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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W00142/0

TITLE: Oregon Contraceptive Care (CCare) (Formerly Oregon Family Planning Program) Section 1115 Demonstration

AWARDEE: Oregon Health Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Oregon for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities, except those specified below as not applicable to these expenditure authorities. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as "not applicable" enable Oregon to operate this section 1115 Medicaid family planning demonstration effective through December 31, 2028.

1. **Family Planning Services**. Expenditures for family planning services to individuals who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and whose household income is at or below 250 percent of the Federal poverty level.

2. **Continuous Eligibility.** Expenditures for continued benefits for individuals who have been determined eligible who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 16.b.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

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

   To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of approved family planning services. The not applicable of comparability does not apply to non-emergency medical transportation (NEMT) services after December 31, 2024.

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

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

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

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

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

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

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

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

6. Enrollment Simplification and Coordination with State Health Insurance Exchanges **Section 1943**

To the extent necessary to allow the state to transition to compliance, for the period prior to December 31, 2028, with respect to family planning services to individuals who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and whose household income is at or below 250 percent of the Federal poverty level.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Oregon Contraceptive Care (CCare) (Formerly Oregon Family Planning Program) Section 1115 Demonstration**

AWARDEE: **Oregon Health Authority**

I. PREFACE

The following are the Special Terms and Conditions (STC) for the "Oregon Contraceptive Care" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Oregon Health Authority (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authority authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on the expenditure authority, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional expenditure authorities, nor expand upon those separately granted. The demonstration will be statewide and is approved through December 31, 2028, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Program Benefits
VI. Cost Sharing
VII. Delivery System
VIII. Monitoring and Reporting Requirements
IX. Evaluation of the Demonstration
X. General Financial Requirements
XI. Monitoring Budget Neutrality for the Demonstration
XII. Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: Approved Evaluation Design
Attachment D: Mitigation Workplan and Timeline

II. PROGRAM DESCRIPTION AND OBJECTIVES

Effective through December 31, 2028, the Oregon CCare section 1115(a) Medicaid demonstration expands the provision of family planning services to individuals who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and whose household income is at or below 250 percent of the Federal Poverty Level (FPL).

Historical Context and Objectives

On October 14, 1998, CMS approved the precursor to this Medicaid section 1115(a) demonstration proposal titled "Oregon Family Planning Expansion Project" (now known as "Oregon Contraceptive Care" or "CCare"), designed to expand the availability of Medicaid-supported contraceptive management services to a wider population base. The program was implemented on January 1, 1999 and has been consistently extended by CMS since that date.

On July 7, 2021, the state submitted a five-year request to extend the demonstration with no programmatic changes. The demonstration was scheduled to expire on December 31, 2021, but on December 15, 2021, CMS approved a temporary extension of the demonstration until June 30, 2022, to allow for additional time for the state and CMS to continue to work on finding an amenable approval path for the extension request. A subsequent temporary extension was approved on June 8, 2022, which extended the demonstration period until June 30, 2023. A third temporary extension was approved on June 23, 2023, to extend the demonstration through December 31, 2023. The current extension of this demonstration is being granted for an additional five years through December 31, 2028.

Approval of this demonstration extension will allow the state to continue to expand access to family planning services and increase the chances of more healthy outcomes for Medicaid recipients and will align the continued eligibility period with the 24-month period approved in the Oregon Health Plan demonstration.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

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

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with

any changes in law, regulation, or written policy affecting the Medicaid and/or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state thirty (30) calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or written policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement and/or a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7) as a result of the change in FFP.

    b. If mandated changes in the federal law, regulation, or policy require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements authorized through these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes or begin operational changes to these demonstration elements without prior approval. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for amendments to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3 or otherwise specified in the STCs.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay

approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty (30) day public

comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the thirty (30) day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

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

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1) or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. The state must comply with all applicable notice requirements for Medicaid found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to review consistent with 42 CFR 457.1180. In addition, the state must assure all applicable Medicaid appeal and hearing rights are afforded to Medicaid beneficiaries in the demonstration as outlined in 42 CFR, part 437 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six (6) months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. Adequacy of Infrastructure. The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted

entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

IV. ELIGIBILITY AND ENROLLMENT

16. Eligibility Requirements.

Eligibility for this demonstration is limited to individuals who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP), whose household income is at or below 250 percent of the FPL, and who meet all other eligibility requirements.

For an individual found to be income-eligible for this demonstration upon initial application or annual redetermination, the state will provide twenty-four (24) months continuous eligibility during which the state will not terminate coverage based on a change in circumstance.

a. Continuous Eligibility. The continuous eligibility period begins on the effective date of the individual's eligibility determination or the effective date of the most recent renewal of eligibility. Given individuals are continuously eligible regardless of changes in circumstances (except as provided under STC 16.b.), the state will conduct renewals of eligibility at the end of the individual's continuous eligibility period. The state will continue to redetermine eligibility during a period of continuous eligibility in limited circumstances, if appropriate, as described in STC 16.b.

b. Continuous Eligibility Exceptions. Notwithstanding STC 16.a, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be redetermined or terminated:
    i. The individual becomes pregnant or otherwise eligible for Medicaid or CHIP;
    ii. The individual is no longer an Oregon resident;
    iii. The individual requests termination of eligibility;
    iv. The individual dies; or
    v. The agency determines that eligibility was erroneously granted at the most

recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

17. Streamlined Application and Eligibility Determination Process. Application and enrollment processes for this demonstration must comply with section 1943 of the Act and implementing regulations at 42 CFR part 435. Transition to full compliance must be completed no later than December 31, 2028.

a. Mitigation Work Plan and Timeline. The state must submit for CMS review and approval a work plan describing the changes the state will make to its demonstration application and enrollment processes that meet the intent of section 1943 of the Act and regulations at 42 CFR part 435 (referred to herein as mitigations) and the timeline for implementing the mitigations. The work plan must be submitted to CMS no later than 120 calendar days after approval of this demonstration extension. The state must implement all mitigations no later than a date mutually agreed to by CMS and the state through the mitigation work plan review and approval. The mitigation work plan must address each of the following areas:

i. Application
ii. Eligibility Hierarchy and Determination Cascade
iii. Opportunity to Apply
iv. Verification
v. Renewals of eligibility
vi. Notices
vii. Coordination with Other Insurance Affordability Programs
viii. Fair Hearings

b. Systems coordination and full compliance with section 1943 and implementing regulations at 42 CFR part 435. The state must achieve compliance with section 1943 of the Act and implementing regulations at 42 CFR part 435. The state must specifically address the following issues: coordination between the family planning program and the full benefit Medicaid program application processes such that individuals can file a single application to be considered for all bases of eligibility; integrating family planning eligibility into the state's Medicaid eligibility hierarchy; redetermining a beneficiary's Medicaid eligibility on all bases of eligibility and without re-application; conducting verification in accordance with 42 CFR 435.916 and 42 CFR 435.956; providing all applicants and beneficiaries with timely and adequate written notice in accordance with 42 CFR 435.917 and 42 CFR 435.918; and maintaining a fair hearing system that meets the requirements of 42 CFR 431.205 and 431.220-246. The state must be in full compliance with applicable statute and regulations no later than December 31, 2028.

i. *Documentation*. The state must notify CMS in writing when it achieves full compliance with applicable statute and regulations. This notification must include documentation to demonstrate the state's compliance.

ii. *CMS Review*. Upon receipt of the documentation in STC 17(b)(i), CMS will review the information and work with the state to verify compliance with applicable statute and regulations.

A delay in implementing the processes necessary to align with section 1943 of the Act (and implementing federal regulations at 42 CFR part 435) may subject the state to the penalty described in STC 10.

18. Demonstration Disenrollment. If an individual becomes pregnant while enrolled in the demonstration, they may be determined eligible for Medicaid under the state plan. The state must not submit claims under the demonstration for any individual who is found to be eligible under the Medicaid state plan.

V. PROGRAM BENEFITS

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

a. FDA approved methods of contraception;
b. Laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception;
c. Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements, subject to the national drug rebate program requirements;
d. Contraceptive management, patient education, and counseling; and
e. Vasectomies for men over the age of 21.
f. As of January 1, 2025, non-emergency transportation to covered family planning services.

20. Minimum Essential Coverage (MEC). The CCare demonstration is limited to the provision of family planning services as described in STC 22; thereby, the demonstration is not recognized as MEC as communicated by CMS in its February 12, 2016 correspondence to the state regarding our designation of MEC for the state's section 1115 demonstrations.

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

materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.

VI. COST SHARING

22. Cost Sharing. Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

23. Delivery System. All demonstration beneficiaries will continue to receive services through the same delivery system arrangements as currently authorized in the state. Services under this demonstration are provided through a fee-for- service (FFS) delivery system.

VIII. MONITORING AND REPORTING REQUIREMENTS

24. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

In the event that either (1) the state has not submitted a written request to CMS for approval of an extension, as described below, within thirty (30) calendar days after the deliverable was due, or (2) the state has not submitted a revised resubmission or a plan for corrective action to CMS within thirty (30) calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement including the information needed to bring the deliverable into alignment with CMS requirements; the following process is triggered:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an

interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

25. Submission of Post-Approval Deliverables. The state must submit all required analyses, reports, design documents, presentations, and other items specified in these STCs ("deliverables"). The state shall use the processes as stipulated by CMS and within the timeframes outlined within these STCs.

26. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

27. Annual Monitoring Reports. The state must submit one (1) Annual Monitoring Report each demonstration year (DY) that is due no later than ninety (90) calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within sixty (60) calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Reports must follow the

framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's goals. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing family planning services to beneficiaries, as well as access to and utilization of care, outcomes of care, and quality and cost of care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

   The state and CMS will work collaboratively to finalize the list of metrics to be reported on in Annual Monitoring Reports. The demonstration's monitoring metrics must cover categories to include, but not limited to, enrollment, utilization of services, unpaid medical bills at application, and quality of care and health outcomes. The state should also report payment-related and provider-level metrics, if applicable. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policies and objectives to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race and ethnicity, primary language, disability status, and geography) and by demonstration component, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

   The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration.

The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements Section X of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state must include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

28. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing family planning services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

29. Close-Out Report. Within one hundred twenty (120) calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 41 and 42, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out Report.

d. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.

e. The final Close-Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 27.

30. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

31. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

IX. EVALUATION OF THE DEMONSTRATION

32. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 27.

33. Independent Evaluator. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an

agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

34. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) calendar days after the approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

    The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 41 and 42.

    For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than one hundred eighty (180) calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the Monitoring Reports. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

    In the event of demonstration extensions, for components that are continuing from the prior demonstration approval period, the state's Evaluation Design must reframe and refocus as needed the evaluation hypotheses and research questions to appropriately factor in where it can reasonably expect continued improvements, and where the demonstration's role might be more to help stabilize outcomes. Likewise, for continuing policies, the state must revisit its analytic approaches compared to those used in the prior approval period evaluation activities, to ensure that the evaluation of those policies taps into the longer implementation time span.

35. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or

if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

36. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

37. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

    The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must cover outcomes, such as enrollment, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of family planning services. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Maternal and Perinatal Health Care Quality Measures for Medicaid and CHIP Consumer Assessment of Health Care Providers and Systems (CAHPS) the National Survey of Family Growth (NSFG), the Pregnancy Risk Assessment Monitoring System (PRAMS), and/or measures endorsed by the National Quality Forum (NQF).

    Specifically, evaluation hypotheses must focus on the impact of the demonstration in helping eligible beneficiaries access family planning services. Hypotheses must include, but not be limited to, outcomes such as beneficiary access to and utilization of family planning services (e.g., percentage of beneficiaries reporting difficulty obtaining preferred contraceptive and percentage of beneficiaries who utilized any contraceptives by method effectiveness) and maternal health and birth outcomes (e.g., unintended pregnancies, teen birth rates, and the rate of preterm and low birthweight births), with a focus on addressing any demographic disparities. The state must also collect necessary data to accommodate CMS's evaluation expectations to assess the effects of not providing retroactive eligibility

on beneficiaries and providers, for example, by examining outcomes such as beneficiary financial status, including changes in incidence of medical debt and provider uncompensated care costs.

The state should ideally undertake a well-designed beneficiary survey, which would significantly strengthen the demonstration's evaluation. Finally, to the best extent feasible, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race and ethnicity, primary language, disability status, and geography). Such stratified analyses will provide a fuller understanding of existing shortcomings or disparities in access to and quality of care and health outcomes and help inform how the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

38. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting an extension for the demonstration, the Interim Evaluation Report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

39. **Summative Evaluation Report.** The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs, and in alignment with the approved Evaluation Design.

    a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.

    b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

40. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

41. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

42. **Public Access.** The state shall post the final documents (e.g., Monitoring Reports, Close-Out Report, the approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's website within thirty (30) calendar days of approval by CMS.

43. **Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) calendar days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

X. GENERAL FINANCIAL REQUIREMENTS

44. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

45. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter that just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

46. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

47. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures are met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain one hundred (100) percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to

Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

48. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

49. Requirements for Health Care- Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

50. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC XX. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

51. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section X:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

52. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

53. Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit

calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a list of MEGs defined for this demonstration.

Table 1: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Family Planning	Hypo	X		X	Eligible individuals who are not otherwise eligible for Medicaid or CHIP and whose household income is at or below 250 FPL.
ADM	N/A				All additional administrative costs that are not directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

54. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-0036/2). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c) or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported

separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table and in the STCs in section X, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in Section X, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 2: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Family Planning	Report all expenditures related to those eligible individuals under this demonstration.	**[PO Instructions: Discuss with the state if any exclusions should be listed]**	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	01/01/1999	12/30/2028
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N		

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

54. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 3: Demonstration Years		
Demonstration Year 26	January 1, 2024 to December 31, 2024	12 months
Demonstration Year 27	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 28	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 29	January 1, 2027 to December 31, 2027	12 months
Demonstration Year 30	January 1, 2028 to December 31, 2028	12 months

55. **Budget Neutrality Monitoring Tool.** The state must provide CMS with annual budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality

expenditure limits described in Section X. CMS will provide technical assistance, upon request.[1]

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

57. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the

[1] Per 42 CFR 431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

58. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration -covered service or population and that is likely to further strengthen access to care.

    a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 60.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

    b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

        i. Provider rate increases that are anticipated to further strengthen access to care;

        ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

        iii. Changes in federal statue or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

59. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

60. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1 Master Meg Chart and Table 2, MEG Detail for Expenditure and Member Months Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the

state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

61. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
62. **Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests, including "capped hypotheticals". Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.
63. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

64. **Hypothetical Budget Neutrality Test 1:** Family Planning. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are

designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 4: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 26	DY 27	DY 28	DY 29	DY 30
Family Planning	PC	Both	5.3%	$27.50	$39.89	$42.00	$44.23	$46.57

65. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

66. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from January 1, 2024 through December 31, 2028. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

67. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for

CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 5: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 26	Cumulative budget neutrality limit plus:	2.0 percent
DY 26 through DY 27	Cumulative budget neutrality limit plus:	1.5 percent
DY 27 through DY 28	Cumulative budget neutrality limit plus:	1.0 percent
DY 28 through DY 29	Cumulative budget neutrality limit plus:	0.5 percent
DY 29 through DY 30	Cumulative budget neutrality limit plus:	0.0 percent

XII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 6: Schedule of Deliverables for the Demonstration Period		
Date	**Deliverable**	**STC**
30 calendar days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
180 calendar days after approval date	Draft Evaluation Design	STC34
60 calendar days after receipt of CMS comments	Revised Evaluation Design	
120 calendar days after approval date	Mitigation Work Plan and Timeline	STC 17
One year prior to demonstration expiration, or with extension application	Draft Interim Evaluation Report	STC 38
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 38
No later than 18 months after expiration of this demonstration period	Draft Summative Evaluation Report	STC 39
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 39
No later than 120 calendar days after the end of the demonstration, applicable only if not to be extended	Draft Close-Out Report	STC 29
30 calendar days after receiving CMS comments	Revised Close-Out Report	STC 29

Annually		
90 calendar days after the end of each demonstration year	Draft Annual Monitoring Report	STC 27
60 calendar days after receiving CMS comments	Revised Annual Monitoring Report	STC 27

The state is held to all reporting requirements as outlined in the STCs. This schedule of deliverables should serve only as a tool for informational purposes.

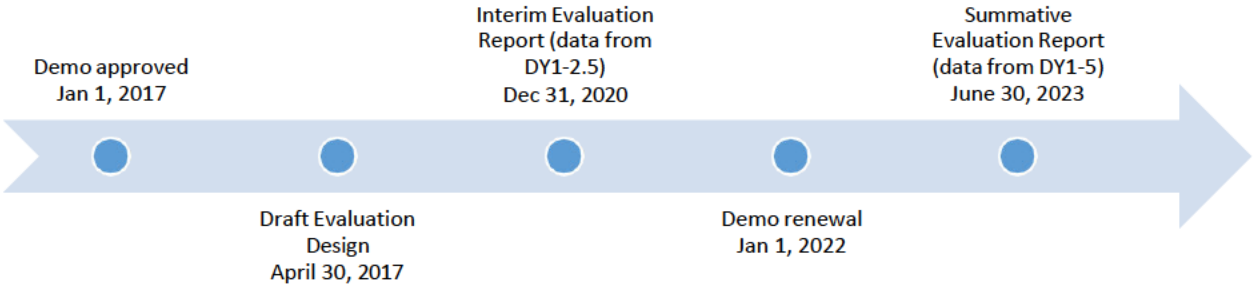
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to

which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the

primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure. Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate. The state also should include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.
5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If

the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;

c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

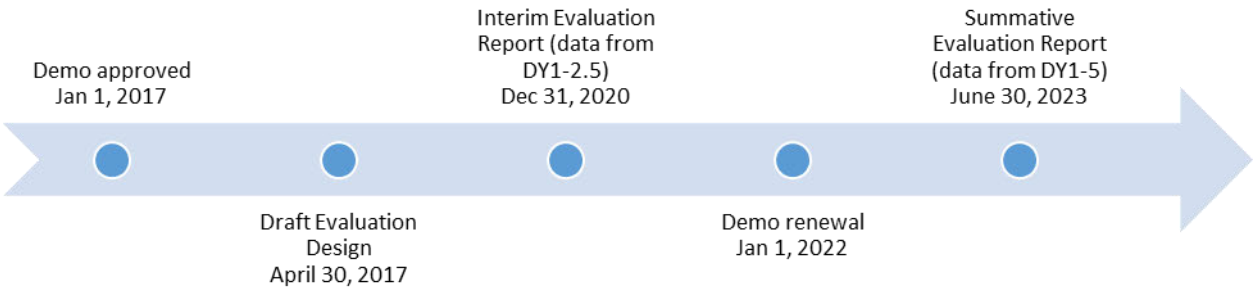
Attachment B:
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2. *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected.
4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

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.

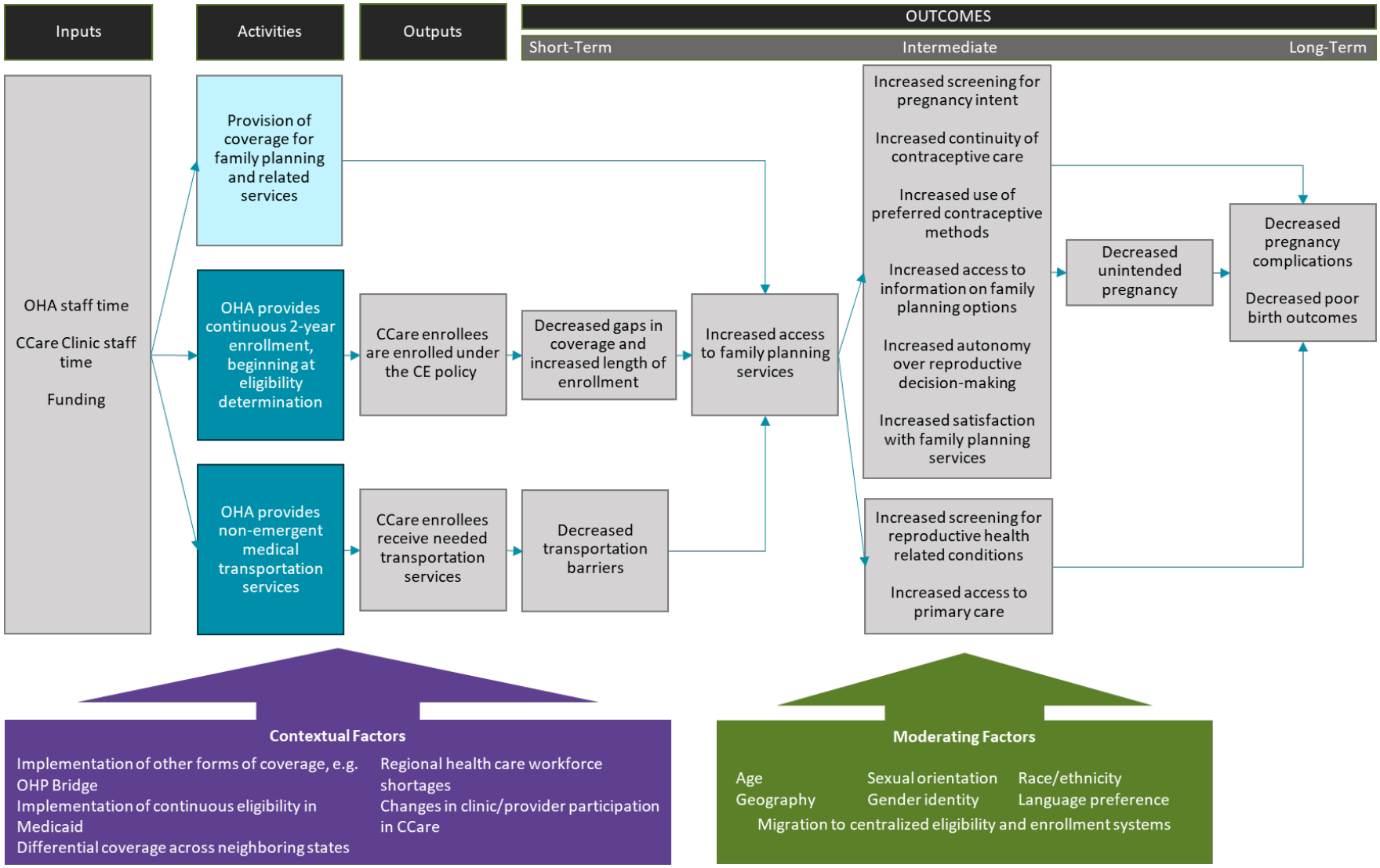
- *Research Question 5a.* How does the demonstration impact unintended pregnancy rates among CCare enrollees?
- *Research Question 5b.* How does the demonstration impact pregnancy complications, such as gestational diabetes or hypertension, among CCare enrollees?
- *Research Question 5c.* How does the 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.

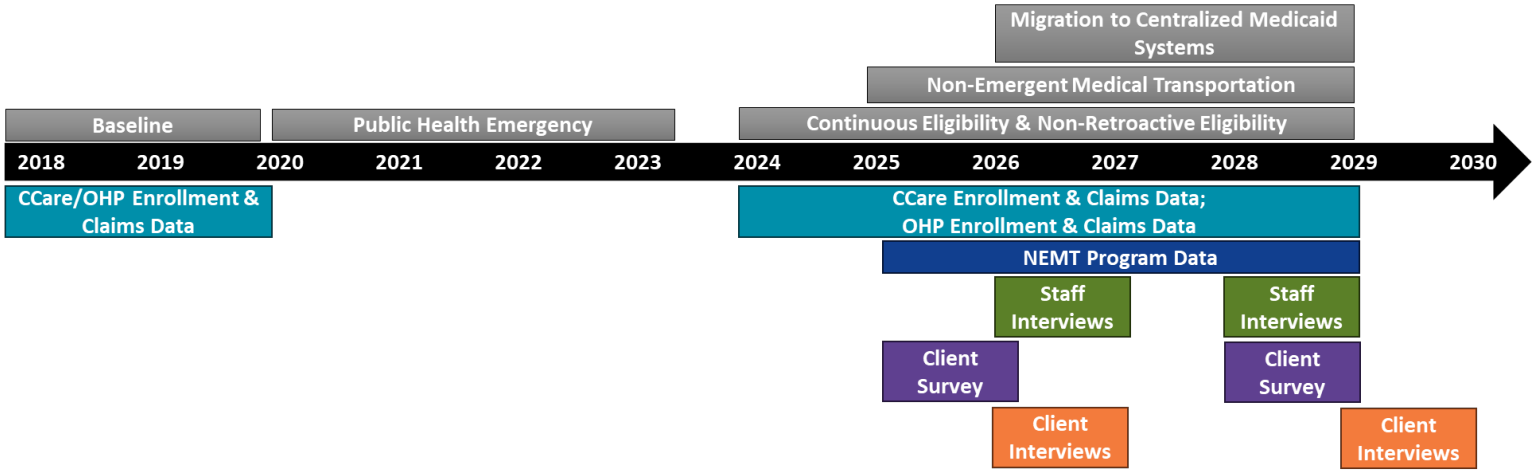
Evaluation Period

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				

Attachment D
Mitigation Workplan and Timeline

Workplan Table of Contents:

Introduction:

The Centers for Medicare and Medicaid Services (CMS) approved renewal of the Oregon ContraceptiveCare (CCare) (formerly Oregon Family Planning Program) section 1115 demonstration waiver on November 9, 2023 for the period January 1, 2024 through December 31, 2028 (Project 11-W-00142/0). 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 are outlined in the Special Terms and Conditions (STCs) and 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

Per STC 17, the state is required to transition to full compliance in the above areas no later than December 31, 2028. In the interim, the state is required to submit for CMS review and approval, no later than April 30, 2024, a workplan describing the changes the state will make to its demonstration application and enrollment processes that meet the intent of section 1943 of the Act and regulations at 42 CFR part 435 and the timeline for implementing these mitigations. This document fulfils the state's obligations under STC 17a.

After extensive review, including consultation with CMS subject matter experts, the state intends 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 following workplan outlines the requirements associated with each topic area, the current state (i.e., current operationalization), and the plan for implementation. Interim steps/milestones for implementation and estimated dates of completion for each step/milestone in the project can be found at the end of the document.

A note about program structure: Unlike other states, the CCare waiver is administered by the Reproductive Health (RH) Program within the Oregon Health Authority's Public Health Division, and not by the state's Medicaid division. The RH Program utilizes an integrated funding structure whereby its three primary sources of funding – CCare, federal Title X grant, and Reproductive Health Equity Act state funds – are braided to form one coverage program, the Reproductive Health Access Fund (RHAF). Individuals complete a RHAF application to receive reproductive health benefits and are assigned to the appropriate funding source (CCare, RHEA, and/or Title X) based on their eligibility for each source. The RH Program uses a set of system rules based on each funding source's eligibility and service coverage requirements to determine the appropriate fund source to draw from. For the purposes of the below workplan, the term RHAF, not CCare, will be used when describing application and eligibility systems and processes.

The system changes and process changes described in this mitigation plan will be implemented concurrently with a number of high-priority Medicaid-related projects, including the Public Health Emergency (PHE) unwinding, Oregon Health Plan 1115 waiver implementation, and Non-Emergency Medical Transportation implementation for RHAF. The successful implementation of this plan will require close coordination with these other resource-intensive projects.

The state anticipates compliance with all relevant federal requirements related to application and eligibility determination processes by January 1, 2027.

Workplan:

1. Application

Relevant requirement(s):

- The state must use either the Secretary-approved single streamlined application or an alternative to that application consistent with the standards established by the Secretary.
- The agency must accept an application via the internet website described in §435.1200(f), by telephone, via mail, in person and through other commonly available electronic means. The application must be the single, streamlined application for all insurance affordability programs developed by the Secretary or an alternative approved by the Secretary.

Current state:

- Individuals complete the Reproductive Health Access Fund (RHAF) Enrollment Form (hereafter referred to as 'application') directly at clinic sites contracted with the RH Program. The application is used by the RH Program to determine eligibility for RHAF coverage which is comprised of three funding sources: CCare, Reproductive Health Equity Act (REHA) funds, and federal Title X grant funds.
- Upon arrival at the clinic, clinic staff assess whether the individual is currently enrolled in the state's full benefit program, the Oregon Health Plan (OHP), by checking the state's MMIS provider portal. If it is determined that the individual does not have active eligibility in OHP, clinic staff provide the applicant with a paper version of the application. Once completed, the individual returns the application to clinic staff who review the form for completeness. If available, the individual may also provide documentation of U.S. citizenship or eligible immigration status.
- Because the RH Program utilizes a braided funding matrix, including CCare, individuals are eligible for RHAF coverage as long as they meet the following criteria: (1) have an income at or below 250% FPL and (2) have reproductive capacity. After determining the application is complete, clinic staff enter the information provided on the application into the state's web-based eligibility database. The eligibility database calculates the individual's FPL, and if all other criteria have been met, the individual is considered provisionally enrolled in RHAF coverage. Based on other information provided by the individual, specifically their citizenship/immigration status and state residency status, the RH Program eligibility database uses a pre-established algorithm to determine which funding source (CCare, RHEA, and/or Title X) to assign to the enrolled individual.

Implementation plan:

- The agency 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.
- The agency will continue to maintain a RHAF-only application. The RHAF-only application will be updated to include text that informs individuals the application is for limited benefits specific to reproductive health, and should they wish to be evaluated for full Medicaid coverage, it will include information and instructions on how to do so. The application will remove any mention of the term "reproductive capacity".
- The single streamlined application will be updated to allow individuals to "opt-in" to being assessed for RHAF coverage in addition to full Medicaid coverage.
- The existing single streamlined application already adheres to the requirement that individuals can apply through multiple modalities, including phone, mail, in-person, and electronically/online. The RHAF-only application will also be available in all of the modalities currently available through the single streamlined application.
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

2. Eligibility hierarchy and determination cascade

Relevant requirement(s):

- Prior to making a determination of ineligibility, the state must consider all bases of eligibility. If ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs.
- The state must promptly and without undue delay determine potential eligibility for and, as appropriate, transfer the applicant's account to, other insurance affordability programs.

Current state:

- Since its approval in 1998, Oregon has utilized an eligibility and enrollment system for the family planning eligibility group (CCare) that is separate and distinct from the state's single streamlined application. The RH Program contracts with a 3rd party vendor, Ahlers and Associates, to administer its program-specific eligibility and claims processing systems. Once clinic staff confirm the applicant has no existing Medicaid coverage in MMIS, information provided by the applicant is entered directly into the web-based eligibility database by clinic staff and RH Program staff use this information to verify and make final determinations of eligibility for RHAF coverage.

Implementation plan:

- The agency 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.
- The agency will continue to maintain a RHAF-only application. The RHAF-only application will be updated to include text that informs individuals the application is for limited benefits specific to reproductive health, and should they wish to be evaluated for full Medicaid coverage, it will include information and instructions on how to do so. The application will remove any mention of the term "reproductive capacity".
- The single streamlined application will be updated to allow individuals to "opt-in" to being assessed for RHAF coverage in addition to full Medicaid coverage.
- An individual will be able to see what coverage, RHAF or full Medicaid benefits, they have in their ONE applicant account. Should an individual with existing RHAF or full Medicaid benefits decide to be evaluated for the other coverage, they can request this.
- Individuals who apply via the single streamlined application will continue to be referred to the Marketplace if ineligible for full Medicaid, regardless of RHAF eligibility determination.
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

3. Opportunity to apply

Relevant requirement(s):

- The agency must afford an individual wishing to do so the opportunity to apply for Medicaid without delay.

Current state:

- Individuals complete the RHAF application at the point of service/clinic on or before their appointment. Because the RH Program has multiple sources of state and federal funding available, individuals are eligible for RHAF coverage as long as they meet the following criteria: (1) have an income at or below 250% FPL and (2) have reproductive capacity. This allows individuals to be provisionally enrolled in RHAF coverage before they receive services.

Implementation plan:

- The agency will continue to maintain a RHAF-only application. The RHAF-only application will be updated to include text that informs individuals the application is for

limited benefits specific to reproductive health, and should they wish to be evaluated for full Medicaid coverage, it will include information and instructions on how to do so. The application will remove any mention of the term “reproductive capacity”.
- The single streamlined application will be updated to allow individuals to “opt-in” to being assessed for RHAF coverage in addition to full Medicaid coverage.
- ONE will determine eligibility real-time, whether an individual completes an application with a provider using the system, through their own applicant account, or by contacting the state directly.
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA’s statutory authority.

4. Verification

4a. Verification of citizenship and non-citizen status

Relevant requirement(s):

- The state must verify citizenship (SSA and DHS SAVE) and immigration status (DHS SAVE) through use of the Hub or an approved alternative for people who attest to satisfactory immigration status.
- The state may not accept attestation of U.S. citizenship or satisfactory immigration status.
- The state must verify citizenship status electronically using the Hub or an approved electronic mechanism.
- The agency must promptly evaluate information received to determine eligibility.
- The state must promptly attempt electronic verification of citizenship or satisfactory immigration status.
- Individuals must not be required to provide documentation unless information cannot be obtained electronically, or it is not reasonably compatible.

Current state:

- Individuals completing the RHAF application self-attest to their citizenship or non-citizenship status. On a monthly basis, RH Program staff verify citizenship and immigration status for individuals who applied or re-applied for RHAF during the prior month.
- RH Program staff use secure electronic processes to match applicant data to sources including Social Security Administration (SSA), Oregon Vital Records (Birth Records), and Systematic Alien Verification for Entitlements (SAVE).
- Non-matches and discrepancies are reviewed manually. RH Program staff search State Benefit and Employment databases to look for alternate information to resubmit to SSA.

If an individual's information cannot be verified, their CCare eligibility is suspended in the RHAF Eligibility Database. If an individual's citizenship or non-citizenship status cannot be verified electronically and the individual does not present their own documentation, their CCare eligibility is terminated following the end of a 90-day Reasonable Opportunity Period. Any individual whose CCare eligibility is suspended or terminated due to lack of verification of citizenship or non-citizenship status will still maintain RHAF coverage and claims will be paid using other funding sources that do not require verification of citizenship or non-citizenship status.

Implementation plan:

- As part of systems migration into ONE, citizenship and eligible immigration status verification for RHAF applicants will be aligned with the electronic verification processes used for full Medicaid programs, which includes comparing attested information with electronic verification systems within the Federal Data Services Hub (or "Hub"). These verification checks include the Social Security Administration (SSA) and Verify Lawful Presence (VLP) interface with the Department of Homeland Security. Data returned from these checks is then compared to the attested information to determine if immigration information is considered verified.
- When VLP is down or cannot verify immigration status, Systematic Alien Verification for Entitlements (SAVE) can be accessed manually by eligibility processing staff to verify non-citizen status.
- When citizenship or immigration status cannot be verified electronically or manually by eligibility processing staff, ONE will grant conditional approval and issue a Request for Information (RFI) pend for applicants to supply verification for ongoing eligibility (a 'Reasonable Opportunity Period').
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

4b. Verification of SSN

Relevant requirement(s):

- Individuals seeking coverage are required, as a condition of eligibility, to furnish an SSN, unless the individual meets an exception to providing one.
- If an applicant cannot recall their SSN or if an SSN has not been issued, the agency must assist the applicant in completing an application for an SSN.
- The state cannot deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN by SSA.
- The state is required to verify an applicant's or beneficiary's SSN with SSA.
- The agency must promptly evaluate information received.

Current state:

- On the first day of each month, RH Program staff generate a list of individuals who applied or re-applied for RHAF coverage during the prior month. Staff use a secure electronic process with the Social Security Administration (SSA) to verify the Social Security Number (SSN) provided by each individual upon application. RH Program staff submit a file to SSA with individuals' names, SSNs and DOBs. An electronic results file is created the following business day.

  When individuals' information does not match SSA records, RH Program staff manually search the State Benefit and Employment Databases for alternate information to resubmit to SSA. If CCare staff cannot verify the SSN of a client, their eligibility for CCare funding is suspended in the eligibility database, though RHAF coverage will be maintained and claims will be paid using other funding sources.

Implementation plan:

- RHAF eligibility and verification processes will be incorporated into ONE, which conducts all required electronic verification processes used for full Medicaid programs, which includes comparing attested information with electronic verification systems within the Federal Data Services Hub (or "Hub"). These verification checks include the Social Security Administration (SSA).
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

4c. Verification of income

Relevant requirement(s):

- The state must explain income and other verification policies in the state's approved verification plan. Neither PEV of income nor suspension of eligibility is permitted per Oregon's approved verification plan, which states that prior to an eligibility determination, Oregon will use available electronic sources to verify income. If attested income information is not reasonably compatible with electronic verification sources, the applicant will be requested to provide verification or a reasonable explanation of the discrepancy.
- If the state obtains new information post-enrollment that indicates an individual may not be eligible, the state must evaluate that information and redetermine eligibility as appropriate, and may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received unless the agency has sought additional information from the individual, and provided advance notice and fair hearing rights in accordance with subpart E of part 431.

Current state:

- Every three months, RH Program staff generate a list of individuals who applied or re-applied for RHAF coverage during the prior quarter. RH Program staff use a secure electronic process with the Oregon Employment Department to find income records for the quarter of enrollment into RHAF. RH Program staff upload a file with individuals' names, SSNs, and dates of birth to the Employment Department's secure web portal, after which, Employment Department records are automatically searched and matched to individuals' records. An electronic results file is automatically created. RH Program staff add up each individual's total quarterly income and determine whether it is above the eligibility threshold for their household size.
- Prior to August 2024, the process included the following steps: Individuals who were determined to have average monthly income above the eligibility threshold (based on a maximum of 250% of the Federal Poverty Level for the individual's household size) had their eligibility suspended. Individuals were offered the opportunity to explain or correct the discrepancy and could have their eligibility reinstated within 45 days of the suspension date. If eligibility was not reinstated during this time, the individual's eligibility was terminated.
- As of August 2024, we will not deny, terminate, or suspend eligibility or reduce benefits prior to reaching out to the beneficiary for additional information to verify information obtained from an electronic data source indicating potential ineligibility.

Implementation plan:

- RHAF eligibility and verification processes will be incorporated into ONE, which conducts all required electronic verification processes used for full Medicaid programs, which includes comparing attested information with electronic verification systems within the Federal Data Services Hub (or "Hub"). These verification checks include the Social Security Administration (SSA), Verify Current Income (VCI)/WorkNumber, and Unemployment Compensation. Data returned from these checks is then compared to the attested information to determine if it's reasonably compatible, and if not, ONE may issue a Request for Information (RFI) pend for applicants to supply verification for ongoing eligibility.
- CMS has approved Continuous Eligibility (CE) policies with RHAF. CE will protect individuals' coverage from terminating during certain reported changes in eligibility criteria, such as going over income.
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

4d. Provision of benefits during a reasonable opportunity period (ROP)

Relevant requirement(s):

- For individuals attesting to citizenship or satisfactory immigration status, the state is required under sections 1902(ee), 1902(a)(46)(B), 1903(x)(4), and 1137(d) of the Act, and 42 CFR § 435.956(b) to provide applicants and the state with a reasonable opportunity period (ROP) to verify their status, during which time states must provide full benefits. The ROP begins on the date on which the notice is received by the individual, which is 5 days after the date of the notice in accordance with 42 CFR 435.956(b).

Current state:

- The 90-day Reasonable Opportunity Period begins on the date the individual signed the RHAF application. As described in the current state section for '4a. Verification of citizenship and non-citizen status', RH Program staff verify citizenship and immigration status each month for individuals who applied or re-applied for RHAF during the prior month. If an individual's citizenship or immigration status cannot be verified electronically and the individual does not present their own proof, their eligibility in CCare is terminated following the end of a 90-day Reasonable Opportunity Period. However, their RHAF eligibility is maintained, and an alternate funding source is used to cover their services.

Implementation plan:

- Once RHAF eligibility and verification processes are incorporated into the ONE system, the provision of benefits during the ROP and the ability to extend the ROP will align with Medicaid processes. This includes alignment with the state plan provisions to extend the ROP for non-citizens making a good faith effort to resolve any inconsistencies or obtain needed documentation, or if the agency needs more time to complete the verification process.
- When citizenship or immigration status cannot be verified electronically or manually by eligibility processing staff, ONE will grant conditional approval and issue a Request for Information (RFI) pend for applicants to supply verification for ongoing eligibility.
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

5. Renewals of eligibility

Relevant requirement(s):

- Individuals whose Medicaid eligibility is based on MAGI methods must be renewed once every 12 months and no more frequently.
- The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or more current information available to the agency.
- If the agency is not able to renew consistent with 435.916(a)(2), then the agency must provide the individual with a prepopulated renewal form.

Current state:

- Individuals with RHAF coverage are currently provided with 12-months of continuous eligibility. At the end of the 12-month eligibility period, an applicant must complete a new application to re-enroll in RHAF.
- As provided for in the current STCs, the RH Program implemented 24-month continuous eligibility June 1, 2024. Until systems migration occurs, applicants will still be required to complete a new application to re-enroll in RHAF when their 24-month eligibility period ends.

Implementation plan:

- As part of system migration to ONE, RHAF renewals will utilize the same automated renewal process currently in place for other state medical programs.
- Individuals for whom passive renewal (ex-parte) is possible will be issued a new continuous eligibility period for 2-years (24 months). Individuals for whom eligibility cannot be automatically renewed will receive a prepopulated renewal form that must be returned, and individuals must be found still eligible for a new continuous eligibility period to be established.
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

6. Notices

Relevant requirement(s):

- Adverse action notices, including denials, terminations, and suspensions of eligibility, must include the information described at 42 CFR §431.206 and §431.210-214, including fair hearing rights and the effective date of the action.
- The state is required to provide an eligibility determination notice to provide all applicants and beneficiaries timely and adequate written notice of any decision affecting their eligibility and describes the required content for eligibility determination notices, as described in 42 CFR §435.917 and §435.918.

- Notices must be posted to a beneficiary's electronic account and that confidential information not be included in an email or electronic alert.

Current state:

- No written notices are sent to beneficiaries at application or renewal. Clinics provide verbal notice of eligibility.

Implementation plan:

- Prior to system migration to ONE, the state will take the following interim measures to meet the intent of federal notice requirements by April 2025:
    - OHA will develop a generic fillable notice of eligibility with information about:
        - Individual-level approval for reproductive health benefits
        - Coverage start date
        - How to report changes
        - Hearing rights
    - Initially, the form will be made available in English and Spanish, with translation into other languages as time and capacity allows.
    - The following statement will be included on the form: "You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact [Program Contact name] at [email] or [phone number] (voice and text). We accept all relay calls."
    - CCare clinics will fill out paper versions of the notice at the front desk, adding client name and eligibility dates by hand to the form once the client has enrolled at the clinic site.
    - Written guidance for best practices in using the form will be provided to CCare clinics about how to use the form. This will be in the form of sub-regulatory guidance (with more formal administrative rule changes occurring as part of the migration process).
- As part of system migration, existing notices of eligibility, including initial determinations, terminations, suspensions, and renewals, generated from ONE will be updated and/or new notices will be created for individuals applying for RHAF coverage, consistent with relevant CFRs.
- Requests for additional information and/or verification will be generated, as needed.
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

7. Coordination with other insurance affordability programs

Relevant requirement(s):

- The state is required to evaluate eligibility for other insurance affordability programs for individuals not determined eligible for Medicaid.

Current state:

- Currently there is no coordination with other insurance affordability programs. Beneficiaries are given information at the point of enrollment about how to access primary care services and how to enroll in insurance coverage.

Implementation plan:

- Individuals who apply via the single streamlined application will continue to be referred to the Marketplace if ineligible for full Medicaid, regardless of RHAF eligibility determination.
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

8. Fair hearings

Relevant requirement(s):

- The state is required to maintain a fair hearing system that meets the requirements of 42 CFR part 431 subpart E.
- The state must grant an opportunity for a fair hearing for individuals who believe the agency has taken an action erroneously, denied their claim for eligibility or for covered benefits or services, or issued a determination of an individual's liability, or has not acted upon the claim with reasonable promptness. The state must establish procedures that permit an individual to submit a fair hearing request and, in certain circumstances, continue to provide benefits and services until a decision is rendered after the hearing. States must also take final administrative action within 90 days from the date the agency receives a request for a fair hearing.

Current state:

- Applicants denied eligibility may request a contested case hearing within 60 calendar day following the date of the decision notice. OHA will take final administrative action on the contested case hearing request within the time limits set forth in 42 CFR Part 431.

- Applicants may also request an informal conference without the presence of an Administrative Law Judge (ALJ) at any time prior to the hearing. OHA may grant the request if it finds in their sole discretion that the additional informal discussion will facilitate the hearing process or resolution of disputed issues.
- Applicants may withdraw their request for a hearing at any time.

Implementation plan:

- Upon completion of system migration, RHAF beneficiaries will have access to the same fair hearing/contested case hearing process as OHP beneficiaries.
- Relevant Oregon Administrative Rules (OARs) will be revised to reflect updated processes. All public engagement requirements related to rulemaking will be adhered to and the rulemaking is within OHA's statutory authority.

Milestones and Estimated Dates of Completion:

- Agency leadership will prioritize project on agency's strategic roadmap (SRM) with identified timeline for implementation. July 2024 (completed).
- Agency subject matter experts will develop level of effort (LOE) with agency's contracted ONE vendor, Deloitte, to scope out project components. January 2025.
- A generic fillable notice of eligibility with information about individual-level approval for reproductive health benefits, coverage start date, how to report changes, and hearing rights will be developed as an interim measure to meet the intent of federal notice requirements. April 2025.
- All relevant Oregon Administrative Rules (OARs) relating to RHAF application, enrollment, and eligibility will be revised. June – December 2026.
- Agency subject matter experts and ONE contractor will conduct joint application design (JAD) work sessions to design system updates. May – July 2026.
- The ONE system's single streamlined electronic application will be updated to ensure individuals can apply for both RHAF and Medicaid at the same time. January 2027.
- The OHP paper application will be updated to ensure it collects all necessary information to determine RHAF eligibility should someone opt-in to being evaluated. October – December 2026.
- The RHAF-only paper application will be updated to inform applicants where they can apply for Medicaid. October – December 2026.
- The agency will update existing notices, develop draft notices, seek input from beneficiaries and partners, and request a formal review from Oregon Department of Justice. March – July 2026.
- The RHAF application and benefits will be fully incorporated into the ONE system. January 2027.

- Create eligibility worker workflows and tools. Fall 2026.
- Conduct eligibility worker training. Winter 2026.
- Develop promotional materials for current and potential applicants. Fall-Winter 2026.