 business days)	**Refer for**
Hormonal and nonhormonal IUDs	Internal condoms	Sterilization, both tubal and vasectomy
Subdermal implant	Either diaphragm or cervical cap	
Hormonal injection	Ring, if not available onsite	
Combination oral contraceptives	Patch, if not available onsite	
Progestin-only pill		
At least one non-oral combination contraception (ring or patch)		
Vaginal pH modulators		
Fertility Awareness Method (FAM)		
Information about abstinence and withdrawal		
Emergency contraception (Ella and Plan B)		
Latex and non-latex external condoms		
Spermicide		

2. **Core reproductive health services:**
    - Obtaining a medical history;
    - Clarifying the enrollee'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 enrollee's contraceptive experiences and preferences;
    - Working with the enrollee 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 enrollee's understanding;
    - Follow-up and additional counseling as needed.

4. **Counseling and Education services:**
    - Contraception
    - Sterilization, vasectomy and tubal
    - STI risk reduction
    - Adult engagement
    - Healthy relationships, including relationship safety and consent
    - 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 enrollee 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 screening, per national standards;
        - Referral for abnormal results per national standards; and
        - Referral for additional procedures outside of scope (e.g. colposcopy).
    - Breast Cancer services include:
        - Providing a clinical breast exam when indicated per national standards;
        - Screening for BRCA risk by medical and family history; and
        - Referral for abnormal exam results or positive results on risk assessment tool, 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, 2015. Update: Providing Quality Family Planning Services – Recommendations from CDC and the U.S. Office of Population Affairs. Retrieved from: https://www.cdc.gov/mmwr/volumes/65/wr/mm6509a3.htm

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

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

- D.2.a. Clinics must offer the full scope of clinical services and contraceptive supply requirements by Appendix A to all CCare-eligible clients enrolled in the RH Access Fund.

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 driven.
- 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