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

April 8, 2025

Emma Sandoe
Medicaid Director
Oregon Health Authority
500 Summer Street NE, E35
Salem, OR 97301

Dear Director Sandoe:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Evaluation Design, which is required by the Special Terms and Conditions (STCs), specifically, STC 34, of the section 1115 demonstration, "Oregon Contraceptive Care" (Project Number 11-W-00142/0), effective through December 31, 2028. CMS has determined that the Evaluation Design, which was submitted on November 20, 2024, and revised on March 26, 2025, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's Evaluation Design.

CMS has incorporated the approved Evaluation Design into Attachment C of the demonstration's STCs. A copy of the STCs, which includes the updated attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Oregon on the 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: 2025.04.08 12:30:45 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Nicole Lemmon, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Oregon's 1115(a) Medicaid Family Planning Waiver Evaluation Design

Draft updated after CMS review

March 2025

Table of Contents

Acronyms

- **CCare:** Contraceptive Care
- **CE:** Continuous Eligibility
- **CFR:** Code of Federal Regulations
- **CORE:** Center for Outcomes Research and Education
- **CVR:** Clinic Visit Record
- **MMIS:** Medicaid Management Information System
- **NEMT:** Non-Emergent Medical Transportation
- **NICU:** Neonatal Intensive Care Unit
- **ODHS:** Oregon Department of Human Services
- **OHA:** Oregon Health Authority
- **OHP:** Oregon Health Plan
- **ONE System:** Oregon Eligibility System
- **RHAF:** Reproductive Health Access Fund
- **RH Program:** Reproductive Health Program

General Background

Demonstration name:	Oregon Contraceptive Care (CCare) Section 1115 Demonstration, Project Number 11-W00142/0
Approval date:	November 8, 2023
Waiver time period:	January 1, 2024 through December 31, 2028

Operating continuously since 1999, Oregon's section 1115(a) Medicaid family planning waiver expands Medicaid coverage for family planning services to all individuals of reproductive age with household incomes at or below 250% of the federal poverty level (FPL) who are not otherwise eligible for Medicaid or the Children's Health Insurance Program. The overarching goal of the Oregon Contraceptive Care (CCare) Program is to improve the health and well-being of Medicaid recipients by reducing unintended pregnancies via access to family planning services and improved connections to primary health care services. Enrolled individuals, who currently number approximately 25,000 (point in time count) as of October 2024, receive office visits for contraceptive management services, limited laboratory services, contraceptive devices, and pharmaceutical supplies. There is no cost-sharing for coverage.

CCare is administered by the Reproductive Health Program (RH Program) at the Oregon Health Authority (OHA). Along with CCare, the program supports access to reproductive health services with Title X grant funds and state financing provided through Oregon's Reproductive Health Equity Act. The Program "blends" all three payment sources into a Reproductive Health Access Fund (RHAF) and uses a set of rules based on each funding source's eligibility and service coverage requirements to determine which fund is most appropriate to pay for each client and visit. Services are provided through a statewide network of agencies, the majority of which of which receive funding from all three sources. As of October 2024, 40 agencies and 132 individual clinic locations participate in CCare.

The current CCare demonstration period includes four primary policy and/or operational changes, or clarifications:

1. As of June 1, 2024, CCare is providing **24 months of continuous eligibility (CE)** for enrollees rather than 12 months as in previous demonstration periods. Strong evidence exists showing that continuity of coverage and reduced frequency of disenrollment and re-enrollment (also known as churn) supports better access to and continuity of care.[1,2] Better access in turn leads to increased utilization of important preventive care services, which include family planning services; for example, insurance coverage is associated with use of most and moderately effective contraceptive methods.[1-4] This change also aligns CCare eligibility periods with those of the Oregon Health Plan (OHP), Oregon's broader 1115a Medicaid waiver.

2. Beginning in January 2025, CCare is required to cover **non-emergent medical transportation (NEMT)** services for enrollees. Recent data suggest that up to a third of Medicaid and Medicare beneficiaries have delayed care or run out of medications because of transportation barriers.[5] NEMT interventions are associated with fewer missed health care appointments.[6]
3. The demonstration approval also clarifies that individuals enrolled in the family planning demonstration will **not be retroactively eligible**. This is consistent with existing CCare policy and practices.
4. In addition, the demonstration approval requires the state to bring CCare **application and eligibility determination processes into compliance** with section 1943 of the Social Security Act and implementing regulations at 42 CFR part 435 by December 31, 2028. OHA will accomplish this by integrating CCare into the statewide Medicaid eligibility practices and systems, including the ONE Eligibility System and Medicaid Management Information System (MMIS).

This Evaluation Design describes plans to evaluate each of the four demonstration components listed above. The following sections outline implementation evaluation questions and research hypotheses, provide a logic model for the demonstration, and describe the proposed evaluation design, focus and comparison populations, measures, data sources, analytic methods, and limitations.

Evaluation Questions and Hypotheses

This evaluation design includes both implementation questions that focus on understanding how the CCare demonstration policies were implemented and research hypotheses/evaluation questions that focus on assessing the impact of the policy on CCare enrollees.

Implementation Questions

Implementation Question 1. How is the continuous eligibility (CE) policy being implemented?

- *Implementation Question 1a.* Did implementation of the CE policy happen as expected, and what factors facilitated or impeded success?
- *Implementation Question 1b.* What impact did the CE policy have on administrative burden related to renewals for clinic staff?
- *Implementation Question 1c.* What impact did the CE policy beginning at eligibility determination (i.e. the lack of retroactive eligibility) have on clinics' financial health?

Implementation Question 2. How is the non-emergent medical transportation (NEMT) policy being implemented?

- *Implementation Question 2a*. What resources were needed to implement the NEMT policy?
- *Implementation Question 2b*. What organizations and partnerships engaged in implementation of the NEMT policy, and what strategies were used for collaboration?
- *Implementation Question 2c.* What proportion of clinics serve CCare enrollees using NEMT services?
  Implementation Question 2d. What factors have facilitated or impeded success?

Implementation Question 3. What is the process of migrating to centralized Medicaid eligibility and enrollment systems?

- *Implementation Question 3a.* How did OHA and clinic staff experience this transition?
- *Implementation Question 3b.* How did CCare enrollees experience this transition?
- *Implementation Question 3c.* What benefits, drawbacks, and unanticipated outcomes are associated with the migration?

Research Hypotheses

Research Hypothesis 1. The CE policy will increase enrollment in CCare, increase continuity of CCare coverage and reduce churn overall and among specific subgroups of enrollees.

- *Research Question 1a*: How does the CE policy impact CCare enrollment and renewal rates?
- *Research Question 1b*: How does the CE policy impact rates of churn in CCare?
- *Research Question 1c*: How long are individuals enrolled in CCare under the CE policy?
- *Research Question 1d*: How does the CE policy increase enrollment and coverage continuity and reduce churn among specific subgroups of CCare enrollees?
- *Research Question 1e*. What impact does the CE policy beginning at eligibility determination (i.e. lack of retroactive eligibility) have on CCare enrollees' financial strain due to medical bills for family planning services?

Research Hypothesis 2. The provision of NEMT services will decrease overall transportation-related barriers, as well as barriers among specific subgroups, to accessing family planning care.

- *Research Question 2a.* How do CCare enrollees use NEMT services?
- *Research Question 2b.* What is the experience of accessing NEMT services for CCare enrollees?
- *Research Question 2c:* What impact did the provision of NEMT services have on self-reported transportation-related barriers to accessing care?
- *Research Questions 2d.* How does the provision of NEMT services impact transportation-related barriers to accessing care among specific subgroups?

Research Hypothesis 3. The demonstration will increase access to and utilization of family planning services and primary care for CCare enrollees overall, as well as among specific subgroups of CCare enrollees.

- *Research Question 3a.* What proportion of CCare enrollees receive screening for pregnancy intent?
- *Research Question 3b.* How does the demonstration impact continuity of contraceptive care?
- *Research Questions 3c.* How does the demonstration impact screening for reproductive-health related conditions, including cervical cancer and STIs, among CCare enrollees?
- *Research Question 3d.* How does the demonstration impact access to primary care?
- *Research Question 3e.* How does the demonstration increase access to and utilization of family planning services among specific subgroups of CCare enrollees?

Research Hypothesis 4. The demonstration will increase reproductive autonomy among CCare enrollees overall and among specific subgroups.

- *Research Question 4a.* How does the demonstration impact CCare enrollees use of preferred contraceptive methods?
- *Research Question 4b.* How does the demonstration impact CCare enrollees' access to high quality information on family planning options?
- *Research Question 4c.* How does the demonstration impact self-reported autonomy over reproductive decisions among CCare enrollees?
- *Research Questions 4d.* How satisfied are CCare enrollees with their access to and receipt of family planning services?
- *Research Question 4e.* How does the demonstration increase reproductive autonomy among specific subgroups of CCare enrollees?

Research Hypothesis 5. The demonstration will improve maternal health and birth outcomes among CCare enrollees overall and among specific subgroups.

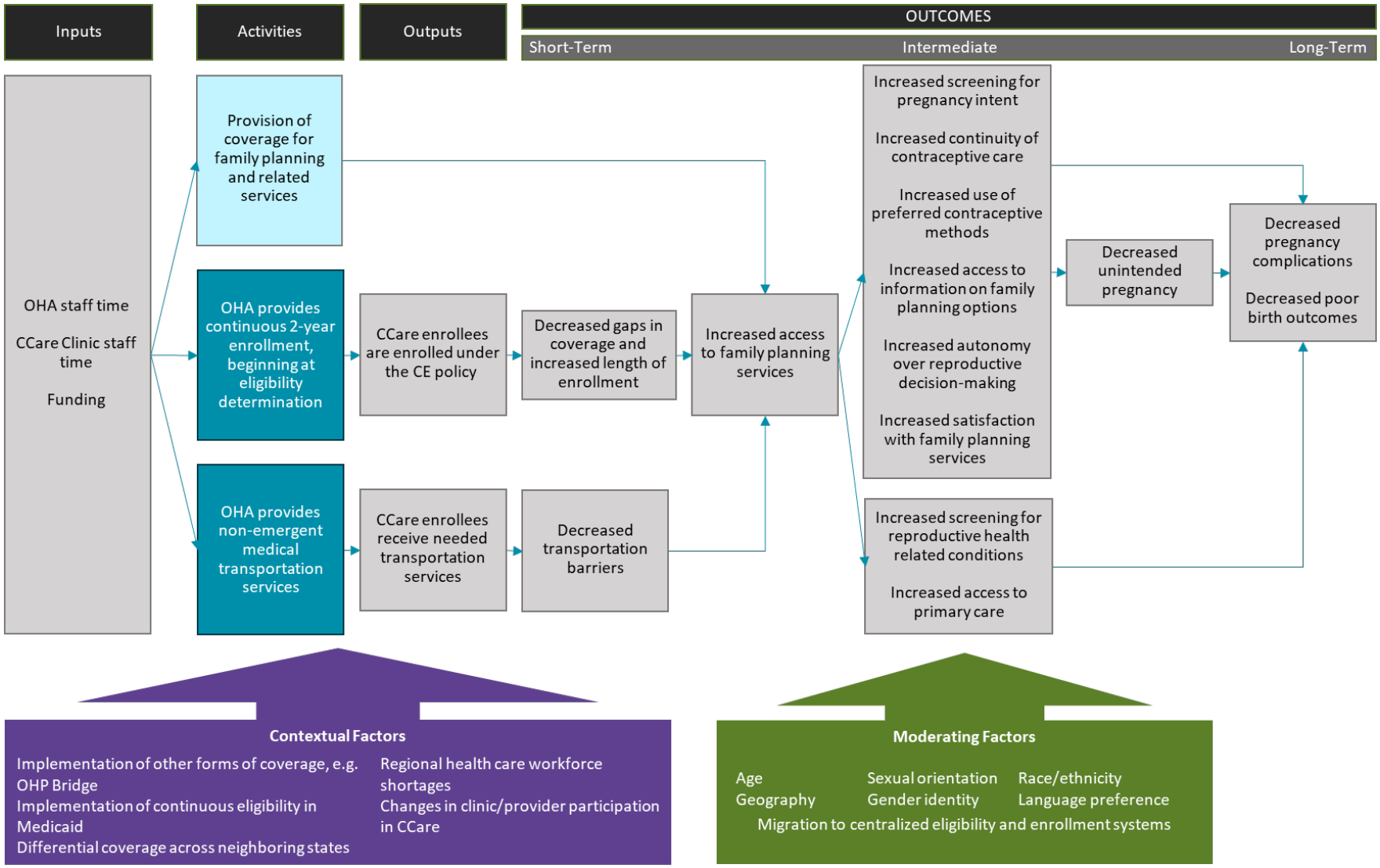
- *Research Question 5a.* How does the demonstration impact unintended pregnancy rates among CCare enrollees?
- *Research Question 5b.* How does the demonstration impact pregnancy complications, such as gestational diabetes or hypertension, among CCare enrollees?
- *Research Question 5c.* How does the demonstration impact poor birth outcomes, including preterm birth, low birthweight, and NICU stays among CCare enrollees?
- *Research Question 5d.* How does the demonstration improve maternal health and birth outcomes among specific subgroups of CCare enrollees?

Logic Model

The logic model below shows the three proposed pathways through which the CCare demonstration impacts outcomes for CCare enrollees. First is the provision of coverage for family planning services under the CCare Program, which increases access to family planning services. Second is the continuous eligibility policy, which extends enrollment in CCare to 24 months (beginning at time of enrollment, e.g. no retroactive eligibility), resulting in decreased gaps in coverage and increased length of enrollment. Third is the provision of NEMT services, which reduces transportation barriers for CCare enrollees. The two latter pathways (the CE policy and the provision of NEMT services) then also lead to increased access to family planning services.

Increased access to family planning services can lead to increased use of such services, including increased screening for pregnancy intent and increased continuity of contraceptive care; and increased reproductive autonomy, including increased use of preferred contraceptive methods, receipt of high quality information about family planning options, autonomy over reproductive decision-making, and satisfaction with family planning services. This increased use of family planning services and increased reproductive autonomy can both directly improve maternal health and birth outcomes, as well as indirectly improve these outcomes through the pathway of reducing unintended pregnancies. Additionally, because the CCare program includes referrals to other forms of care such as primary care and screening for reproductive health conditions (e.g. sexually transmitted diseases, cervical cancer, etc), increased access to family planning services under this program can lead to increased use of these other services, which in turn also improves maternal health and birth outcomes.

Finally, the logic model includes contextual and moderating factors. Contextual factors are environmental conditions that need to be taken into account when analyzing the data and interpreting results, including changes to other forms of health care coverage that may impact this population and challenges with health care workforce capacity. Moderating factors are those that can impact the strength of the various pathways in the model; these includes demographic and geographic characteristics of CCare enrollees, as well as the change to centralized Medicaid eligibility and enrollment systems expected to happen under the current CCare demonstration.


Inputs
Activities
Outputs
OUTCOMES
Short-Term
Intermediate
Long-Term
OHA staff time
CCare Clinic staff time
Funding
Provision of coverage for family planning and related services
OHA provides continuous 2-year enrollment, beginning at eligibility determination
OHA provides non-emergent medical transportation services
CCare enrollees are enrolled under the CE policy
CCare enrollees receive needed transportation services
Decreased gaps in coverage and increased length of enrollment
Decreased transportation barriers
Increased access to family planning services
Increased screening for pregnancy intent
Increased continuity of contraceptive care
Increased use of preferred contraceptive methods
Increased access to information on family planning options
Increased autonomy over reproductive decision-making
Increased satisfaction with family planning services
Increased screening for reproductive health related conditions
Increased access to primary care
Decreased unintended pregnancy
Decreased pregnancy complications
Decreased poor birth outcomes
Contextual Factors
Implementation of other forms of coverage, e.g. OHP Bridge
Implementation of continuous eligibility in Medicaid
Differential coverage across neighboring states
Regional health care workforce shortages
Changes in clinic/provider participation in CCare
Moderating Factors
Age
Geography
Sexual orientation
Gender identity
Race/ethnicity
Language preference
Migration to centralized eligibility and enrollment systems

Approach Overview

For each implementation or research question listed above, the table below provides: proposed outcomes measures; sample/population, comparison groups, and subgroups; data sources; and analytic methods. Further details on the outcomes, focus and comparison populations, data sources, and analytic methods are given in the Methodology section following the table.

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
Implementation Question 1. How is the CE policy being implemented?				
Implementation Question 1a. **Did implementation of the CE policy happen as expected, and what factors facilitated or impeded success?**	- Deviations from the implementation plan - Successes and challenges - Barriers and facilitators - Lessons learned from implementation	OHA staff CCare Clinic staff	Interviews	Qualitative analysis
Implementation Question 1b. **What impact did the CE policy have on administrative burden related to renewals for clinic staff?**	- Time spent on renewals - Other resources spent on renewals	CCare Clinic staff	Interviews	Qualitative analysis
Implementation Question 1c. **What impact did the CE policy beginning at eligibility determination (i.e. the lack of retroactive eligibility) have on clinics' financial health?**	- Financial burden for clinics - Uncompensated care	CCare Clinic staff	Interviews	Qualitative analysis
Implementation Question 2. How is the NEMT policy being implemented?				
Implementation Question 2a**. What resources were needed to implement the**	- Resources needed - Effectiveness of available resources	OHA Staff CCare Clinic staff	Interviews	Qualitative analysis

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
NEMT policy?	- Gaps in available resources	NEMT Brokerage staff		
***Implementation Question 2b*. What organizations and partnerships engaged in implementation of the NEMT policy, and what strategies were used for collaboration?**	- Organizations involved - Organizations missing from the partnership - Collaboration strategies used and effectiveness - Organization staff experience	OHA Staff CCare Clinic staff NEMT Brokerage staff	Interviews	Qualitative analysis
***Implementation Question 2c.* What proportion of clinics serve CCare enrollees using NEMT services?**	- Proportion of clinics serving enrollees using NEMT services - Characteristics of clinics serving enrollees using NEMT services	CCare Clinics	NEMT program data	Descriptive statistics
***Implementation Question 2d.* What factors have facilitated or impeded success?**	- Success and challenges - Barriers and facilitators - Lessons learned from implementation	OHA Staff CCare Clinic staff NEMT Brokerage staff	Interviews	Qualitative analysis
Implementation Question 3. What is the process of migrating to centralized Medicaid eligibility and enrollment systems?				
***Implementation Question 3a.* How did OHA and clinic staff experience this transition?**	- Overall staff experience with the transition - Facilitators and successes - Barriers, and the strategies used to overcome them	OHA and Oregon Department of Human Services (ODHS) staff CCare Clinic staff	Interviews	Qualitative analysis
***Implementation Question 3b.* How did CCare enrollees**	- Application burden - Integration with OHP	CCare enrollees	Interviews	Qualitative analysis

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
experience this transition?	coverage			
***Implementation Question 3c.* What benefits, drawbacks, and unanticipated outcomes are associated with the migration?**	- Benefits and drawbacks of the migration - Unanticipated outcomes, and if/how they were addressed - Lessons learned from the migration - Proportion of clients identifying as specific demographic group - Proportion of clients from urban/rural areas, or other geographies	OHA and ODHS staff CCare Clinic staff CCare enrollees	Interviews CCare enrollment data	Qualitative analysis Interrupted time series
Research Hypothesis 1. The CE policy will increase enrollment in CCare, increase continuity of CCare coverage and reduce churn overall and among specific subgroups of enrollees..				
***Research Question 1a*: How does the CE policy impact CCare enrollment and renewal rates?**	- Enrollment rates - Renewal rates - Reasons for renewal	CCare enrollees	CCare enrollment data CCare enrollee survey	Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable regression
***Research Question 1b*: How does the CE policy impact rates of churn in CCare?**	- Rates of gaps in CCare coverage - Length of gaps in CCare coverage	CCare enrollees	CCare enrollment data	Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
				regression
***Research Question 1c*: How long are individuals enrolled in CCare under the CE policy?**	- Length of continuous enrollment in CCare	CCare enrollees	CCare enrollment data	Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable regression
***Research Question 1d*: How does the CE policy increase enrollment and coverage continuity and reduce churn among specific subgroups of CCare enrollees?**	- All outcomes listed above	Groups disaggregated to the greatest degree possible: - Age - Sexual orientation and gender identity - Race/ethnicity - Language preference - Geography (e.g., urban, rural, frontier)	CCare enrollment data CCare enrollee survey	Comparative statistics for group differences
***Research Question 1e*. What impact does the CE policy beginning at eligibility determination (i.e. lack of retroactive eligibility) have on CCare enrollees' financial strain due to medical bills for family planning services?**	- Unpaid family planning services bills - Out-of-pocket expenditures on family planning services - Financial strain due to medical expenses for family planning services	CCare enrollees Groups disaggregated to the greatest degree possible: - Age - Sexual orientation and gender identity - Race/ethnicity	Interviews CCare enrollee survey	Qualitative analysis Descriptive statistics Comparative statistics for group differences

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
		- Language preference - Geography (e.g., urban, rural, frontier)		
Research Hypothesis 2. The provision of NEMT services will decrease overall transportation-related barriers, as well as barriers among specific subgroups, to accessing family planning care.				
Research Question 2a. **How do CCare enrollees use NEMT services?**	- Number of people using NEMT services - Types of NEMT services used - % of CCare enrollees who used NEMT more than once - Per Member Per Year (PMPY) NEMT service use	CCare enrollees	NEMT program data	Descriptive statistics
Research Question 2b. **What is the experience of accessing NEMT services for CCare enrollees?**	- Experience accessing NEMT services	CCare enrollees	Interviews CCare enrollee survey	Qualitative analysis Descriptive statistics
Research Question 2c: **What impact did the provision of NEMT services have on self-reported transportation-related barriers to accessing care?**	- Transportation-related barriers to accessing care	CCare enrollees	CCare enrollee survey	Descriptive statistics
Research Questions 2d. **How does the provision of NEMT services impact self-reported transportation-**	- All outcomes in Research Question 2c	Groups disaggregated to the greatest degree possible: - Age	CCare enrollee survey	Comparative statistics for group differences

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
related barriers to accessing care among specific subgroups of CCare enrollees?		- Sexual orientation and gender identity - Race/ethnicity - Language preference - Geography (e.g., urban, rural, frontier)		
Research Hypothesis 3. The demonstration will improve access to and utilization of family planning services for CCare enrollees overall, as well as among specific subgroups of CCare enrollees.				
Research Question 3a. **What proportion of CCare enrollees receive screening for pregnancy intent?**	- Proportion receiving screening for pregnancy intent at least once - Proportion receiving screening for pregnancy intent at every visit	CCare enrollees	Family Planning Clinic Visit Record (CVR) data	Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable regression
Research Question 3b. **How does the demonstration impact continuity of contraceptive care?**	- Proportion of first time CCare enrollees returning for additional family planning services - Proportion of CCare enrollees using most & moderately effective methods - Proportion of CCare enrollees provided long-acting reversible contraception	CCare enrollees Subgroups: - Clients with and without pregnancy intentions	CVR data CCare enrollee survey	Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable regression

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
	- Self-reported continuity of contraceptive care - Self-reported connection to pre-pregnancy care			
Research Question 3c. **How does the demonstration impact screening for reproductive-health related conditions among CCare enrollees?**	- STI screening - Breast exam - Pelvic exam - Pap test	CCare enrollees	CVR data	Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable regression
Research Question 3d. **How does the demonstration impact access to primary care?**	- Referral to primary care - Access to primary care - Ease of transition to primary care	CCare enrollees Subgroups: - Clients at FQHCs/primary care clinics vs other clinics	CCare enrollee survey	Descriptive statistics
Research Question 3e. **How does the demonstration increase access to and utilization of family planning services among specific subgroups of CCare enrollees?**	- All outcomes listed above	Groups disaggregated to the greatest degree possible: - Age - Sexual orientation and gender identity - Race/ethnicity - Language preference - Geography (e.g., urban, rural,	CVR data CCare enrollee survey	Comparative statistics for group differences

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
		frontier)		
Research Hypothesis 4. The demonstration will increase reproductive autonomy among CCare enrollees overall and among specific subgroups.				
Research Question 4a. **How does the demonstration impact CCare enrollees' use of preferred contraceptive methods?**	- Proportion of CCare enrollees reporting access to preferred contraceptive methods - Proportion of CCare enrollees changing contraception methods after a visit - Experience obtaining contraception	CCare enrollees	Interviews CVR data CCare enrollee survey	Qualitative analysis Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable regression
Research Question 4b. **How does the demonstration impact CCare enrollees' access to high quality information on family planning options?**	- Proportion of CCare enrollees receiving education - Types of education provided - Proportion of CCare enrollees reporting all their questions answered - Information provided in preferred language	CCare enrollees	Interviews CVR data CCare enrollee survey	Qualitative analysis Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable regression
Research Question 4c. **How does the demonstration impact self-reported autonomy over reproductive decisions among CCare enrollees?**	- Autonomy over decision-making – partner or parent/guardian - Autonomy over decision-making – health care provider	CCare enrollees	Interviews CCare enrollee survey	Qualitative analysis Descriptive statistics

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
Research Questions 4d. **How satisfied are CCare enrollees with their access to and receipt of family planning services?**	- Satisfaction with family planning services - Feelings of judgement from health care providers - Experiences of discrimination	CCare enrollees	Interviews CCare enrollee survey	Qualitative analysis Descriptive statistics
Research Question 4e. **How does the demonstration increase reproductive autonomy among specific subgroups of CCare enrollees?**	- All outcomes listed above	Groups disaggregated to the greatest degree possible: - Age - Sexual orientation and gender identity - Race/ethnicity - Language preference - Geography (e.g., urban, rural, frontier)	CVR data CCare enrollee survey	Comparative statistics for group differences
Research Hypothesis 5. The demonstration will improve maternal health and birth outcomes among CCare enrollees overall and among specific subgroups.				
Research Question 5a. **How does the demonstration impact unintended pregnancy rates among CCare enrollees?**	- Unintended pregnancy	CCare enrollees who transition to OHP for pregnancy coverage	CVR data OHP claims data (MMIS)	Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable regression
Research Question 5b. **How does the demonstration**	- Gestational diabetes - Hypertension	CCare enrollees who transition to OHP for	OHP claims data (MMIS)	Descriptive statistics

Question	Outcome Measures or Domains	Sample or Population Subgroups	Data Sources	Analytic Methods
impact pregnancy complications, such as gestations diabetes or hypertension, among CCare enrollees?	- Perineal laceration - Insufficient prenatal care - C-Section	pregnancy coverage		Comparative statistics - Pre-post comparison - Multivariable regression
Research Question 5c. **How does the demonstration impact poor birth outcomes, including preterm birth, low birthweight, and NICU stays among CCare enrollees?**	- Preterm birth - Low birthweight - NICU stays - Hypoglycemia - Respiratory distress syndrome - General delivery complications	CCare enrollees who transition to OHP for pregnancy coverage	OHP claims data (MMIS)	Descriptive statistics Comparative statistics - Pre-post comparison - Multivariable regression
Research Question 5d. **How does the demonstration improve maternal health and birth outcomes among specific subgroups of CCare enrollees?**	- All outcomes listed above	Groups disaggregated to the greatest degree possible: - Age - Sexual orientation and gender identity - Race/ethnicity - Language preference - Geography (e.g., urban, rural, frontier)	CVR data OHP claims data (MMIS)	Comparative statistics for group differences

Methodology

Methodological Design

We propose a mixed-methods study design for the evaluation of the CCare demonstration, relying on both qualitative and quantitative data collection and analysis to assess the implementation questions and research hypotheses. Implementation Questions 1 and 2 will employ interviews with OHA and clinic staff to understand how the continuous eligibility, lack of retroactive eligibility, and NEMT policies are being implemented; Implementation Question 2 will also use interviews with NEMT brokerage staff and NEMT program data to explore the implementation of the NEMT policy. Implementation Question 3 will then combine interviews with OHA/ODHS and clinic staff with interviews with and enrollment data from CCare enrollees to understand the process of migrating from the current standalone CCare eligibility and enrollment system to a centralized Medicaid system.

The Research Hypotheses will then test the impact of the CCare demonstration. Research Hypothesis 1 will assess the impact of the continuous eligibility policy via CCare enrollment data that can be used to calculate enrollment and gaps in coverage, interviews with CCare enrollees which will explore reasons for renewals, and the CCare enrollee survey which will ask about the financial impact of not having retroactive eligibility. Research Hypothesis 2 will use NEMT program data, the CCare enrollee survey, and interviews with CCare enrollees to understand use of NEMT services and impact on transportation-related barriers to accessing care. Research Hypotheses 3 through 5 will then bring together CCare enrollment and claims data, OHP enrollment and claims data, and CCare enrollee survey and interviews to explore the impact of the demonstration as a whole on access to and use of family planning services, reproductive autonomy, and maternal and birth outcomes.

Finally, all research hypotheses will also importantly explore how the demonstration policies impact hypothesized inequities in outcomes of interest, with a focus on inequities by sexual orientation, gender identity, race/ethnicity, language preference, and geography.

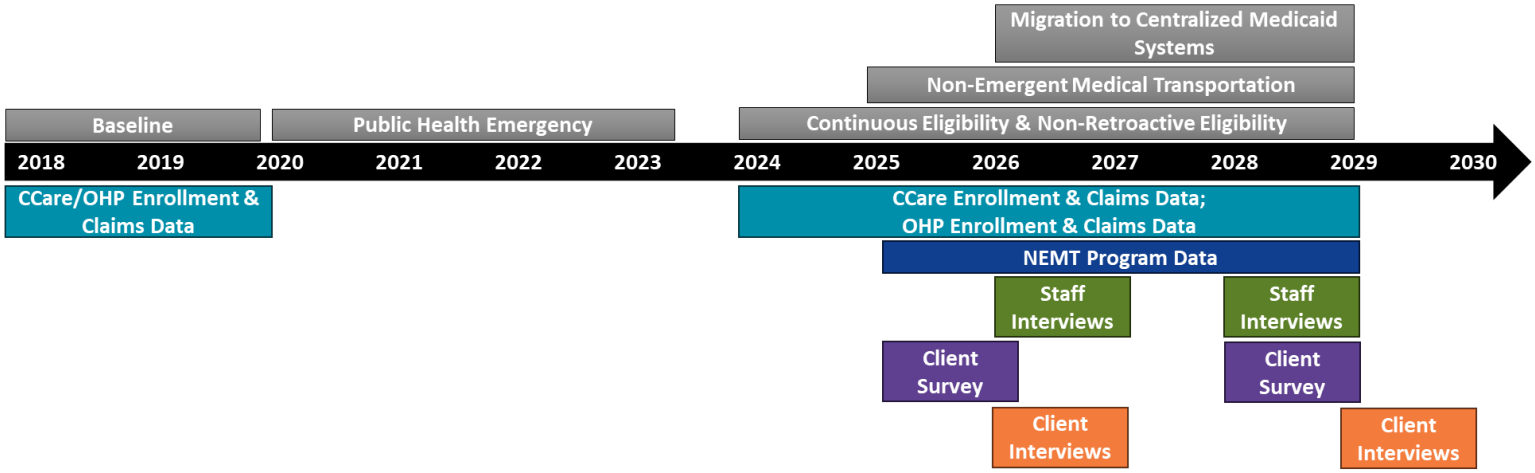
Evaluation Period

The evaluation period for the CCare demonstration will begin in 2024, with the implementation of the continuous eligibility policy, and end in 2028 when the demonstration concludes. An additional 18 months beyond the demonstration will be used for analysis and dissemination. Figure 1 depicts the timing of data collection for the evaluation.

- **Interviews with OHA/ODHS, CCare Clinic, and NEMT Brokerage Staff.** Interviews with staff at organizations responsible for implementing the demonstration policies will be conducted twice, in 2026 and 2028. In 2026, the interviews will focus on the implementation of the CE and NEMT policies; in 2028, they will focus on the continued provision of NEMT services and the migration to centralized Medicaid systems.

- **CCare Enrollment and Claims Data.** Information on CCare enrollment and use of family planning services will be collected for the entire demonstration period, 2024 through 2028. For evaluation questions that rely on pre-period data for comparison, the pre-period will cover 2018 and 2019, but will not include 2020 through 2023 in order to exclude the COVID-19 pandemic and public health emergency.
- **OHP Enrollment and Claims Data.** Information on OHP enrollment and use of health care services will be collected for the entire demonstration period, 2024 through 2028. For evaluation questions that rely on pre-period data for comparison, the pre-period will cover 2018 and 2019, but will not include 2020 through 2023 in order to exclude the COVID-19 pandemic and public health emergency.
- **CCare Enrollee Survey.** CCare enrollee experience with the demonstration will be assessed via a client survey fielded twice, once in 2025 and once in 2028.
- **Interviews with CCare Enrollees.** More in-depth information about the enrollee experience will be collected through interviews with CCare enrollees. The interviews will be conducted twice, in 2026 and 2029; this timing allows for the interview questions to build off of what is learned in the CCare enrollee survey.
- **NEMT Program Data.** Information on NEMT services will be collected from the implementation of the NEMT policy in 2025 through the end of the demonstration period in 2028.

Figure 1. CCare Demonstration Evaluation Period



Target and Comparison Populations

Target Populations

The demonstration applies to all CCare enrollees; we anticipate this to be approximately 60,000 individuals over 5 years.

Both staff responsible for implementing the various policy components and CCare enrollees will be engaged to understand the implementation and impacts of each policy component of the demonstration, as well as the impacts of the demonstration as a whole. The population focus and size may vary based on the specific data being captured; below we provide a breakdown of these populations, including potential comparison populations where appropriate.

OHA/ODHS and CCare Clinic Staff. The independent evaluator will collaborate with OHA and the RH Program's Advisory Committee to identify staff most appropriate for interviews. This will likely include: staff involved in technical and logistical aspects of both the continuous eligibility implementation and the migration to centralized Medicaid eligibility and enrollment systems (including staff at ODHS who oversee the ONE system); staff responsible for managing contracts with NEMT brokerages; staff who process enrollments and redeterminations; staff who conduct outreach and education about CCare and NEMT benefits; and staff who oversee the delivery of family planning services at the CCare clinics. We anticipate up to 20 interviews conducted twice over the demonstration period – for a total of 40 interviews – to support reaching saturation. Staff interviews will support answering the following questions:

- **Implementation Question 1.** How is the CE policy being implemented?
- **Implementation Question 2.** How is the NEMT policy being implemented?
- **Implementation Question 3.** What is the process of migrating to centralized Medicaid eligibility and enrollment systems?

NEMT Brokerage Staff. The independent evaluator will collaborate with OHA to identify staff at NEMT brokerages most appropriate for interviews. These will include staff responsible for arranging contracts with OHA and/or clinics and staff who connect CCare enrollees to NEMT services. We anticipate up to 10 interviews conducted twice over the demonstration period – for a total of 20 interviews – to support reaching saturation. NEMT brokerage staff interviews will support answering the following question:

- **Implementation Question 2.** How is the NEMT policy being implemented?

CCare enrollees. For outcomes derived from the CVR data, the primary eligibility criteria is that an individual be enrolled in CCare during the demonstration period, although there may be specific eligibility criteria associated with some outcomes of interest (as described in the **Measures** section below). In general, all CCare enrollees will be included in assessing the following hypotheses:

- **Research Hypothesis 1.** The CE policy will increase enrollment in CCare, improve continuity of CCare coverage, and reduce churn overall and among specific subgroups of enrollees.

- **Research Hypothesis 3.** The demonstration will increase access to and utilization of family planning services overall and among specific subgroups of CCare enrollees.
- **Research Hypothesis 4.** The demonstration will increase reproductive autonomy among CCare enrollees overall and among specific subgroups.

For outcomes derived from additional sources of administrative data (i.e. NEMT program data or OHP enrollment and claims data), the population will be restricted further. This will include limiting to individuals who used NEMT services when exploring the impact of the demonstration on transportation-related barriers, and limiting to individuals who become pregnant and enroll in OHP during the demonstration period when exploring the impact of the CCare demonstration on maternal and birth outcomes:

- **Research Hypothesis 2.** The provision of NEMT services will decrease overall transportation-related barriers, as well as barriers among specific subgroups, to accessing family planning care.
- **Research Hypothesis 5.** The demonstration will improve maternal health and birth outcomes among CCare enrollees overall and among specific subgroups.

For process and outcome measures derived from the CCare enrollee survey, the population will be further restricted to survey respondents. CCare enrollees will be invited to complete a survey to understand the impact of the demonstration. Surveys will be fielded to approximately 7,000 CCare enrollees in 2025 and in 2028. Depending on enrollment, this may cover all CCare enrollees during each year; if there are more than 7,000 individuals enrolled in CCare per year, CCare enrollment data may be used to ensure demographic and geographic representation. Anticipating a 30% response rate, we therefore expect an approximate sample size of 2,100 individuals in each year. Surveys will support assessing the following hypotheses:

- **Research Hypothesis 1.** The CE policy will increase enrollment in CCare, improve continuity of CCare coverage, and reduce churn overall and among specific subgroups of enrollees.
- **Research Hypothesis 2.** The provision of NEMT services will decrease overall transportation-related barriers, as well as barriers among specific subgroups, to accessing family planning care.
- **Research Hypothesis 3.** The demonstration will increase access to and utilization of family planning services overall and among specific subgroups of CCare enrollees.
- **Research Hypothesis 4.** The demonstration will increase reproductive autonomy among CCare enrollees overall and among specific subgroups.

For process and outcome measures derived from interviews, the population will be further restricted to CCare enrollee interviewees. CCare enrollees will be invited to participate in interviews to understand more about their experiences with the CCare demonstration. Information from CCare enrollment files will be used to ensure demographic and geographic representation in the interview sample. Interviewees may also be selected based on different

types of program participation (e.g. individuals who use NEMT services, or who enroll in OHP during the demonstration) or experiences (e.g. individuals who indicate they are or are not satisfied with their CCare benefit on the CCare enrollee survey) in order to more fully explore the impact of the demonstration policies. We anticipate up to 25 interviews conducted twice over the demonstration – for a total of 50 interviews – to support reaching saturation. Interviews will support answering the following implementation questions and assessing the following hypotheses:

- **Implementation Question 3.** What is the process of migrating to centralized Medicaid eligibility and enrollment systems?
- **Research Hypothesis 2.** The provision of NEMT services will decrease overall transportation-related barriers, as well as inequities in these barriers, to accessing family care.
- **Research Hypothesis 4.** The demonstration will increase reproductive autonomy among CCare enrollees overall and among specific subgroups.

Comparison populations

For the research hypotheses that rely on CCare or OHP enrollment or claims data, there are three potential comparison populations to support understanding the impact of the demonstration on client outcomes, detailed below. We anticipate the first comparison population (CCare enrollees prior to the demonstration) to be the best option; however, we describe two other possibilities (non-CCare enrollees served through the RHAF, and OHP beneficiaries seeking family planning services) if a closer assessment of the data suggests that pre-period CCare enrollees differ too substantially from those enrolled in CCare during the demonstration.

- **CCare enrollees prior to the demonstration**. Given the drastic changes in health care access and use caused by the COVID-19 pandemic, as well as the policy changes to Medicaid coverage that were implemented in response, 2020 through 2023 may not serve as an appropriate pre-period; therefore, pre-period data would need to come from 2019 or earlier. Having this large of a gap between the intervention period and the pre-period introduces opportunities for bias due to secular trends in health care utilization and changes to public policies that may have impacted use of family planning care; this will be mitigated as best as possible by the use of nearest neighbor matching or a similar technique to create focus and comparison groups that are similar on key demographic and geographic characteristics. Nearest neighbor matching uses an underlying regression model with the key demographic and geographic characteristics as predictors to identify a comparison group that matches the treatment group as closely as statistically possible in a predetermined ratio (eg. 1:1 or 1:2). Key characteristics could include age, sex, race/ethnicity, and county/ZIP code.

- **Clients served through the RHAF**. Non-CCare enrollees served through the RHAF could provide a contemporaneous comparison group. Individuals in this group receive family planning, contraceptive, and reproductive health services through the same network of clinics as CCare enrollees, and their enrollment and encounter data is tracked through the same systems. However, differences in eligibility between CCare enrollees and non-CCare enrollees – as well as differences in the services covered by CCare versus the RHAF more broadly – may threaten the validity of comparisons between these groups. As with CCare enrollees prior to the demonstration, nearest neighbor matching or a similar technique can somewhat mitigate this concern.
- **OHP beneficiaries seeking family planning services**. Similar to clients served through the RHAF, OHP beneficiaries could provide a contemporaneous comparison group less subject to bias from secular trends in health care utilization and changes to public policies than pre-period CCare enrollees. However, there are multiple concerns with this comparison: differences in eligibility between CCare enrollees and OHP beneficiaries threatens the validity of comparisons between the two groups; OHP implemented continuous eligibility at the same time as CCare, making it challenging to assess the impact of that specific policy component; and not all outcomes collected in the CVR are available in OHP data, meaning those outcomes would not be available for the comparison population.

The independent evaluator will explore these populations more fully and determine the most appropriate comparison once they have access to the data. The independent evaluator may further decide to use multiple comparison populations, if different comparison populations are deemed more appropriate for each implementation and evaluation question.

Evaluation Measures

The tables below list the proposed outcome measures to be included in this evaluation design, organized by implementation question/research hypothesis and data source. In addition to these outcomes, information may be collected on various demographic, geographic, and health-related characteristics of CCare enrollees and any comparison populations in order to facilitate appropriate analysis and interpretation of results.

Implementation Question 1. How is the CE policy being implemented? Measures for this implementation question will come from interviews with staff from OHA and CCare Clinics.

Data Source	Measure
Interviews with OHA Staff, CCare Clinic Staff	***Interview domains – barriers and facilitators*** ▶ Any deviations from the original implementation plan, and the reason for the deviations

	▶ Challenges and barriers encountered, and how they were overcome or not ▶ Facilitating factors and successes ▶ Lessons learned from implementation ***Interview domains – administrative burden*** ▶ Changes in the amount of time and other resources spent on CCare renewals ▶ Financial impacts of lack of retroactive eligibility ▶ Uncompensated care

Implementation Question 2. How is the NEMT policy being implemented? Measures for this implementation question will come from interviews with staff from OHA and CCare clinics, staff at NEMT brokerages, and NEMT program data.

Data Source	Measure
Interviews with OHA Staff, CCare Clinic Staff	***Interview domains – resources*** ▶ Description of resources needed to implement NEMT ▶ Effectiveness of the available resources ▶ Gaps in needed resources, and how they were addressed or not ***Interview domains – collaboration*** ▶ Description of organizations involved in implementing NEMT ▶ Organizations missing from the planning and implementation process ▶ Collaboration strategies used ▶ Staff experience with implementation ***Interview domains – barriers and facilitators*** ▶ Challenges and barriers encountered, and how they were overcome or not ▶ Facilitating factors and successes ▶ Lessons learned from implementation
Interviews with NEMT Brokerages Staff	***Interview domains*** ▶ Description of resources needed to expand NEMT ▶ Challenges and barriers encountered, and how they were overcome or not ▶ Facilitating factors and successes
NEMT Program Data	▶ Proportion of clinics serving CCare enrollees who use NEMT services per year ▶ Proportion of clinics serving CCare enrollees who use NEMT services for the majority of the demonstration period ▶ Types of clinics serving CCare enrollees who use NEMT services

	▶ Geography of clinics serving CCare enrollees who use NEMT services ▶ Average size of clinics serving CCare enrollees who use NEMT services

Implementation Question 3. What is the process of migrating to centralized Medicaid eligibility and enrollment systems? Measures for this implementation question will come from interviews with staff from OHA/ODHS and CCare clinics, and CCare enrollees.

Data Source	Measure
Interviews with OHA/ODHS Staff, CCare Clinic Staff	***Interview domains – barriers and facilitators*** ▶ Challenges and barriers encountered, and how they were overcome or not ▶ Facilitating factors and successes ▶ Overall staff experience with the migration ***Interview domains – impacts*** ▶ Perceived benefits and drawbacks of the migration ▶ Unanticipated outcomes of the migration, and how they were addressed or not ▶ Lessons learned from the migration
Interviews with CCare Enrollees	***Interview domains*** ▶ Experience enrolling in CCare coverage after the migration, including barriers and facilitators ▶ Experience transitioning to OHP coverage
CCare enrollment data	▶ Proportion of clients identifying as specific demographic group. *Denominator: All CCare enrollees* ▶ Proportion of clients from urban/rural areas, or other geographies. *Denominator: All CCare enrollees*

Research Hypothesis 1. The CE policy will increase enrollment in CCare, improve continuity of CCare coverage, and reduce churn overall and among specific subgroups of enrollees.. Measures of the impact of the CE policy on CCare enrollees will come from CCare enrollment data.

Data Source	Measure
CCare Enrollment Data	▶ Number of CCare enrollees. *Denominator: All CCare enrollees* ▶ Renewal rates. *Denominator: CCare enrollees eligible for renewal each year* ▶ Rates of gaps in CCare coverage. *Denominator: CCare enrollees eligible for renewal each year* ▶ Lengths of gaps in CCare coverage. *Denominator: CCare enrollees eligible for renewal each year*

	▶ Length of continuous enrollment in CCare. *Denominator: CCare enrollees with coverage gaps*
CCare enrollee Survey	***Survey domains*** ▶ Unpaid family planning services bills ○ *Example survey question: Do you currently have any medical bills for contraceptive care you are paying off over time?*[1] ▶ Out-of-pocket expenditures on family planning services ○ *Example survey question: How did you pay for your most recent birth control method?*[2] 1. *Insurance covered the full cost* 2. *Insurance covered part of the cost and I paid the rest out-of-pocket* 3. *I used Medicaid or some other public program* 4. *I did not have any coverage for birth control and paid for it myself* 5. *I had coverage, but didn't use it, and paid for it myself* 6. *Other* 7. *Don't know* 8. *Refuse to answer*
Interviews with CCare Enrollees	***Interview domains*** ▶ Reasons for renewal. ▶ Financial strain due to medical expenses for family planning services

Research Hypothesis 2. The provision of NEMT services will decrease overall transportation-related barriers, as well as barriers among specific subgroups, to accessing family planning care. Measures of the impact of the NEMT policy on CCare enrollees will come from three sources: NEMT program data; interviews with CCare enrollees who used NEMT services; and the CCare enrollee survey.

Data Source	**Measure**
NEMT Program Data	▶ Number of CCare enrollees using NEMT services. *Denominator: All CCare enrollees* ▶ Proportion of CCare enrollees using NEMT services. *Denominator: All CCare enrollees* ▶ Proportion of CCare enrollees using NEMT services more than once: *Denominator: All CCare enrollees*

[1] Adapted from Health Care Affordability Survey by Commonwealth Fund
[2] Adapted from KFF Women's Health Survey

	▶ Average amount of NEMT service use per client per year. *Denominators: All CCare enrollees, CCare enrollees using NEMT* ▶ Types of NEMT services used. *Denominator: CCare enrollees using NEMT*
Interviews with CCare enrollees	***Interview domains*** ▶ Experience accessing NEMT services ▶ Facilitating factors and successes ▶ Challenges and barriers encountered, and how they were overcome or not
CCare enrollee Survey	***Survey domains*** ▶ Experience accessing NEMT services ○ *Example survey question: Overall, how satisfied were you on average with all the non-emergency medical transportation services you received from in the past 12 months?*[3] ▶ Transportation-related barriers to accessing care ○ *Example survey question: Have you had difficulty finding a ride to a medical appointment in the past 6 months? If yes, please select all reasons that apply?*[4] 2. *I need a wheelchair accessible vehicle.* 3. *I don't have enough money for the fare.* 4. *I don't know who to call to request a ride.* 5. *My friends and family are not available to take me.* 6. *There are no rides available when I call.* 7. *I can't get a ride at the time I need to go.* 8. *I have to wait too long for a ride back home after my appointment.* 9. *I have not had difficulty finding a ride to a medical appointment in the past 6 months*

Research Hypothesis 3. The demonstration will increase access to and utilization of family planning services and primary care for CCare enrollees overall, as well as among specific subgroups of CCare enrollees. Measures of the impact of the demonstration on access to and utilization of family planning services for CCare enrollees will come from two data sources: CVR data and the CCare enrollee survey.

Data Source	Measure

[3] Texas Health and Human Services NEMT Experience Survey
[4] Hospital Utilization and Access to Care – HUQ

CVR data	▶ Proportion receiving screening for pregnancy intent at least once. *Denominator: All CCare enrollees* ▶ Proportion receiving screening for pregnancy intent at every visit. *Denominators: All CCare enrollees, CCare enrollees with more than 1 visit* ▶ Proportion of first time CCare enrollees returning for additional family planning services. *Denominator: First-time CCare enrollees* ▶ Proportion of CCare enrollees using most & moderately effective contraception methods. *Denominator: All CCare enrollees age 15-44. Measure steward: HHS Office of Population Affairs* ▶ Proportion of CCare enrollees provided long-acting reversible contraception. *Denominator: All CCare enrollees age 15-44. Measure steward: HHS Office of Population Affairs* ▶ STI screening. *Denominator: All CCare enrollees* ▶ Breast exam. *Denominator: All CCare enrollees eligible for a breast exam.* ▶ Pelvic exam. *Denominator: All CCare enrollees eligible for a pelvic exam.* ▶ Pap test. *Denominator: All CCare enrollees eligible for a pap test.*
CCare enrollee survey	***Survey domains*** ▶ Self-reported continuity of contraceptive care ▶ Self-reported connection to pre-pregnancy care ○ *Example survey question: In the past 6 months, did anyone at this clinic connect you with a health care provider who could provide prenatal care, such as an obstetrician/gynecologist, midwife, or doula?*[5] ▶ Referral to primary care ○ *Example survey question: In the last 6 months, did anyone at this clinic connect you with a primary care provider, such a doctor or nurse practitioner?*[6] ▶ Access to primary care ○ *Example survey question: In the last 6 months, were you able to obtain all of the medical care, tests, or treatments you or your primary doctor believed necessary?*[7] ▶ Ease of transition to primary care

[5] Previous survey conducted by the Independent Evaluator
[6] Previous survey conducted by the Independent Evaluator
[7] NHANES Hospital Utilization and Access to Care Subscale

	○ *Example survey question: The following statements are about the cooperation between care providers in general practice (e.g. between general practitioner and nurse practitioner or between several general practitioners).*[8] ▪ *These care providers transfer information very well to each other.* ▪ *These care providers work together very well.* ▪ *The care of these care providers is very well connected.* ▪ *These care providers always know very well from each other what they do.*

Potential benchmarks that could be used in this section include the Family Planning Annual Report measures of screening for pregnancy intent, current contraceptive use, using moderately and most effective methods, and screening for other reproductive health conditions (e.g. Pap test, STI screening).

Research Hypothesis 4. The demonstration will increase reproductive autonomy among CCare enrollees overall and among specific subgroups. Measures of the impact of the demonstration on reproductive autonomy for CCare enrollees will come from three data sources: CVR data, the CCare enrollee survey, and interviews with CCare enrollees.

Data Source	Measure
CVR data	▶ Proportion of CCare enrollees changing contraception methods after a visit. *Denominator: All CCare enrollees* ▶ Proportion of CCare enrollees receiving education *Denominator: All CCare enrollees* ▶ Types of education provided. *Denominator: CCare enrollees receiving education*
CCare enrollee survey	***Survey domains*** ▶ Access to preferred contraceptive methods ○ *Example survey question: What is the primary reason you are not using your preferred method of birth control?*[9] *1. My preferred method was not available* *2. I could not get an appointment to get my preferred method* *3. I can't afford my preferred method*

[8] Adapted from Nijmegen Continuity Questionnaire
[9] NHANES Hospital Utilization and Access to Care Subscale

4. *I have medical conditions that make me ineligible for using my preferred method*
5. *My provider recommended a different method*
6. *My partner does not want me to use my preferred method*
7. *I'm concerned about side effects*
8. *Other*

- Self-reported frequency of getting questions answered
  - *Example survey question: Please rate the health care provider you saw today with respect to the following qualities: Answering all my questions?*[10]
- Information provided in preferred language
  - Example survey question: *Have you ever received information about contraceptive care in your preferred language?*[11]
- Autonomy over decision-making – partner or parent/guardian
  - Example survey question: *Who has the most say about whether you use a method to prevent pregnancy?*[12]
    1. *My sexual partner (or someone else such as a parent or mother in-law/father in-law)*
    2. *Both me and my sexual partner (or someone else such as a parent or mother in-law /father in-law) equally*
    3. *Me*
- Autonomy over decision-making – health care provider
  - *Example survey question: Please rate the health care provider you saw today with respect to the following qualities:*[13]
    - *Letting me say what mattered to me about my birth control method.*
    - *Taking my preferences about my birth control seriously*
    - *Working out a plan for my birth control with me*
- Satisfaction with family planning services
  - *Example survey questions: How satisfied are you with your access to family planning services?* [14]
- Feelings of judgement from health care providers

[10] Interpersonal Quality of Family Planning (IQFP) scale
[11] Previous survey conducted by the Independent Evaluator
[12] Adapted from Reproductive Autonomy Scale
[13] Interpersonal Quality of Family Planning (IQFP) Scale
[14] THE WHOQOL-100 Australian Version (May 2000)

	○ *Example survey question: When getting any kind of family planning services, have you ever had any of the following things happen to you because of your race or ethnicity, preferred language, gender or gender identity, sexual orientation, income, disability status, or health needs:*[15] ▪ *Been treated with less courtesy than other people.* ▪ *Been treated with less respect than other people.* ▶ Experiences of discrimination ○ *Example survey question: When getting any kind of family planning services, have you ever had any of the following things happen to you because of your race or ethnicity, preferred language, gender or gender identity, sexual orientation, income, disability status, or health needs:*[16] ▪ *Been treated with less courtesy than other people.* ▪ *Been treated with less respect than other people.* ▪ *Received poorer service than others.* ▪ *Had a doctor or nurse act as if they think you are not smart.* ▪ *Had a doctor or nurse act as if they are better than you.* ▪ *Felt like a doctor or nurse was not listening to what you were saying.*
Interviews with CCare enrollees	***Interview domains*** ▶ Experience obtaining contraception ▶ Autonomy over decision making ▶ Communication from providers ▶ Experiences of discrimination

Research Hypothesis 5. The demonstration will improve maternal health and birth outcomes among CCare enrollees overall and among specific subgroups. Measures of the impact of the demonstration on maternal health and birth outcomes for CCare enrollees will come from two data sources: CCare claims data and OHP claims data.

Data Source	Measure

[15] National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III)
[16] National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III)

CVR data	▶ Unintended pregnancy. *Denominator: CCare enrollees who are/were pregnant*
OHP claims data	▶ Gestational diabetes. *Denominator: CCare enrollees with OHP birth claims. Measure Steward: International Classification of Diseases (ICD)* ▶ Hypertension. Denominator: *CCare enrollees with OHP birth claims. Measure Steward: ICD* ▶ Perineal laceration. Denominator: *CCare enrollees with OHP birth claims. Measure Steward: ICD* ▶ Insufficient prenatal care. Denominator: *CCare enrollees with OHP birth claims. Measure Steward: ICD* ▶ Cesarean section. Denominator: *CCare enrollees with OHP birth claims. Measure Steward: ICD* ▶ Preterm birth. Denominator: *Matched babies of CCare enrollees with OHP birth claims. Measure Steward: ICD* ▶ Low birthweight. Denominator: *Matched babies of CCare enrollees with OHP birth claims. Measure Steward: ICD* ▶ NICU stay. Denominator: *Matched babies of CCare enrollees with OHP birth claims. Measure Steward: ICD* ▶ Hypoglycemia. Denominator: *CCare enrollees with OHP birth claims. Measure Steward: ICD* ▶ Respiratory distress syndrome. Denominator: *Matched babies of CCare enrollees with OHP birth claims. Measure Steward: ICD* ▶ General delivery complications. Denominator: *CCare enrollees with OHP birth claims. Measure Steward: ICD*

Data Sources

This section describes the primary and secondary data sources needed for the evaluation.

Primary data collection

Interviews. Interviews will be conducted with two distinct groups: staff implementing the CCare policies, including OHA/ODHS, CCare clinic, and NEMT brokerage staff; and CCare enrollees. The independent evaluator will determine the key elements of each of these qualitative data collections efforts, including selecting the number of and sampling frame for interviewees, designing the interview guide to reflect the evaluation questions of interest, providing for translation/transcreation and contracting with interpreters if needed, and setting the location and timing of each interview.

As described earlier in the Target and Comparison Population section, the draft design anticipates the following interview groups and timing:

- OHA and clinic staff: Up to 20 interviews conducted twice over the demonstration period, for a total of 40 interviews

- NEMT Brokerage staff: Up to 10 interviews conducted twice over the demonstration period, for a total of 20 interviews
- CCare enrollees: Up to 25 interviews conducted twice over the demonstration, for a total of 50 interviews

CCare enrollee surveys. The independent evaluator will collaborate with CCare Program staff and the Advisory Committee to develop and field a well-designed survey twice during the evaluation period, anticipated to be 2025 and 2028. The survey will include questions on using NEMT services, financial burden related to family planning services, experience accessing family planning services, and impact on reproductive autonomy; these questions will be obtained from validated sources and existing surveys where possible. Where previously validated and/or fielded survey questions do not exist, new questions will be created and undergo cognitive testing before inclusion in the survey. The survey will then be provided to CMS for review and approval before fielding.

Over 99 percent of CCare enrollees report either English or Spanish as their preferred language; we therefore anticipate fielding the survey in these two languages. Due to the sensitive nature of contraceptive care, we anticipate needing to collaborate with program staff to develop an appropriate fielding plan, which may include some form of convenience sampling. This may include working with CCare clinics to create systems for fielding the survey during a clinic visit or using a multi-model outreach approach relying on mail, email, and text messages, as available. Depending on the fielding approach and the number of CCare enrollees in 2025 and 2028, this may result in only a selection of CCare enrollees receiving the survey. Survey respondents will receive monetary compensation (e.g. $10) for their time.

Secondary data

Health care enrollment and claims data. Information on CCare enrollment and health care encounter data will come from three data sources: the Client Visit Record (CVR) and Ahlers eligibility database, and, after the migration to centralized Medicaid eligibility and enrollment systems is complete, the Oregon ONE Eligibility System and the Medicaid Management Information System (MMIS). MMIS will also be the source of OHP enrollment and health care encounter data.

- *Client Visit Record and Ahlers Eligibility Database.* The CVR is a data collection tool and claims form for services provided to clients enrolled in RHAF. Information collected on the CVR includes client sociodemographic, payment and provider information, type of visit and health care services received, education or counseling provided, client's primary contraceptive method, and client's pregnancy intent. CVR data can currently be collected through a variety of mechanisms, including within a clinic's electronic health record system, standalone software (WinCVR), an online tool (WebCVR), or via paper

CVR forms. CVR data and claims are processed once per month, and information from the CVR, including eligibility and enrollment information, is stored in the Ahlers system.

The CVR will be updated in 2025, based on new data collection requirements associated with Title X grant funds. Data fields that will only be available in 2024 (i.e. removed from the CVR in 2025) include information on referrals to follow-up or other types of health care; data fields that will only be available 2025 – 2028 (i.e. added to the CVR in 2025) include sexual orientation, gender identity, height, weight, blood pressure, smoking status, pregnancy status, and desire to discuss contraception, as well as additional response options for pre-existing questions around provider type, service type, and primary contraceptive method.

- *Oregon ONE Eligibility System.* The Oregon ONE Eligibility system is a platform that simplifies the application process for Oregon residents seeking medical, food, cash, and childcare benefits. The ONE Eligibility system gathers various information about the applicant, including demographic information, household income, current benefits, household composition, disability and activities of daily living, and data on current and past insurance coverage.
- *Medicaid Management Information System.* MMIS is a comprehensive database that contains detailed, timely, year-over-year data about Medicaid enrollees and the health care services paid by Medicaid and will eventually include health care services paid by CCare. The MMIS data are used for monitoring, reporting, and improving Oregon's Medicaid delivery system. The data can provide insights into various aspects, such as telehealth use, Medicaid enrollment, prenatal visits, and vaccination rates. The MMIS data are collected from two main sources: eligibility data and claims/encounter data.

OHA has invested in systems to report and house race, ethnicity, language, and disability (REALD) data, as well as data on sexual orientation and gender identity (SOGI). The REALD & SOGI Data Repository began development in 2022 in OHA's Equity & Inclusion (E&I) Division to maximize the use of REALD data, drawing from the ONE eligibility system as well as high quality REALD data from other internal sources (Birth Certificate and Acute and Communicable Disease data). Additionally, OHA is now ingesting data from medical providers via CSV standard formats, and directly from provider offices via the Patient Facing Survey Tool which utilizes an embedded QR code for flexible data collection. REALD & SOGI data can be linked to Medicaid members via a unique member identifier that exists in both datasets. Currently, over 90% of the records in the Repository include demographic data from Medicaid member.

NEMT Program data. Information on use of NEMT services will come from NEMT program data; this includes client ID, date of service, type of service, and the total price associated with the service. Prior to the migration to centralized Medicaid eligibility and enrollment systems, this information will be provided to OHA from the NEMT brokerages in an Excel template, and OHA

staff will manually review and keep a log of paid services. NEMT data can be linked from this Excel template to CVR and eligibility data via a unique member identifier that exists in both datasets. This process will change as part of the migration to centralized Medicaid eligibility and enrollment systems, at which point claims for NEMT services will be submitted to MMIS in a standard format, similar to clinical services.

Analytic Methods

Qualitative Analysis

Thematic analysis of interviews. We anticipate the following steps for conducting and analyzing interviews: creating structured interview guides that cover key topics of interest; translating guides into multiple languages as needed (and providing interpretation for the interviews); assessing the validity of the guides through cognitive interviews with individuals selected from the study population; transcribing and coding all interviews, with double-coding for accuracy; and using thematic analysis to organize codes into categories, examine patterns, and transform them into themes.

Quantitative Analysis

Descriptive statistics. All implementation and evaluation questions that require quantitative analysis will begin with descriptive statistics, for example means, medians, or percentages, or measures of distribution and spread such as the interquartile range. For some questions, descriptive statistics may be the most appropriate quantitative analytic technique and therefore the only ones used. The descriptive analyses of time trends can be done using pooled cross-sectional analysis, comparing cross-sections of the study population at different points in time, or time series analysis of panel data, which follows the same individuals over time. Given that we expect individuals in the study population to change over time, the pooled cross-section analysis is likely most appropriate.

Comparative statistics. Quantitative analytic techniques that use comparison groups provide stronger evidence of the impacts of new CCare policies by helping to control for external factors that would otherwise obscure results.

- *Pre-post comparisons.* Using the proposed comparison population of CCare members from 2018 and 2019 requires the use of a pre-post comparison. This can be done through tests of means or proportions comparing summary statistics from the pre-period to summary statistics from the period post-implementation. It can also be done using an interrupted time-series analysis, with each year of the post-implementation period being compared to the pre-period year or years. Differences in the demographic makeup of the population can be adjusted for, but this method does suffer from the inability to discern environmental changes from the impact of the demonstration.

However, as the demonstration affects everyone in the population, the environmental impacts would need to be significant to mask the demonstration effect.

- *Multivariable regression*. Regression models will provide estimates of the differences in health care outcomes between treatment (CCare enrollee) and prospective comparison groups (non-CCare enrollees served through the RHAF, and OHP beneficiaries seeking family planning services) and can be adjusted for key covariates that may differ between these groups. Covariates should be limited to demographic differences, as environmental factors should be washed out between treatment and comparison groups.

Comparative statistics will be used for the following Implementation Questions and Research Hypotheses:

- **Implementation Question 3.** What is the process of migrating to centralized Medicaid eligibility and enrollment systems?

- **Research Hypothesis 1.** The CE policy will increase enrollment in CCare, improve continuity of CCare coverage, and reduce churn overall and among specific subgroups of enrollees.
- **Research Hypothesis 3.** The demonstration will increase access to and utilization of family planning services for CCare enrollees overall and among specific subgroups.
- **Research Hypothesis 4.** The demonstration will increase reproductive autonomy among CCare enrollees overall and among specific subgroups.
- **Research Hypothesis 5.** The demonstration will improve maternal health and birth outcomes among CCare enrollees overall and among specific subgroups.

Comparative statistics for subgroup differences. For evaluation questions assessing the impact of new CCare policies on groups with current or historical health care inequities, differences between groups can be assessed by tests of interaction terms between time and group in regressions known as difference-in-difference models (DiD). This technique would be appropriate where there is data for both pre (2018-2019) and post (2024-) periods and data that can identify groups with inequities. This analysis design provides three estimates: the expected background change in health care outcomes over time regardless of demographic group; the difference in health care outcomes between groups with and without inequities before any policy changes; and the change over time in health care outcomes between groups with and without inequities. It is this last estimate that allows for assessing the impact of new CCare policies on health care outcomes in these subgroups. A DiD model excels in isolating the impact of the demonstration by ensuring the only difference between each subgroup is the subgroup qualifier itself, as all groups are subject to the same external changes over time and individuals act as their own controls. The main assumption unique to the DiD model is that of parallel trends in the outcome at baseline. Because there is no statistical test for this assumption, it is often assessed by plotting the patterns for the intervention and control states during the pre-period and visually comparing the trends between the two groups.

Comparative statistics for subgroup differences will be used for all Research Hypothesis.

Methodological Limitations

Limitations inherent to the evaluation design can be divided into two categories: methodological concerns such as the validity of the comparison populations and bias in survey responses; and contextual and environmental concerns such as changes to provider participation and other external pressures on access to care.

Methodological limitations

Comparison populations. While all of the implementation questions and some of the evaluation questions can be answered through qualitative analysis or descriptive quantitative analysis, several evaluation questions – particularly those focused on the impact of the demonstration on use of family planning services and maternal and birth outcomes – would benefit from statistical comparisons. However, as described in the Target and Comparison Populations section, each potential comparison population has limitations. A pre-period comparison group would be impacted by secular trends in health care utilization and changes to public policies over time; a comparison group of clients served through the RHAF would be subject to different eligibility criteria and receive different family planning services; and an OHP comparison group, in addition to having different eligibility criteria, is complicated due to the implementation of a similar continuous eligibility policy in 2023, making it challenging to assess the impact of this major policy component of the CCare demonstration. While these concerns can be somewhat mitigated through the use of analytic techniques such as nearest neighbor matching or the creation of synthetic comparison groups, results would still need to be interpreted within the context of these limitations.

Survey responses. Several of our key outcomes rely on self-report data from a CCare enrollee survey. Bias can be introduced into survey analysis in a few distinct ways, two of which are particularly relevant with this survey. First, sample selection and survey response rates can lead to bias if the eventual survey respondent sample is not representative of the CCare enrollee population. We will explore using survey fielding techniques such as quota sampling to increase our chances of a representative sample. Second, given the highly sensitive nature of questions around contraceptive care, responses are likely subject to social desirability bias, whereby respondents give answers that they believe to be more socially acceptable, rather than those that are accurate. We will work with clinic staff to create a fielding plan that promotes the comfort and trust of the survey respondent in order to encourage honesty in survey responses.

Contextual and environmental limitations

Provider participation. The network of clinics providing services to CCare enrollees includes Local Public Health Agencies (LPHAs), Federally Qualified Health Centers (FQHCs), stand-alone family planning clinics, and school-based or university health centers. In recent years, seven LPHAs ceased providing clinical care altogether and have therefore withdrawn from the program; two other high-volume provider agencies have stopped, or have signaled to OHA that

they will stop, participating in CCare. Exogenous changes in the CCare provider network could affect some demonstration evaluation outcomes of interest, such as enrollment rates, churn, and continuity of care, and could diminish the value of pre-demonstration period CCare enrollees as a potential comparison group.

External pressures on access to care. Several current health care infrastructure, policy, and political issues may impact access to care for CCare enrollees in ways that are difficult to isolate from the effects of the demonstration. Regional health care workforce shortages and the challenges of recruiting and retaining providers at public or non-profit clinics may lead to changes in operating hours at CCare agencies. Clinic staff participating in an early 2024 needs assessment for the Title X family planning program in Oregon cited staff availability as one factor limiting their opening hours.[9] Recent coverage expansions in Oregon, such as the launch of the OHP Bridge program for individuals between 138% and 200% FPL in July 2024 or the Healthier Oregon Program in 2022-23 have reduced or are expected to reduce CCare enrollment. Similarly, the introduction of two-year continuous eligibility for adult OHP members in July 2023 may reduce participation in CCare if the program was previously serving clients during gaps in their Medicaid enrollment. Finally, differential health care coverage across neighboring states have led to increases in out-of-state clients at some Oregon CCare agencies, potentially impacting those agencies' ability to serve CCare clients.

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Attachment 1: Independent Evaluator

This draft evaluation design was prepared by the Center for Outcomes Research and Education (CORE). CORE is an independent team of scientists, researchers, and data experts housed within the Providence Health System in Oregon, with a mission to drive meaningful improvements in health and health equity through collaborative research, evaluation, analytics, and strategic consulting. The Oregon Health Authority (OHA) contracted with CORE to develop the evaluation design for the 2024-2028 1115 Medicaid Family Planning Waiver, and to implement the approved evaluation design.

CORE's team has the expertise and experience needed to conduct a successful and meaningful evaluation of the CCare waiver. For over 20 years, CORE has supported mixed-method evaluations of some of Oregon's most innovative Medicaid transformation efforts, including the well-known Oregon Health Insurance Experiment. CORE is currently collaborating with OHA to conduct the independent evaluation for the Oregon Health Plan 2022-2027 1115(a) Medicaid Demonstration waiver, which includes assessing the experience and impact of the continuous eligibility policy in that context. CORE is familiar with many of Oregon's Medicaid and public health data assets and has extensive experience with survey development and fielding as well examining health care utilization patterns, coverage, access to and quality of care, health care experience, and health outcomes (including perinatal and birth outcomes).

The evaluation team is led by Dr. Hannah Cohen-Cline, CORE's Director of Research and Evaluation, who has directed numerous complex evaluations and analyses of health services and cross-sector projects. Dr. Cohen-Cline is supported by a research analyst with a strong background in sexual health research, a Program Director who is very familiar with Oregon's family planning Medicaid waiver, and a Project Manager and a Research Associate with multiple years of experience.

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.

OHA has assured that the independent evaluator is free from any conflict of interest and will conduct a fair and impartial evaluation. CORE has declared they have no financial or other conflicts of interest and no connections with entities that would have a potential interest in shaping the evaluation and its findings.

CORE commits to performing a fully independent evaluation of the Oregon Contraceptive Care 1115 Family Planning demonstration.

Attachment 2: Evaluation Budget

The table below provides a breakdown of the proposed evaluation budget by year. Costs include personnel, survey, interviews, other, and administrative/indirect costs.

	2025	2026	2027	2028	2029	2030	Total (All Years)
Personnel (design, data collection, analysis, reporting, project management, and all other tasks) and fringe benefits	79,373	89,266	39,326	71,185	65,196	61,255	405,601
Survey non-personnel costs (e.g. translation, printing, fielding, incentives)	33,300			33,000			33,000
Interview or focus group costs (e.g. interpretation, incentives)		6150		2,825	3,325		12300
Other (e.g. IRB, in-state travel, software, etc.)	3,233	3,833	1,833	2,833	2,800	2,060	16,592
Administrative and indirect	83,024	69,474	28,811	76,890	49,925	44,320	352,444
Total	**201,630**	**168,723**	**69,969**	**186,732**	**121,246**	**107,635**	**855,935**

More information about these costs are as follows:

Personnel. This includes all staff time to complete the evaluation plan. Staff roles would include research scientists, program managers, project managers, research analysts, research associates, and data engineers. Their work would cover all oversight and planning, design, data collection, analysis, reporting, coordination, and all other tasks related to the successful completion of the evaluation plan. The budget includes fringe benefits.

Survey. This includes all survey non-personnel costs including translation, printing, and fielding. Compensation for survey respondents is also included in this budget line.

Interviews. Cost associated with interviews include translation of materials, verbal translation services, and transcription fees. Budget to compensate interview participants is also included.

Other. Other costs include IRB fees, software, travel (such as travel needed to get to in-person interviews), etc.

Attachment 3: Timeline and Major Milestones

The tables below give the timeline and major reporting milestones for each activity included in this Evaluation Design.

	2025			
	Q1	**Q2**	**Q3**	**Q4**
Milestones / Reporting	Content for Annual Monitoring Report			
Staff Interviews			Develop interview guide	OHA approval of interview guides IRB approval of interview guides
Client Interviews				
Client Survey	Develop survey	Cognitive testing of survey OHA approval of survey CMS approval of survey	IRB approval of survey Survey fielding (round 1)	Survey fielding (round 1)
Secondary Data Sources	Data use agreements and logistics of data acquisition (NEMT, CCare, and OHP data)			

	2026			
	Q1	**Q2**	**Q3**	**Q4**
Milestones / Reporting	Content for Annual Monitoring Report			
Staff Interviews	Conduct interviews (round 1)	Analyze interviews		
Client Interviews	Develop interview guide	OHA approval of interview guides IRB approval of interview guides	Conduct interviews (round 1)	Analyze interviews
Client Survey	Analyze survey	Analyze survey		
Secondary Data Sources	Acquire data Clean and merge data	Analyze data		

	2027			
	Q1	**Q2**	**Q3**	**Q4**
Milestones / Reporting	Content for Annual Monitoring Report			Interim report to OHA
Staff Interviews				
Client Interviews				
Client Survey				
Secondary Data Sources				

	2028			
	Q1	Q2	Q3	Q4
Milestones / Reporting	Content for Annual Monitoring Report Interim report to CMS			
Staff Interviews			Conduct interviews (round 2)	Analyze interviews
Client Interviews				
Client Survey	Survey fielding (round 2)	Survey fielding (round 2)	Analyze survey	Analyze survey
Secondary Data Sources			Acquire data Clean and merge data	Analyze data

	2029			
	Q1	**Q2**	**Q3**	**Q4**
Milestones / Reporting	Content for Annual Monitoring Report			
Staff Interviews				
Client Interviews	Conduct interviews (round 2)	Analyze interviews		
Client Survey				
Secondary Data Sources	Analyze data			

	2030			
	Q1	**Q2**	**Q3**	**Q4**
Milestones / Reporting		Summative report to OHA Summative report to CMS		
Staff Interviews				
Client Interviews				
Client Survey				
Secondary Data Sources				