DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 5, 2025

Emma Sandoe
Medicaid Director
Oregon Health Authority
500 Summer Street NE, E53
Salem, OR 97301

Dear Director Sandoe:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Final Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC 47 "Final Evaluation Report" of the state's section 1115 demonstration, "Oregon Contraceptive Care (CCare)" (Project No: 11-W-00142/10). This report covers the demonstration period from August 2016 through December 2023. CMS determined that the evaluation report, submitted on June 26, 2025, and most recently revised on September 25, 2025, is in alignment with the approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Final Evaluation Report.

While the report primarily relies on descriptive analyses making it difficult to isolate the effects of the CCare demonstration on evaluation outcomes, historical, longitudinal data are provided for many of the outcomes and the outcomes are clearly linked to demonstration goals. Overall, the progress on key CCare goals and related program objectives is mixed. Reductions in unintended pregnancy rates, unintended birth rates, and teen pregnancy rates were observed over the course of the demonstration period. However, the rates of effective contraceptive use remained relatively stable and there was a decrease in the reported provision of information regarding primary care services and coverage. Even though rates of effective contraceptive use remained stable, with 85.5 percent of CCare beneficiaries using a most or moderately effective method in 2023; these rates are much higher than the national average for Medicaid beneficiaries.[1] We look forward to future findings as the state continues to refine demonstration programs and conducts more rigorous analyses during the current demonstration approval period.

[1] The rate of most or moderately effective contraception use among CCare beneficiaries is significantly higher compared to the mean rate of 27.1% among Medicaid beneficiaries living in 2,611 counties across 40 states and DC. Source: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00992?journalCode=hlthaff.56

In accordance with 42 CFR 431.424(c), the approved evaluation report may now be posted to the state's Medicaid website within 30 days. CMS will also post the evaluation report on Medicaid.gov.

We look forward to our continued partnership on the Oregon Contraceptive Care section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2025.12.05 05:00:05 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Sasha Zolynas, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

oregon **contraceptive** care

Oregon Family Planning Medicaid Waiver

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

Demonstration Year 18-25

Summative Evaluation Report

Executive Summary

The Oregon Health Authority (OHA), Public Health Division, Reproductive Health (RH) Program administers Oregon's 1115 family planning Medicaid demonstration waiver titled 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. This report covers the waiver renewal period from August 9, 2016-December 31, 2023 (Demonstration Years 18-25). The current waiver renewal period is January 2024 through December 2028 (Demonstration Years 26-30).

In this Summative Report, we include findings from the waiver period 2016-2023 to evaluate whether the goals and objectives were met in DY18-25. The following outcome goals were identified as part of the Evaluation Design for DY18-25:

- Increase access to contraceptive management services
- Increase use of effective contraceptive methods
- Reduce unintended pregnancies and births
- Reduce teen pregnancy rates

The original Evaluation Design for DY18-25 was limited to simple descriptive statistics. For this Summative Report we have added comparisons where possible, noting the limitations of seeking comparison data retrospectively. Additional analyses in this report include:

- Pre- and post-demonstration unintended birth rates using Pregnancy Risk Assessment Monitoring System (PRAMS) data;
- Population-level contraceptive use for Oregon compared to national data using the Behavioral Risk Factor Surveillance System (BRFSS);
- Teen birth rates for Oregon compared to the United States as a whole.

Overall, the CCare program continues to meet its goals of increasing access to high quality and cost-effective contraceptive management services for Oregonians. There is room for improvement in terms of enrolling and serving more eligible members. The CCare program has contracted with an independent evaluator for the 2024-2028 (DY26-DY30) period and looks forward to the increased utility of a more robust evaluation.

Overview of the Oregon ContraceptiveCare (CCare) Program

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. This report covers the waiver renewal period from January 2016-December 2023 (Demonstration Years 18-25). The current waiver renewal period is January 2024 through December 2028 (Demonstration Years 26-30).

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.[1] 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.

Starting in April 2018, the RH Program has utilized 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

[1] Oregon ContraceptiveCare Certification Requirements
https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/CCare-Cert-Packet.pdf

of system rules based on each funding source's eligibility and service coverage requirements to determine the appropriate fund source to draw from.

During the DY18-25 waiver renewal period, the goals for CCare were 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. For the annual evaluation reports submitted for DY18-25, the approved evaluation design was largely descriptive in nature with no comparisons to other populations. For this summative evaluation report, we have added comparisons to national data where available, and we acknowledge the limitations of seeking appropriate comparison data retroactively. Additional analyses in this report have been included for Outcomes 3, 5 and 7.

(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
- 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.
  Data source: Oregon Behavior Risk Factor Surveillance System (BRFSS)
    - Comparison added for this Summative Report: Population-level contraceptive use for Oregon compared to national data;

- 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.
  Data source: Oregon Healthy Teens survey (OHT)

(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)
    - Comparison added for this Summative Report: Pre- and post-demonstration unintended birth rates;
- 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
- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.
  Data source: Oregon Center for Health Statistics
    - Comparison added for this Summative Report: Teen birth rates for Oregon compared to the United States as a whole.

Summary of Activities DY18-DY25

Communication and Outreach:

Throughout the DY18-25 waiver renewal period, the RH Program made a significant deepening and expansion of communications and outreach work in service to the CCare provider network and the communities served by CCare providers.

Highlights in communication and outreach activities for DY18-25 include:

- The RH Program began a process to review and revise all RH Program educational materials on a rotating 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 2023, the RH Program began a more formal, dedicated, and ongoing update to our website. Reviews identify existing materials needing updates and identify need to create materials to support clinical and community education.

- The RH Program partnered with the OHA Community Partner Outreach Program on community-based outreach and enrollment grants. 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 contraceptive management services.
- In 2020, the RH Program began partnerships with eight organizations in 2020, and now contract with twelve through our 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 contraceptive management services. In these projects, 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 twelve 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.
- Increased our social media presence on both Facebook and Instagram, primarily through adding dedicated FTE to lead this body of work. Through this dedicated staff, 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.

- The RH Program has created new materials in response to community need, including a pregnancy options brochure, a vasectomy brochure and an updated RH Program brochure. These materials are accessible to CCare and community partners. 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.
- Prioritized ease of access to educational materials by creating an online ordering system 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.
- Supported CCare clinics during the COVID 19 pandemic and continue to provide technical and clinical support as the pandemic has shifted.
- In June of 2020, in response to the ongoing COVID pandemic, the RH Program conducted a survey of clinical providers to assess the clinical services they were providing, the manner in which they were serving clients, and their plans for the provision of services and contraception during the restrictions imposed by state orders and in efforts to protect client health.
- Into the second year of the COVID-19 pandemic, the CCare clinical network provided contraceptive services in new and innovative ways. Many clinics shifted a substantial portion of their work to telehealth, providing screenings, health education, and prescriptions through various telehealth modes.

- Increased our presence in community activities including presenting at various conferences serving: Community Health Workers, serving Spanish-speaking communities, and youth.

Provider Training and Education:

Throughout the DY18-25 waiver renewal period, training and education were delivered to the CCare provider network via:

- The RH Newsletter which announces program news, policy updates, training opportunities, and other information to agencies.
- Hosting virtual office hours for clinic staff to provide support and technical assistance.
- Webinars about:
    - CCare Certification Requirements,
    - CCare orientations,
    - Enrollment processes,
    - Billing and data, and
    - Various clinical topics, such as adolescent friendly health services, trauma informed pelvic care, nurse-initiate contraception, HPV Vaccine, STI screening and data collection, etc.

Between DY18-DY21, the RH Program also conducted yearly in-person meetings for representatives from across the provider network, including nurse supervisors, clinic managers, and billing and front desk staff. The meetings allowed shared learning and networking, and focused on topics like Trauma Informed Care, Expanding Access through Family Planning Partnerships, Identifying and Responding to Human Trafficking, Options Counseling, etc. The meeting also included sessions dedicated to operating CCare such

as billing and coding, enrollment, program updates, etc. The meeting was canceled between DY22-DY25 due to the COVID-19 pandemic and is being reinstated for the DY26-DY30 waiver period.

Development of Integrated RH Access Fund:

In 2018, the RH Program implemented an innovative structure to "braid" its three sources of funding, Title X, CCare, and state general funds through the Reproductive Health Equity Act (RHEA), to reimburse its network of certified clinics for services rendered. This allowed for a streamlined model whereby there is "no wrong door" for clients, and clinics have access to FFS (fee-for-service) reimbursement for core reproductive health services. In order to facilitate this model, the RH Program developed a single, streamlined client application that allows individuals to enroll in the RH Program's coverage program, the Reproductive Health Access Fund (RHAF), and receive covered benefits based on their eligibility.

For its FFS reimbursement, the RH Program developed three bundled reimbursement rates based on a weighted average of the different office visits, procedures, and laboratory services conducted within typical family planning visits. These rates are based on Medicaid FFS reimbursement rates and are intended to accommodate the range of typical family planning visits provided for both new and established family planning clients, including language assistance services. Clinics select the appropriate visit type for each encounter which triggers the corresponding reimbursement rate.

Using a set of system rules based on each funding source's client eligibility and service coverage requirements, the RH Program determines the appropriate fund source to draw from. Due to Title X's broad scope, Title X funds are prioritized to cover either individuals and/or services otherwise not covered by CCare or RHEA, including male clients, those interested in pregnancy/parenting, and STI treatment and screening pursuant to a family planning visit. The RH Program maintains a list of primary diagnosis codes allowable for reimbursement by each of its funding streams, and uses an algorithm based on each

funding source's eligibility and coverage requirements to determine the appropriate source for each claim.

The RH Program closely monitors monthly claims processing, both to track CCare payments and to assure appropriate use of funds, including adherence to all CCare requirements.

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. Budget Neutrality activities are described further in Appendix A.

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.

Extension Application:

The RH Program submitted an initial extension application in 2021. As part of waiver extension discussions, CMS identified a number of topic areas related to streamlined application and eligibility determination processes for which the state was not in alignment with the Code of Federal Regulations (CFRs). These topic areas include:

1. Application
2. Eligibility hierarchy and determination cascade
3. Opportunity to apply
4. Verification
5. Renewals of eligibility
6. Notices
7. Coordination with other insurance affordability programs
8. Fair hearings

After providing three temporary extensions, CMS approved renewal of the CCare program on November 9, 2023, for the period January 1, 2024 through December 31, 2028. Per STC 17, the state is required to transition to full compliance in the above areas no later than December 31, 2028. CMS has approved Oregon's Mitigation Workplan to address these requirements. The most significant component of this Workplan is the plan to migrate CCare's current standalone eligibility and claims processing systems to the state's Integrated Eligibility ONE system (hereafter known as ONE) and Medicaid Management Information System (MMIS) claims processing system in order to come into full alignment with federal regulations. ONE serves as the state's single streamlined application for insurance affordability programs. Migration of CCare into ONE will allow for the adoption of a streamlined application and eligibility determination process between all Medicaid programs compliant with federal regulations. The approved Mitigation Workplan outlines the requirements associated with each topic area, the current state (i.e., current operationalization), and the plan for implementation.

Annual Evaluation:

During DY18-25, the RH Program conducted in-house evaluations and submitted annual monitoring and evaluation reports to CMS. During this time the RH Program primarily included simple descriptive statistics in its evaluation reports. For this summative evaluation report we have conducted a few additional statistical analyses based on available data, acknowledging the challenges of finding appropriate comparison data retrospectively. Note that with the recently approved waiver renewal period DY26-30, Oregon has contracted with an independent evaluator to evaluate the CCare program.

Member surveys:

The RH Program conducted a statewide member survey, the Reproductive Health Client Satisfaction Survey (CSS) in 2018. Another survey was planned to be implemented in 2020 but canceled due to the Public Health Emergency. The CSS was conducted every two to three years from 2003 to 2018. Survey content and methodology has been similar with each iteration. The CSS is an important component of the Oregon Reproductive Health Program's quality improvement efforts and provides a detailed look at our clients' values, attitudes, and access to services.

The 2018 CSS assessed client perceptions of care including communication with providers and staff, sources of and access to care, and reasons for choosing the clinic. Additional questions include client preferences for accessing care, interpretation services, and additional services clients would like offered at the clinic. Question types included multiple choice, open ended, and Likert scales.

The RH Program invited all contracted provider agencies with at least 10 reproductive health clients per year to have one clinic participate in the 2018 CSS. Forty-one agencies participated, with one agency conducting the surveys at two clinic sites, making for a total of 42 clinics throughout the state.

Surveys were administered onsite at each clinic for one to four weeks, depending on client volume, during March 2018. Surveys were printed in a booklet format and available in

English and Spanish. Every client with a family planning visit was asked to complete a survey after their clinic visit. A total of 889 surveys were completed for an overall participation rate of 56.5%. Most survey respondents had female sex at birth (97.3%). Other demographics are shown below.

	CSS Participants % (n)
Survey Language	
English	88.3% (785)
Spanish	11.7% (104)
Age Categories	
17 and younger	10.9% (91)
18-19	17.4% (145)
20-24	29.1% (243)
25-29	16.4% (137)
30-34	9.0% (75)
35-39	8.6% (72)
40-44	3.8% (32)
45 and older	4.8% (40)
Mean Age	**25.7 years**

Overall, clients indicated a high level of satisfaction, with 95.6% of respondents indicating that they got what they needed at their clinic visit, and 94.9% of clients indicating that they would recommend the clinic to friends or family.

Impacts of the COVID-19 Public Health Emergency on this Evaluation

The public health emergency (PHE) due to the COVID-19 pandemic was first declared on January 31, 2020, in the fifth year of this waiver renewal period. The PHE was officially lifted on May 11, 2023, in the last year of the temporary extensions for this waiver renewal period. The impacts of the PHE are not specifically evaluated in this report. However, as shown in Chart 1 and Chart 2 below, CCare enrollment and caseload changed substantially during the time of the PHE. Enrollees were able to remain in CCare during the PHE and caseload was elevated compared to the period before the PHE. However, utilization of many services usually provided in-person was disrupted due to clinic

closures and limitations as well as increased enrollment in Oregon's Medicaid program, the Oregon Health Plan (OHP).

In addition, CCare claims expenditures were reduced during the PHE compared to previous years. As shown in Appendix A-Summary of Budget Neutrality Calculations, annual expenditures were reduced during DY22-25 (CY2020-CY2023) compared to previous years. Average annual expenditures for DY18-21 (CY2016-CY2019) were $9,302,992, as reported on the CMS-64 and shown in Appendix A. For DY22-25 (CY2020-CY2023), average annual expenditures were $4,702,113, a nearly 50% decline from DY18-21.

In this summative evaluation report, no attempts have been made to isolate the effects of the PHE from the effects of the demonstration. Outcome measures during the PHE should be interpreted with caution.

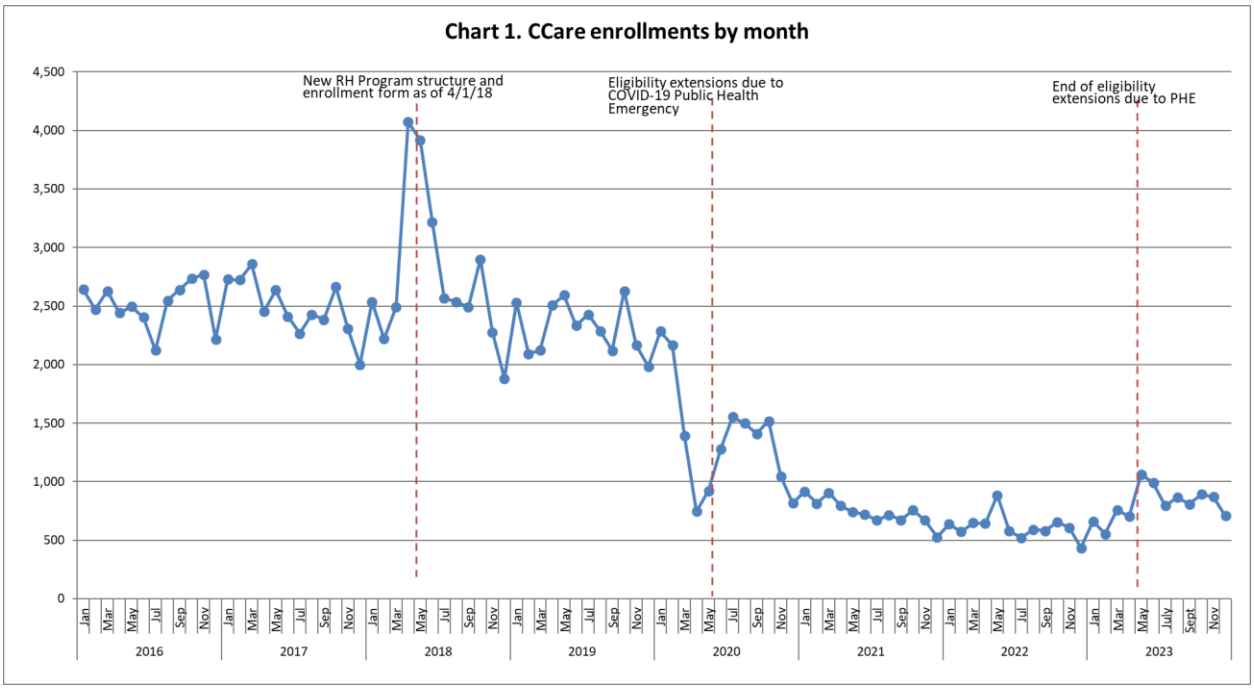
Enrollment

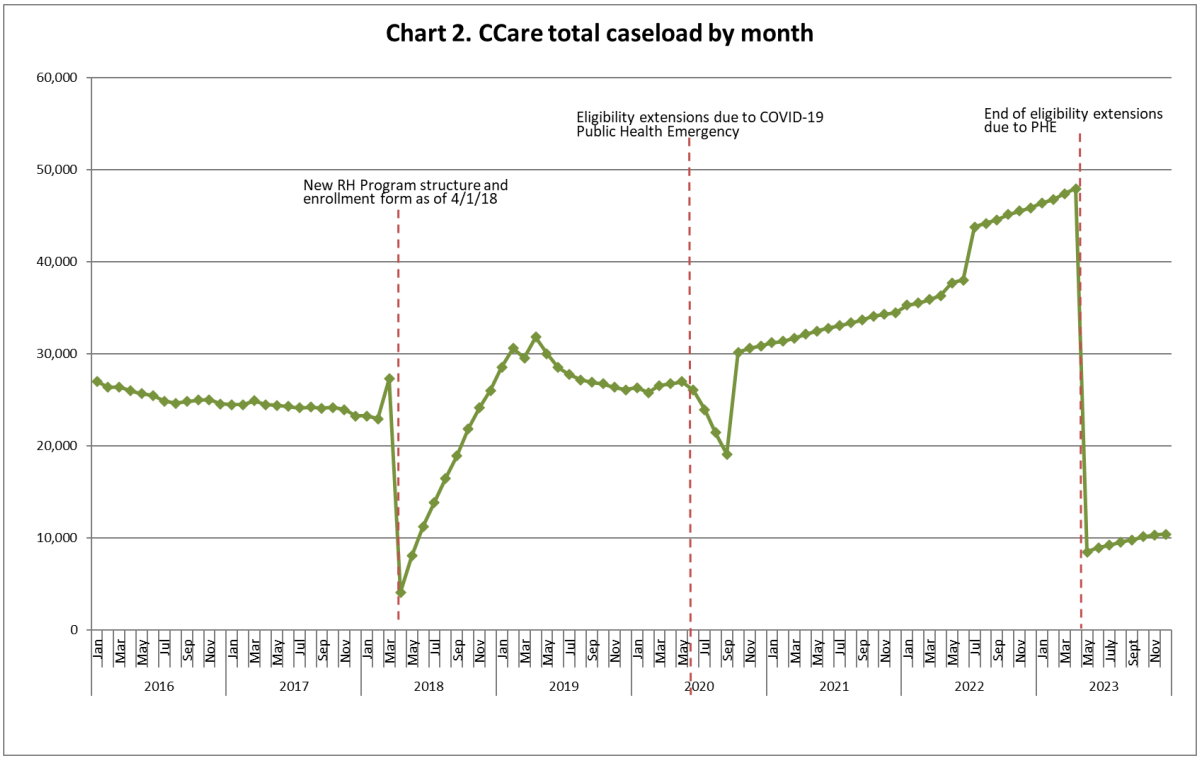
CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client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

Notable events during this time that affected enrollment in CCare include:

- Development and implementation of the braided Reproductive Health Access Fund (RHAF) program described above, which required terminating all active enrollments as of March 31, 2018, and requiring all members to re-enroll after April 1, 2018;
- Eligibility extensions due to the COVID-19 Public Health Emergency during May 2020-April 2023;
- Increased enrollment in Oregon Health Plan during the Public Health Emergency.

Chart 1 below shows the number of individuals who enrolled or re-enrolled in CCare, by month. Chart 2 shows the total number of individuals with active CCare enrollment, by month. The notable events listed above are included in the charts for context.





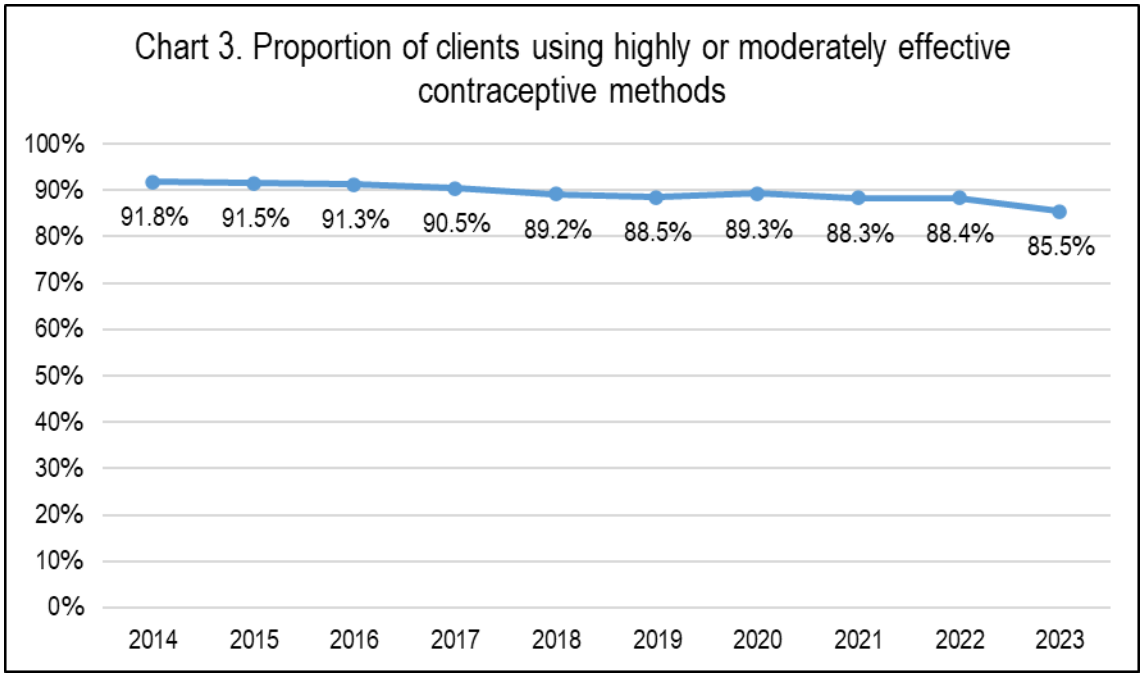
Immediate Outcomes

- **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 includes the following methods: tubal sterilization, vasectomy, IUD, implant, pills, patches, rings, injectable, and diaphragm. The denominator for this measure is women at risk of unintended pregnancy, which 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 85.5% of all clients using a most or moderately effective method in 2023.



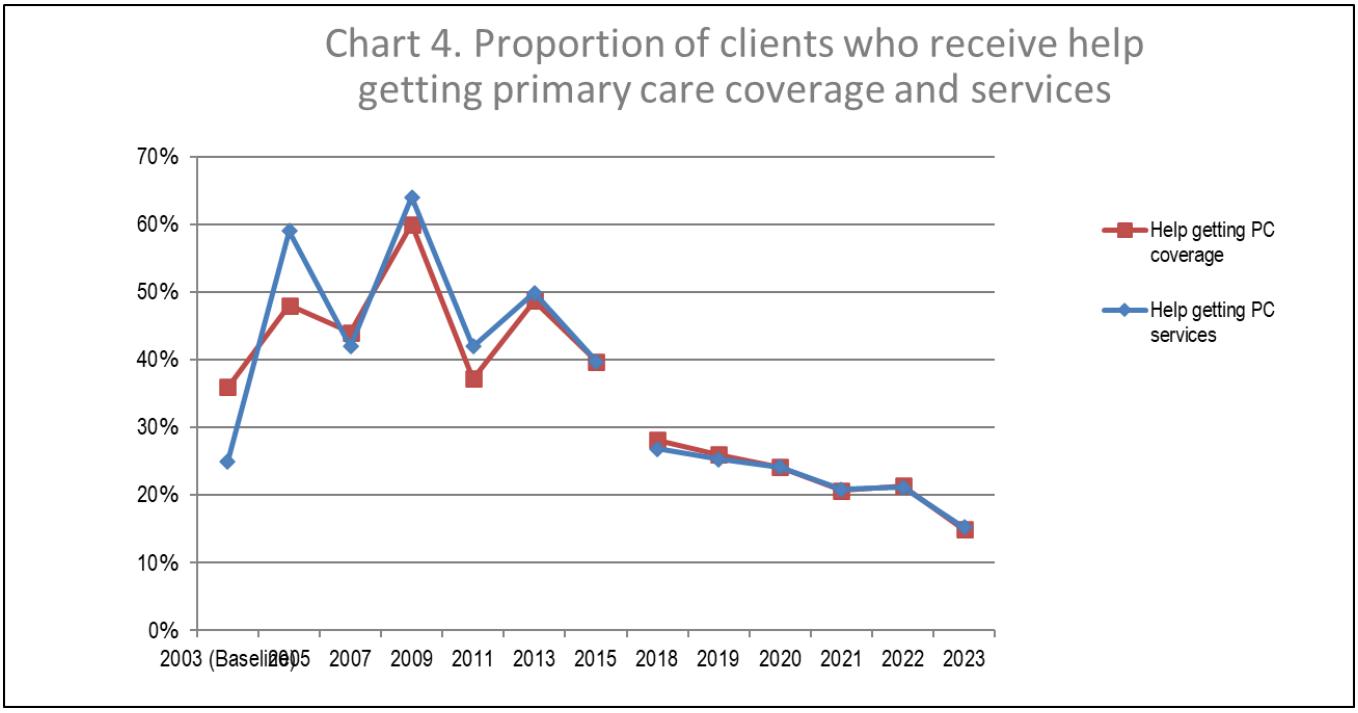
- **Outcome 2** The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.

  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. Further information about CSS methodology is included in the Member Survey section above. 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 4.

  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. The RH Program Enrollment Form is primarily completed by enrollees, however clinic staff indicate whether information was provided regarding primary care services and primary care coverage.

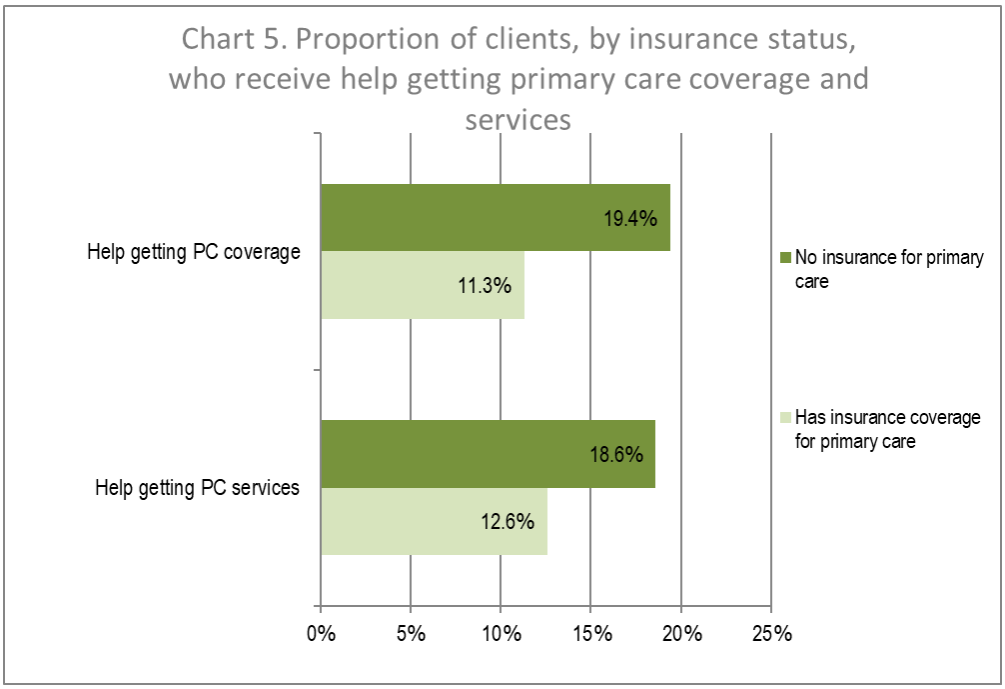


In 2023, less than 20% of CCare enrollees were given information regarding primary care services (15.2% or 1467 of 9634 enrollees) and primary care coverage (14.9% or 1432 of 9634). This represents a decline from previous years, which can be attributed to two factors. First, the wording of these questions has changed from how it was collected in our client survey, and the questions are answered by clinic staff rather than clients. This highlights 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, or if the client has been given the information previously).

As shown in Chart 5, those without insurance for primary care were more likely to have received information about both public health insurance and accessing general health services than those with insurance. Among those with insurance, 12.6% (679 of 5396) received information about primary care services and 11.3% (611 of 5396) received

information about getting primary care coverage. Among those without insurance, 18.6% (788 of 4238) received information about primary care services and 19.4% (821 of 4238) received information about getting primary care coverage. Those without insurance were statistically significantly more likely to receive information about both primary care services (z=-8.13, p<0.001) and primary care coverage (z=-11.09, p<0.001).

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 agency trainings.



Intermediate Outcomes

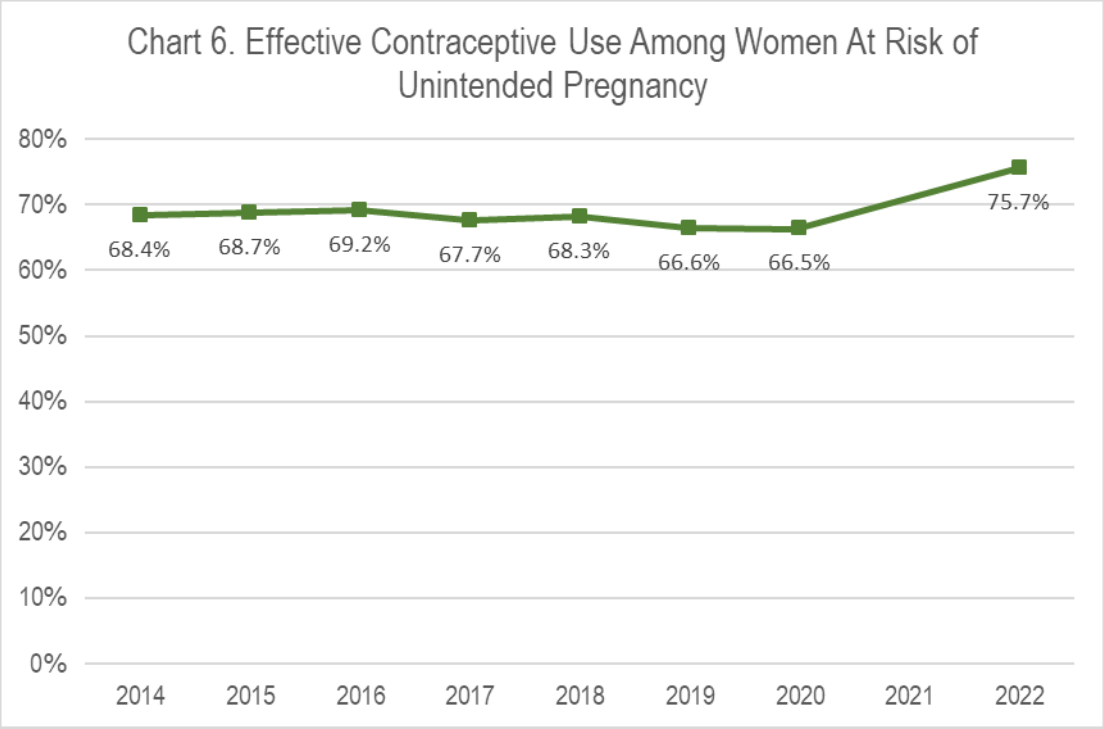
- **Outcome 3** The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.

  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. Tier 1 methods are defined as the most effective methods with typical use failure rates less than 1%, including permanent and long-acting reversible contraceptive methods. Tier 2 methods are defined as moderately effective methods with typical-use failure rates between 3-12% and include contraceptive pills, patches, rings, injections, and diaphragms.[2] Women at risk of unintended pregnancy excludes respondents who have had a hysterectomy, are currently pregnant, 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. After several years of relatively unchanged data on this metric, the 2022 BRFSS data shows an increase in reported effective contraceptive use.

[2] Gavin L, Moskosky S, Carter M, et al. Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs. *MMWR Recomm Rep*. 2014;63(RR-04):1-54.



For an additional comparison, we obtained national BRFSS data for 2022.[3] The national BRFSS dataset includes 22 states that implemented the Family Planning questions in 2022. The proportion of respondents who reported using a most or moderately effective method was statistically significantly higher in Oregon (71.8%) compared to the national average (63.1%). These figures vary from the numbers above because this dataset only includes a subset of Oregon responses, due to variations in survey methodology. Details are shown in the table below.

Table 1. Proportion of BRFSS respondents who reported using a most or moderately effective method of contraception at last intercourse, 2022.

	Oregon		United States	
	Prop.	N	Prop.	N
Most/Moderately effective	0.7184	417	0.6311	8,406
Less effective/No method	0.2817	156	0.3689	3,878
X^2= 4.7989, P<0.05				

[3] National BRFSS data for 2022 obtained from https://www.cdc.gov/brfss/annual_data/annual_2022.html

- **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

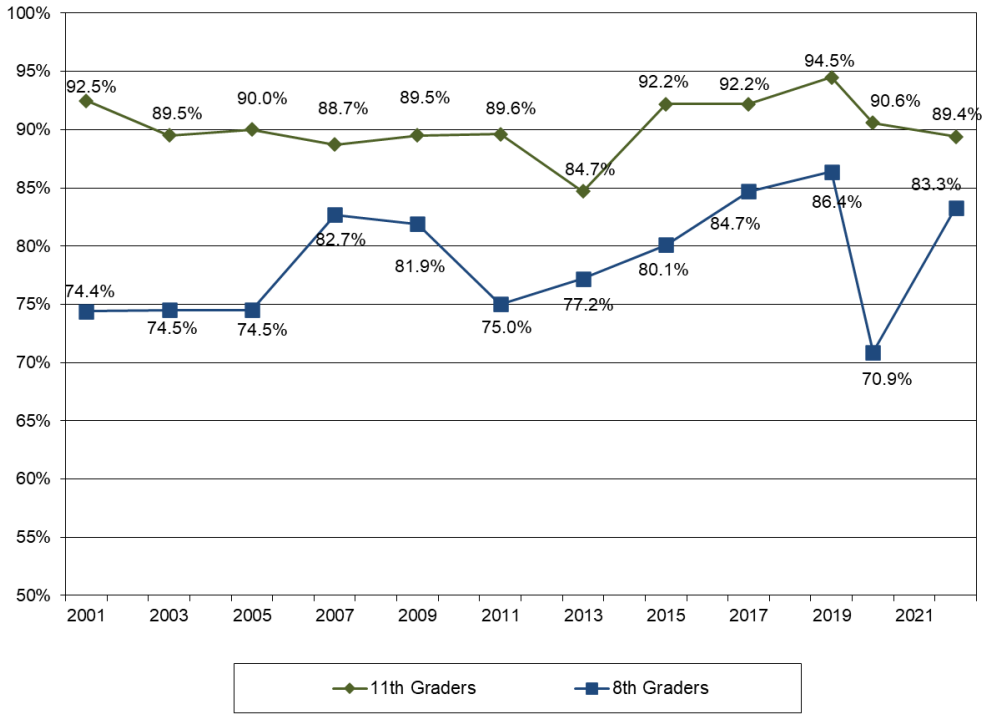
  Progress: To determine whether expanded availability of subsidized birth control and contraceptive management services affects birth control use among teens, data from Oregon's school-based student health surveys are used. From 2001-2019 the survey was called Oregon Healthy Teens (OHT); starting 2020 the survey is called the Student Health Survey (SHS). Both surveys include 8th and 11th grade students.

  The OHT and SHS surveys are anonymous and voluntary research-based surveys conducted among 8th and 11th graders at public schools statewide. Eligible schools are randomly sampled and stratified by county, ensuring that there is representation from each county. There are opportunities for school districts, parents/guardians and students to choose whether to participate. The surveys include questions related to Oregon's State Health Improvement Plan, which addresses the leading causes of death, disease, and injury in Oregon. Question types are mostly multiple choice and Likert scales. Participation rates are usually about 30-35% of those enrolled in the selected schools.

  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. Specifically, in 2020 the SHS methodology was modified to enable remote online survey administration and the data collection period was extended over a six-month period. In both previous and subsequent years, the OHT and SHS surveys were administered in-person over a one-month period in either a paper or web-based format. It is also possible that the decrease in reported contraception use in 2020 is due in part to the COVID-19 pandemic impacting access to contraception through School-Based Health Centers and other youth-friendly clinics. In 2022 the rate returned to 83.3% for 8th graders, although the rate for 11th graders continued a slight decline at 89.4%. We will be monitoring this data in the coming years to see how rates change over time.

Chart 7. Proportion of Oregon students who report using a method of contraception at last intercourse



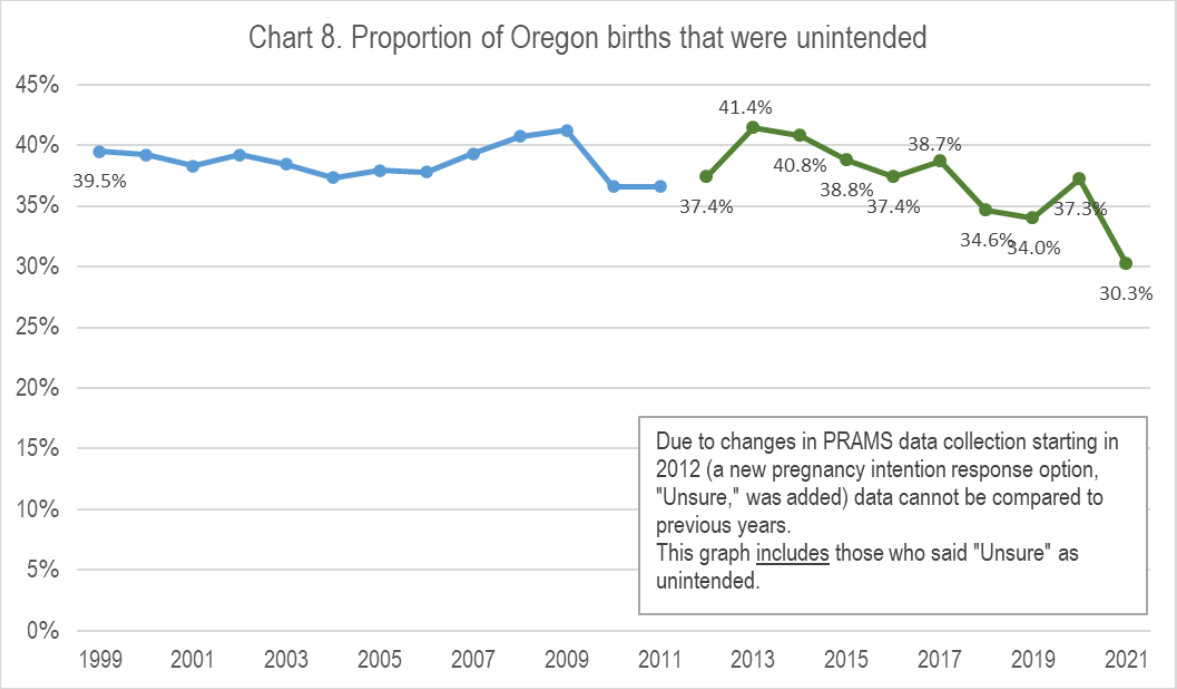
Long Term Outcomes

- **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 8 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.



In the table below we show a hypothetical "pre-post" as an additional comparison, using data from 2015 ("pre") and 2021 ("post") (2023 data is not yet available). The proportion of unintended births in Oregon has decreased significantly between 2015 and 2021, from 38.8% to 30.3% of births.

Table 2. Proportion of unintended births, Oregon PRAMS, 2015-2021

Year	Proportion of births unintended + unsure	N	Std. Dev.	95% CI Lower	95% CI Upper
2015	0.388	1430	0.732	0.3500605	0.4259395
2021	0.303	1834	0.697	0.2711007	0.3348993
Z-score 3.3610, P<0.005					

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

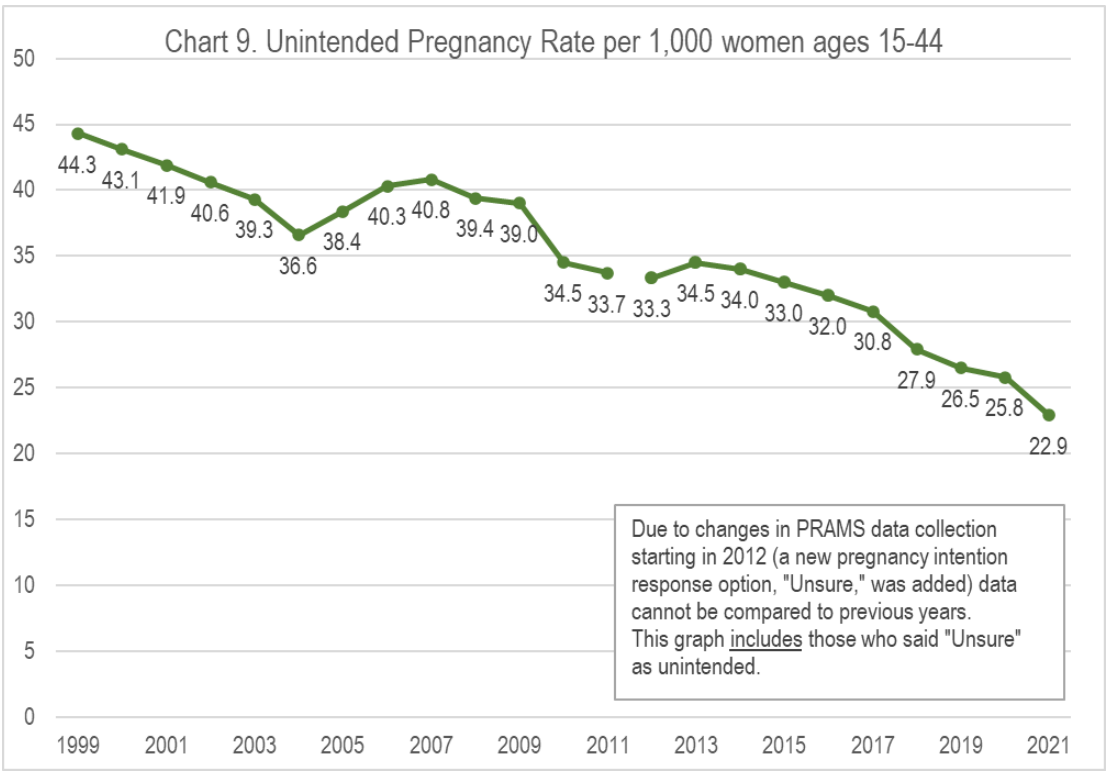
  Data source: Oregon PRAMS and Oregon Center for Health Statistics

  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."[4] 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.[5] 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 are shown in Chart 9. 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 far below the target of 32.0 per 1,000 women aged 15-44.

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

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



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

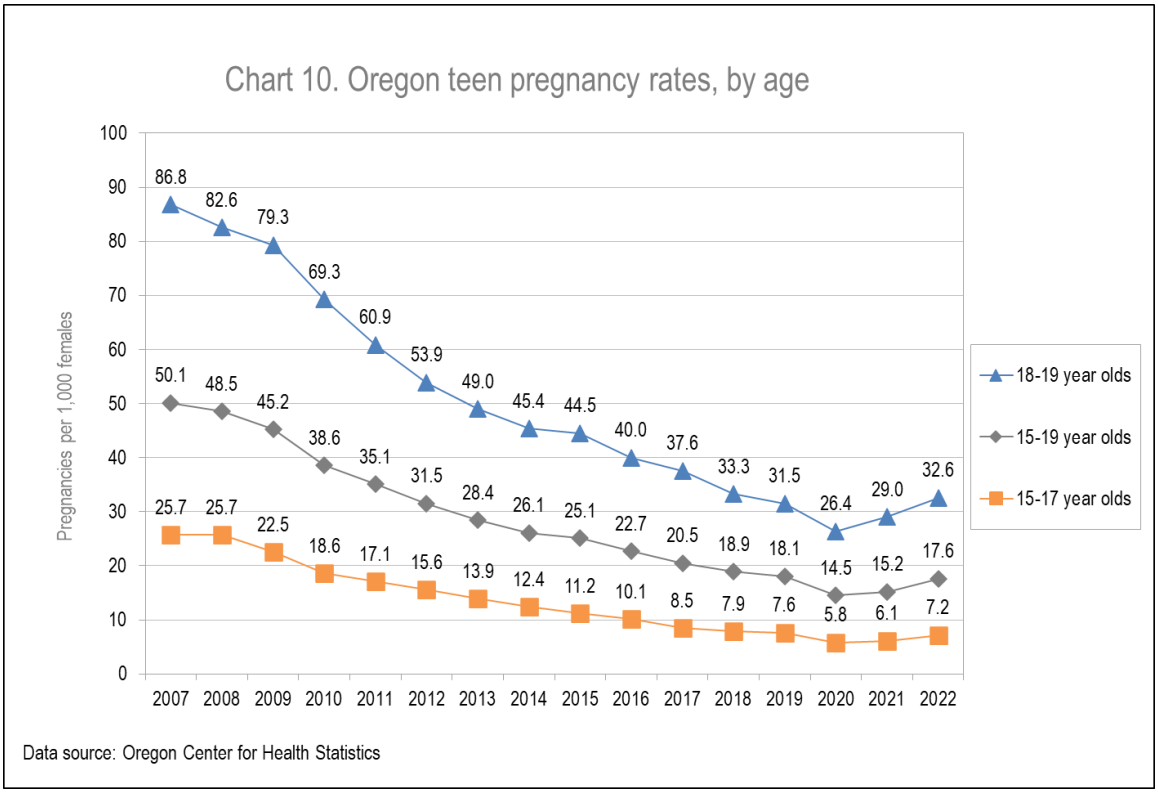
  Data source: Oregon Center for Health Statistics

  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.[6] This increase has since reversed, however, with Oregon teen pregnancy rates among all age groups continuing to dramatically decline between 2007 and 2020. The performance targets were reached as of 2016.

[6] 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

As shown in the chart below, these rates increased slightly from 2020 to 2022 but are well below the performance targets.



As an additional analysis, we compared national teen birth rates with those in Oregon, from 2015 and 2022.[7] Teen birth rates have been declining nationally for many years, although the decline varies across states. The decline in Oregon during 2015-2022 (from 19.0 to 10.1 per 1,000) was statistically significantly larger than the decline seen in the United States overall (from 22.3 to 13.6 per 1,000). See details in Table 3.

Table 3. Birth rates per 1,000 15–19-year-olds, Oregon and United States, 2015-2022

	Oregon	United States
2015	19.0	22.3
2022	10.1	13.6
Difference	-8.9	-8.7
Z=-51.17, P<0.0001		

[7] Osterman MK et al. Births: Final Data for 2022. National Vital Statistics Reports, Vol. 73, No. 2, April 4, 2024. Obtained from: https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-02.pdf

Limitations

There were four main limitations of this evaluation. First, the approved evaluation design for this waiver period did not include any comparison groups. Without comparison groups, it is difficult to isolate the effects of the CCare waiver. Although we retroactively included comparisons to national data for Outcomes 3 and 7 as well as a pre-post comparison for Outcome 5 in this report, a stronger evaluation design would plan for comparison groups prospectively.

Second, we can only account for family planning services obtained through the CCare program. CCare enrollees may obtain full-benefit coverage through Oregon's Medicaid program, the Oregon Health Plan, or commercial coverage through an employer or the Marketplace, and services obtained through such coverage are not included in this report.

Third, although the COVID-19 Public Health Emergency (PHE) undoubtedly affected service provision and utilization, the effects of the PHE were not specifically evaluated.

Finally, the fourth limitation was in the small amount of staff time dedicated to conducting evaluation activities. We look forward to a more robust evaluation for the current DY26-DY30 waiver period, utilizing an independent evaluator to ensure adequate time can be dedicated to these activities.

Conclusions and Recommendations

The data and conclusions included in this summative report show the patterns of outcomes of a mature demonstration program. As CCare embarks on the next waiver renewal period, it is useful to review past progress and identify recommendations for the future.

Overall, the progress on key Oregon ContraceptiveCare goals and related program objectives is mixed. While there has been progress made on unintended pregnancy rates, unintended birth rates, and teen pregnancy rates, rates of effective contraceptive use have remained steady and there has been a decrease in reported provision of information

regarding primary care services and primary care coverage. These objectives are complex and progress is subject to many factors external to the CCare program, including:

- Increased access to and enrollment in full benefit Medicaid (Oregon Health Plan) coverage: While one of the goals of CCare is to increase access to and enrollment in primary care services and coverage, decreases in CCare utilization make CCare's performance measures somewhat less reliable;
- The COVID-19 Public Health Emergency: as described above, the PHE resulted in changes in access to care including clinic limitations and closures as well as increases in full benefit Medicaid (Oregon Health Plan) enrollment. The impact of these changes was not specifically evaluated in this report;
- Geographic variation in clinic accessibility: CCare clinics are currently available in 32 of Oregon's 36 counties, however clients in rural areas may live over 100 miles from the nearest CCare clinic. This report did not include any stratification of outcome measures by urban/rural or other geographic categorization;
- Local policies limiting availability of contraceptive management services, particularly among certain school-based health centers;
- Health professional shortages:[8] There are 39 geographic areas in Oregon designated as Medically Underserved Areas (MUA) due to a shortage of primary care health services. 25 of these areas are rural, 2 are partially rural, and 12 are non-rural. This further highlights the importance of stratifying outcome measures based on geography;

Threats to Success

Success of the CCare program depends on accessibility of clinics and providers as well as awareness among potential beneficiaries/enrollees. Although we do not have data indicating awareness and reach among the eligible population, these items are important

[8] Health Resources and Services Administration Health Workforce Shortage Areas, retrieved June 2025 https://data.hrsa.gov/topics/health-workforce/shortage-areas

to consider when seeking improvements to the CCare program. Key threats to success in the 2024-2028 waiver period include:

- Limited awareness of CCare among prospective enrollees: although we do not have specific data regarding awareness of CCare, there is limited funding available for outreach which likely leads to limited awareness.;
- Low levels of enrollment among the eligible population of Oregonians: although we do not have specific data regarding the total number of potentially eligible Oregonians, it is likely that CCare could increase awareness of and enrollment into the program;
- Health professional shortages: as mentioned above, Oregon has several health professional shortage areas, particularly in rural areas of the state. Provider recruitment and retention can be challenging in these areas and may limit availability of CCare services;
- Limited provider network: between 2016-2023, 14 providers stopped participating in CCare. Some of these providers continue to serve Medicaid (Oregon Health Plan) members while others closed entirely.

Recommendations

As the Oregon ContraceptiveCare program prepares for a major system migration and integration with the Oregon Health Plan enrollment and claims systems, there will be many opportunities to streamline administrative processes, improve the enrollment process for members, and simplify billing processes for providers.

Oregon will implement the system changes needed to migrate eligibility and claims processing functions to the state's Integrated Eligibility ONE system and MMIS claims processing system in order to come into full alignment with federal regulations.

Recommendations for the next waiver period include:

- Increase in outreach to potential members: the upcoming systems migration is an opportunity to increase outreach through enrollment assisters and community partners;
- Continued provider outreach and education: as with outreach to potential members, the upcoming systems migration is an opportunity to enhance educational opportunities to providers and promote CCare to potential providers;
- Monitoring enrollment and utilization across the transition period: it will be important to understand how the system migration impacts enrollment and utilization;
- Stratify outcome measures by geography: as noted above, there is geographic variation in clinic accessibility and health professional shortages. It will be important to analyze how these variations impact outcome measures;
- Ongoing robust evaluation conducted by an independent evaluator: having an independent evaluation team with dedicated time to reviewing data, conducting beneficiary surveys and clinic staff interviews will enhance the utility of the evaluation.

Appendix A. Summary of Budget Neutrality calculations

For the DY18-DY25 waiver renewal period, the budget neutrality requirement for the Oregon ContraceptiveCare program was based on per-member per-month (PMPM) costs. The budget limit was calculated as the projected PMPM cost multiplied by the actual number of member months for the demonstration, multiplied by the compositive federal share. Projected PMPM costs were based on historical expenditures and an approved cost trend.

In the table below we summarize the calculations made on budget neutrality under the DY18-DY25 STCs. As shown, there has been an estimated cumulative savings of over $36 million over the 7-year demonstration period. This indicates the Oregon ContraceptiveCare program achieved the tertiary goal of reducing overall Medicaid costs by providing increased access to cost-effective contraceptive management services.

Table A.1. Budget Neutrality Calculations based on DY18-DY25 STCs

DY	PMPM limit	Cumulative Budget Neutrality Limit	Annual Expenditures reported on CMS-64	Cumulative Savings
18	$34.28	$10,323,388	$11,993,021	($1,669,633)*
19	$34.57	$20,162,148	$8,243,971	$74,844
20	$34.87	$27,859,073	$8,745,890	($1,123,809)**
21	$35.17	$39,619,358	$8,229,086	$2,407,390
22	$35.47	$50,690,290	$6,458,762	$7,019,560
23	$35.78	$64,955,883	$3,923,002	$17,362,151
24	$35.78	$82,437,991	$3,925,609	$30,918,650
25	$35.78	$92,117,090	$4,501,157	$36,096,592
* In DY18, the Oregon Health Authority's Office of Financial Services identified and corrected an error with CMS-64 reporting for CCare, making a significant prior period adjustment for payments during calendar year 2015 (DY17). Actual expenditures for DY18 were $8,420,287.				
** In DY20 CCare implemented its new braided funding structure (described previously) which required ending all active enrollments as of March 31, 2018, and all eligible members were required to re-enroll after April 1, 2018. This artificially deflated the number of member months relative to the number of enrollments, compared to previous years. The actual expenditures for DY20 were fairly consistent with previous years but due to the lower number of member months, the budget limit was lower than actual expenditures.				