oregon **contraceptive** care

Oregon Family Planning Medicaid Waiver

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

Demonstration Year 25

Fourth Quarter (October – December 2023)/Annual Report

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Introduction

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

CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). The goal of the program is to improve the well-being of children and families by reducing unintended pregnancies and improving access to primary health care services. Clients are enrolled in CCare at the point of service (clinic site) but final determinations of eligibility are made by state staff. CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client has lost CCare eligibility for some reason (e.g., acquired and then lost regular Medicaid coverage) and is seeking to reestablish it. CCare covers office visits for contraceptive management services, limited laboratory services, contraceptive devices, and pharmaceutical supplies. There is no cost-sharing for coverage and services are provided through a statewide network of agencies. Participating agencies abide by the program's Certification Requirements (Appendix A). One of these is the requirement to provide all clients with information and resources to help them access primary care services and health coverage on an ongoing basis.

The overall outcomes of CCare can grouped into three categories: (A) immediate outcomes for CCare clients; (B) intermediate outcomes for both CCare clients and the waiver's target population; and (C) long-term outcomes for Oregon's reproductive-age population as a whole.

(A) Immediate Outcomes

- Outcome 1: The program will result in an increase in the proportion of clients who use a highly effective or moderately effective contraceptive method.
- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.

Data source: RH Program Data System

(B) Intermediate Outcomes

- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.
- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.

(C) Long-term Outcomes

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.
- Outcome 6: The program will result in a decrease in the unintended pregnancy rate in Oregon.
- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.

Table 1 shows the quarters for demonstration year (DY) 25 for the waiver and associated report submission due dates.

TABLE 1. Oregon Family Planning Waiver Report Timeline Dates for CY 2023/DY 25			
Quarter	**Begin Date**	**End Date**	**Quarterly Report Due**
1	January 1, 2023	March 31, 2023	May 31, 2023
2	April 1, 2023	June 30, 2023	August 31, 2023
3	July 1, 2023	September 30, 2023	November 30, 2023
4	October 1, 2023	December 31, 2023	March 31, 2024*

*Per STC 27, the state's fourth quarter progress report for each DY serves as the state's annual report. The annual report is due ninety (90) days following the end of the fourth quarter of each DY.

Executive Summary

Current Trends or Significant Program Changes

CCare continues to provide the same services as in the previous demonstration period. For the most part, there have been no noteworthy changes in administration/operations or agency participation. The RH Program has maintained its integrated program structure through DY 25, using three sources of funding to reimburse agencies for services rendered.

As described in prior years annual evaluation reports, the RH Program uses a set of system rules based on each funding source's client eligibility and service coverage requirements to determine the appropriate fund source to draw from. The RH Program uses a single, streamlined client application that allows individuals to enroll in the RH Program and receive covered benefits based on their eligibility (i.e., U.S. citizens that meet all other CCare eligibility requirements will be eligible for CCare and Title X, while those who do not qualify for Medicaid because of their immigration status are eligible for RHEA and Title X). The RH Program

continues to closely monitor monthly claims processing, both to track CCare payments and to assure appropriate use of funds, including adherence to all CCare requirements.

CCare agencies are able to apply and become certified as a fully integrated RHCare agency. Agencies that decline to become certified in RHCare, may be certified as CCare-only. Clients seeking services at CCare-only clinics complete the integrated RH Program Enrollment Form but are only eligible for CCare-covered services unless they seek services at a RHCare-certified agency.

Policy Issues and Challenges

A number of recent policy changes have affected CCare utilization.

Oregon has tried to keep as many people covered by OHP (Oregon Health Plan) during the unwinding of the Public Health emergency as possible. It created the OHP Bridge Plan which expands eligibility to people with incomes 138 – 200% of the federal poverty level (FPL) at no cost to the enrollee. Additionally, Oregon implemented Healthier Oregon which expands OHP eligibility to people of all ages who meet income and other criteria qualify for full OHP benefits and other services and supports, no matter their immigration status.

Due to an increase in the number of people who are eligible for and enrolled in OHP, CCare utilization has not increased to pre-pandemic rates.

As described in previous years' reports, local public health authorities (LPHAs) are one of the few, or sometimes only, CCare agency in the county (particularly in the eastern region of the state) and increasing numbers of LPHAs have stopped providing clinical services. This has resulted in geographic gaps in access to high-quality reproductive health services provided by CCare. In conversations with LPHAs that have continued as CCare agencies, but are considering stopping clinical services, low OHP reimbursement rates have been cited as a major concern. In response to this, the RH Program has begun working with its partners in the OHP office to reassess and revise reimbursement rates for reproductive health services to ensure they reflect current costs to providers. Additionally, the RH Program is working with an evaluation contractor to conduct a statewide Needs Assessment to better understand decreases in client enrollment and service utilization, and how we can support CCare agencies in maintaining financial sustainability.

Enrollment

Annual Enrollment

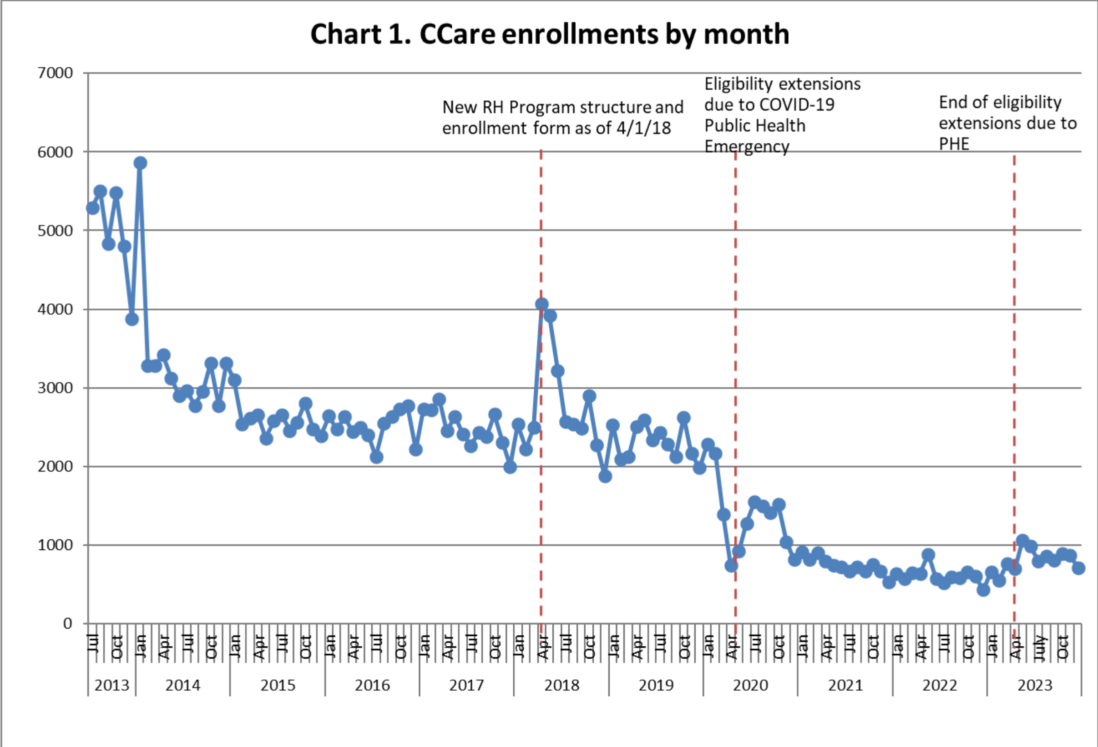
CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client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

During 2023, CCare enrollments and member months continued to be impacted by the COVID-19 pandemic. Throughout the pandemic, many individuals previously not eligible for full Medicaid coverage (Oregon Health Plan or OHP) were able to enroll because of lost employment and income. In addition, both OHP and CCare coverage were extended each time the Public Health Emergency was extended. Combined, these factors resulted in a substantial increase in the number of the member-months relative to the number of enrollees. The last eligibility extension due to the Public Health Emergency ended on April 30, 2023.

	TABLE 2. CY 2023/DY 25			
	Q1. January 1 - March 31	**Q2. April 1 – June 30**	**Q3. July 1 – September 30**	**Q4. October 1 – December 31**
# of Total Enrollees	1,978	2,847	2,604	2,471
# of Member Months	140,438	64,574	28,505	30,600

Prior to 2020, CCare enrollments were impacted by the implementation of the Affordable Care Act. This included Medicaid expansion and the creation of the health insurance marketplace which effectively provided coverage to thousands of Oregonians who were previously uninsured. Enrollment into CCare decreased significantly following ACA implementation efforts in 2014. As expected, many previously enrolled CCare clients shifted to the state's full-benefit Medicaid program, the Oregon Health Plan (OHP). As demonstrated by Chart 1 below, CCare monthly enrollments declined sharply starting in 2014, although enrollment numbers began to level off by mid-2015 and were fairly stable until the COVID-19 pandemic. The ongoing need for CCare coverage is supported by research from the health reform experience of Massachusetts[1] that showed that even with greatly expanded health insurance coverage, significant coverage gaps remain for many individuals in need of family planning, and CCare is uniquely positioned to address these gaps.

[1] Leighton Ku, et al., "Safety-Net Providers After Health Care Reform: Lessons from Massachusetts," *Archives of Internal Medicine*, August 8, 2011, Vol 171, Number 15.



Annual Enrollment by Race/Ethnicity

TABLE 3. Annual Enrollment by Race/Ethnicity, CY 2023/DY 25		
Race/Ethnicity	**% of Total**	**# Enrolled**
Hispanic	17.3%	1673
White, Non-Hispanic	59.6%	5768
Black, Non-Hispanic	2.5%	239
American Indian, Non-Hispanic	0.6%	61
Alaska Native, Non-Hispanic	0.0%	5
Asian, Non-Hispanic	2.6%	256
Hawaiian/Pacific Islander, Non-Hispanic	0.7%	70
More than one race, Non-Hispanic	2.5%	240
Unknown/Not Reported	11.8%	1141
Other	2.3%	219
Total	100.0%	9672

Annual Disenrollment and Retention Figures

Although the RH Program is unable to track reasons for disenrollment, we assume that the majority of disenrollments occur because clients obtained full-benefit insurance coverage either through OHP or through the state's health insurance marketplace. Every CCare claim received is matched against the OHP eligibility file to ensure that no claims are paid for clients

who are eligible for family planning services or supplies under a different Medicaid program. In cases where a match is found, claims are denied and returned to the provider and CCare eligibility is terminated.

Between DY21-DY23, lower client retention rates were likely due in large part to the COVID-19 pandemic, which resulted in limitations in clinic hours as well as increased enrollment in OHP. Eligibility extensions were granted as a result of the Public Health Emergency, reducing the number of clients who needed to re-enroll in DY23 or DY24. These eligibility extensions came to an end during DY25 resulting in a somewhat higher client retention rate. See Table 4 below for enrollment retention figures.

TABLE 4. Annual Retention Rates	CY 2016/ DY 18	CY 2017/ DY 19	CY 2018/ DY20	CY 2019/ DY21	CY 2020/ DY22	CY 2021/ DY23	CY 2022/ DY24	CY 2023/ DY25
Total enrollments per demonstration year (includes clients who enrolled more than once in a single calendar year)	30,130	29,866	33,081	27,799	16,593	8,908	7,020	9,672
# clients who also enrolled the subsequent demonstration year	6,087	8,138	5,860	2,785	614	233	622	
% of clients retained from one year to the next	20.2%	27.2%	17.7%	10.0%	3.7%	2.6%	8.9%	

Service Providers

There are currently 42 agencies enrolled in CCare, representing a total of 132 clinic sites. Among these agencies, 33 are certified to participate in the comprehensive RHCare program, affording them access to the RH Program's three sources of state and federal funding. Clinics are located in nearly every county across the state.

Between October and December 2023, the following training and education activities were provided to the RHCare/CCare provider network:

- Delivery of program news, policy updates, training opportunities, and other information to agencies via the RH Newsletter.
- Hosted three virtual office hours for clinic staff to provide support and technical assistance.

- Two webinars, attended by approximately 56 staff from RHCare/CCare-enrolled clinics, about billing and data.
- Two CCare/RHCare Orientation webinars attended by approximately 56 staff from RHCare/CCare-enrolled clinics.

Program Outreach and Education

The RH Program added new staff to lead outreach and education activities which has allowed us to expand and deepen our activities; we will continue to pursue recruitment of new staff as we are able in the new year. Throughout this demonstration year, the RH Program was able to engage in and support education and outreach activities to CCare priority populations as well as community and clinical partners throughout the state. In the coming year we will increase staffing which will allow for greater capacity in educational and outreach activities and trainings for CCare clinics and other community partners.

Outreach and Awareness Activities

During 2023, the RH Program increased its partnership by funding eleven separate organizations, including Local Public Health Authorities (LPHAs), clinical partners, and community-based organizations, as part of its Community Outreach Project grants. We continued deepening our relationships with Black/African American serving organizations and began a partnership with a Native American serving organization. We will continue these projects and are eager to create educational opportunities that improve reproductive health outcomes in CCare populations.

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

The RH Program's online materials ordering system continues to be used by clinical and community partners to order educational and outreach materials created by our program. This year we hope to continue to assess the types of materials available and to continue the process of identifying, creating and or updating materials as clinical and community partners inform us of needed resources. This ordering system has served to increase accessibility of program

materials and has supported the ease with which community and clinical partners can engage in education and outreach activities. Materials that describe services available at the network of CCare clinics are translated into the 7 most commonly used languages in CCare clinics: English, Spanish, Vietnamese, Korean, Simplified Chinese, Traditional Chinese, and Chuukese. The RH Program continues to convene a quarterly meeting of community members and partners around the state who serve Spanish-speaking populations with varying social and medical services. This meeting is facilitated entirely in Spanish and serves to provide a unique opportunity for Spanish-speaking people interested in learning and sharing more about sexual and reproductive health needs of Spanish-speaking communities throughout the state.

Educational Activities

The RH Program continues to provide training and resources for its clinical network and community partners including trainings to promote client-centered counseling and comprehensive sexual education. Through the Community Outreach Projects, we have developed a model of collaborative leadership in the design and delivery of trainings that are best suited to the needs of community-based organization partners and the CCare priority communities the organizations serve. In the current calendar year, the RH Program will continue to develop partnerships and deliver trainings in response to the needs and interests of the CCare clinical network.

The RH Program is in the final stages of working with the Oregon Health Authority's Communications Office to make final edits to a brochure that provides information about vasectomies and the ways clients can access vasectomy services. Once the brochure is finalized, we will make it available to clinical partners at all CCare clinics. The creation of this brochure was in response to the identified needs of clinical partners.

We anticipate the brochure the RH Program created related to pregnancy options counseling will be finalized and be made available to all CCare clinical partners this within the next calendar year. We will continue to create materials that are requested by clinical and community partners.

Targeted Outreach Campaign

The RH Program manages both Facebook and Instagram social media pages designed to provide outreach and education about accessing services in Oregon to individuals between the ages of 18 and 33. The RH Program contracts with a graphic designer to ensure that our posts are engaging and presented in a way that invites easy comprehension of information. Content on both platforms continues to focus on topics related to pregnancy prevention and contraception as well as a broad range of sexual and reproductive health topics. All posts are written in plain language and are reviewed by a RH Program Nurse Consultant to ensure medical accuracy.

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

Outreach and Education Activities Evaluation

Indicators that the RH Program's outreach and education efforts have met with success include high scoring and positive responses on surveys and training evaluations, social media engagement and responses, successful project reports, and feedback from RH Program agencies, partners, and clients. A formal evaluation of Outreach Projects will be created in 2024 to be administered to partners beginning in 2025.

Materials Evaluation

The RH Program began a process to review and revise all RH Program educational materials on a three-year basis. This new process began in 2020. In 2021, minor changes to our website were made to ensure that the information we created remained accurate. In 2024, the RH Program will continue to update our website, and will identify existing materials and begin to create materials to support clinical and community education.

Program Monitoring and Evaluation

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

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

1. Monthly desk-audits, including reviews of data and claims to identify potential improper billing practices.
2. Random-sample chart audits to verify documentation supporting contraceptive management services, billed at the appropriate visit level.
3. Enrollment form audits to assess for completeness and accuracy. The Enrollment Forms are checked against information entered into the eligibility database.

4. Chart reviews during onsite clinic reviews where reviewers follow a checklist of components to review charts with visits billed to CCare.
5. Monthly duplicate claims audit process to identify and correct any duplicate claims inadvertently submitted to and paid by CCare.

A total of eight agencies were reviewed in the 4th quarter of 2023 using the audit processes noted above. For DY25, a total of 32 agencies were reviewed. The audit results showed common issues related to enrollment form completion and storage as well as billing at the wrong visit level. Issues are addressed through Corrective Action Plans (CAPs) and/or by correcting claims.

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

Evaluation of CCare Program Outcome Measures

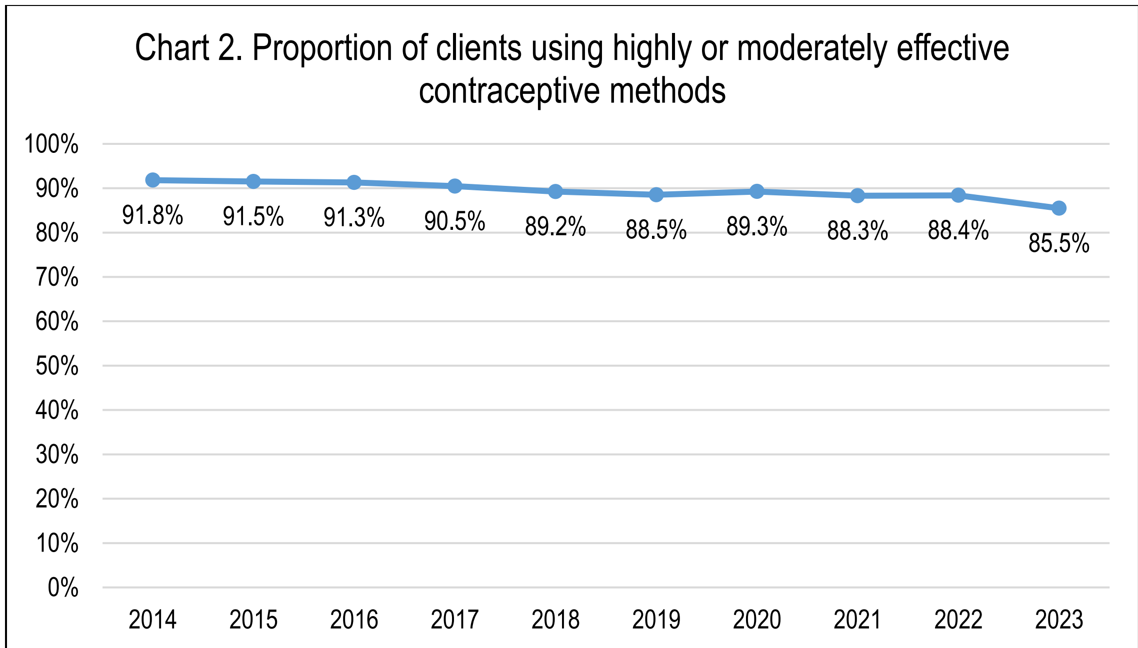
(A) Immediate Outcomes:

- Outcome 1: The program will result in an increase in the proportion of clients who use a highly effective or moderately effective contraceptive method.

  Data source: RH Program Data System, Clinic Visit Record (CVR) data

  Performance target: 92.5%

  Progress: This outcome measure uses encounter data for clients with CCare source of coverage served within publicly supported family planning clinics. Effective contraceptive use is defined as all Tier 1 and Tier 2 contraceptive methods among unduplicated female clients of all ages at risk of unintended pregnancy. Women at risk of unintended pregnancy excludes clients who are using no method because they are pregnant, seeking pregnancy, or not currently sexually active. In 2014, when this measure was first tracked, 91.8% of all clients used a most or moderately effective method. This rate has declined slightly since 2014, with 85.5% of all clients using a most or moderately effective method in 2023.

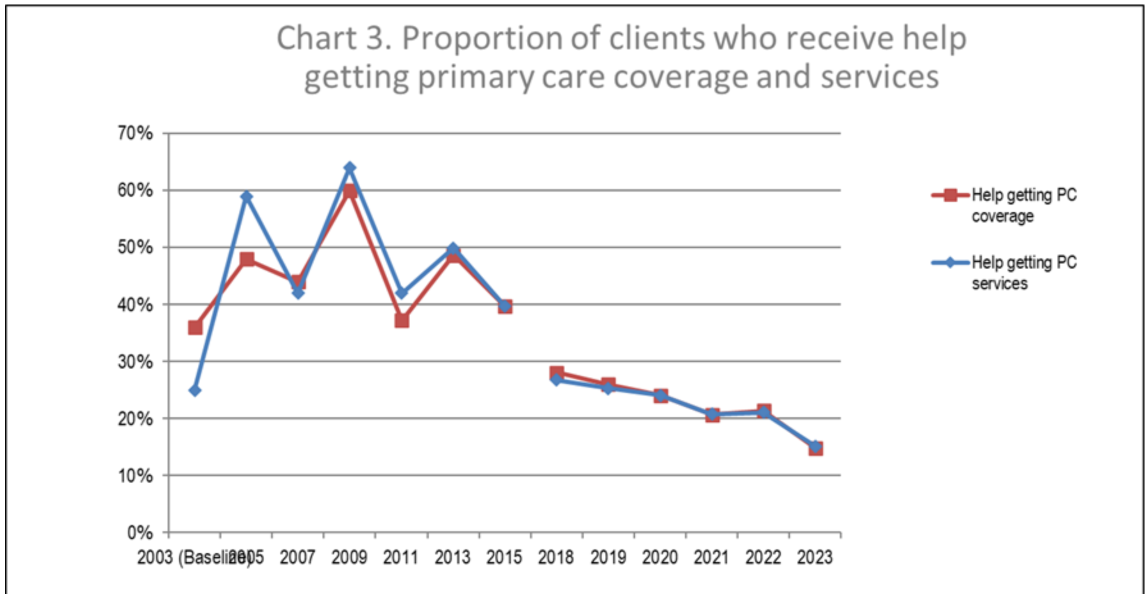


- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.

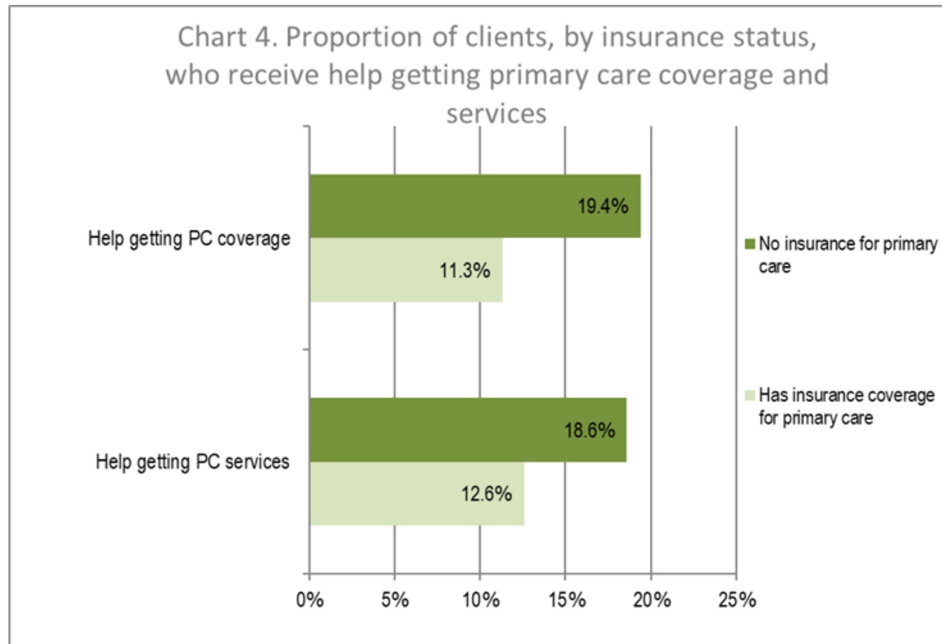
  Data source: RH Program Customer Satisfaction Survey (2003-2015), RH Program Enrollment Form (2018-present)

  Performance target: 50%

  Progress: This outcome was established at the time of CCare's first renewal to monitor progress toward the newly added goal of ensuring that clients received assistance with access to primary care services and coverage. To track this outcome, we use data from our own Customer Satisfaction Survey (CSS), a system-wide, self-administered client exit survey conducted approximately every other year. Sample selection for the CSS takes place at the clinic level and is typically designed to ensure representation of all but the very smallest volume clinics (those with less than 10 visits per week). Both CCare and non-CCare clients participate at the sampled clinics. The most recent data available come from the CSS administered in the fall of 2015. Results from 2003 (baseline) through 2015 are shown in Chart 3. Beginning in 2018, this information is collected on the RH Program Enrollment Form rather than the CSS, so the 2018 figures cannot be compared to previous years. Because this is a new data source, we will be tracking this moving forward to reestablish trends.



In 2023, less than 30% of CCare enrollees indicated that they had received help getting primary care services and coverage. This represents a decline compared to the client survey results, which can be attributed to two factors. First, the wording of these questions has changed from how it was collected in our client survey, highlighting the need to review the phrasing of these questions and possibly reword them in future iterations of the RH Program Enrollment Form. Second, as more individuals gain comprehensive insurance coverage and access to primary care services through ACA and Medicaid expansion, it is possible that clinic staff are not offering assistance to individuals to get primary care coverage or services if there is no need (i.e. the client already has both coverage and access to services). As shown in Chart 4*,* those without insurance for primary care were more likely to have received information about both public health insurance and accessing general health services than those with insurance.



RH Program staff continue to conduct ongoing RH Program Enrollment Form audits on a random sample of medical records. These audits include a review of the primary care referral requirement to ensure that this objective is met. Furthermore, the primary care referral requirement continues to be a focus for agency trainings.

(B) Intermediate Outcomes

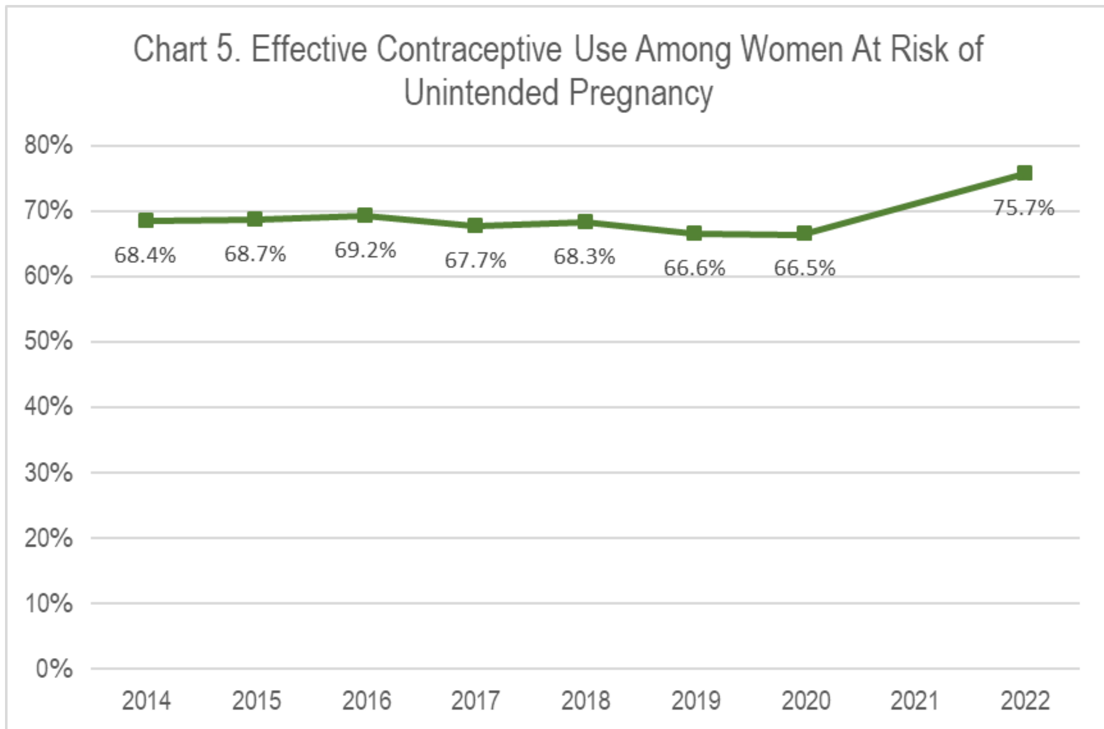
- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.

  Data source: Oregon Behavior Risk Factor Surveillance System (BRFSS)

  Performance target: 76.0%

  Progress: To monitor this outcome, we use data from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a CDC-sponsored, population-based, telephone survey of non-institutionalized adults in the state. The specific BRFSS item used to track this outcome first appeared on the questionnaire in 1998 and asks respondents what method they and/or their partners currently use to prevent pregnancy. In certain years, both female and male respondents answered this item but we restrict our analysis to female respondents to facilitate year-to-year comparisons. Effective contraceptive use is defined as use of all Tier 1 and Tier 2 methods among women 18-49 at risk of unintended pregnancy. Women at risk of unintended pregnancy excludes respondents who have had a hysterectomy, are currently pregnant, have a same sex partner, report being too old, report wanting to get pregnant, or who refuse to answer or respond “Don’t Know” to the birth control use questions. After several years of relatively

unchanged data on this metric, the 2022 BRFSS data shows an increase in reported effective contraceptive use.



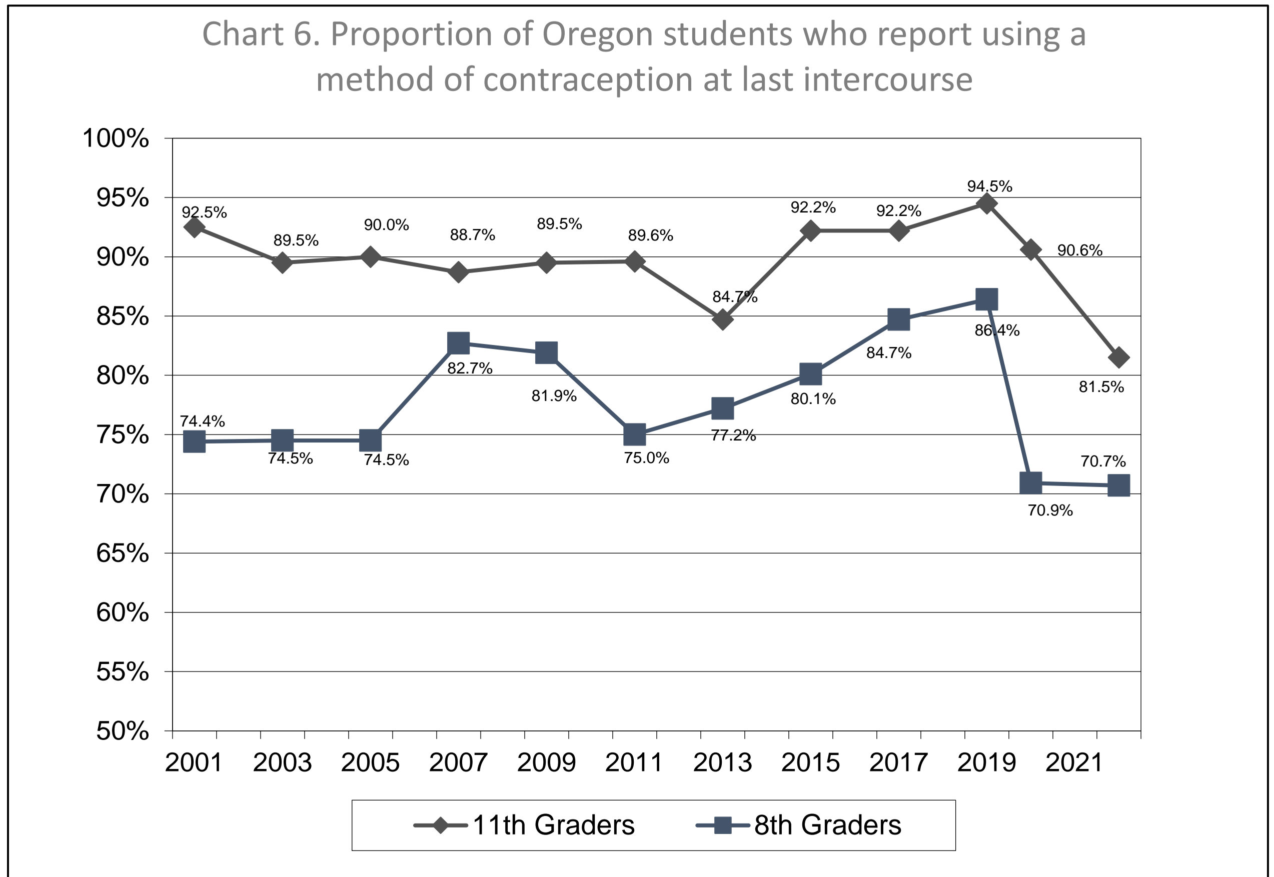
- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.

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

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

  Progress: To determine whether expanded availability of subsidized birth control and contraceptive management services affects birth control use among teens, data from Oregon's school-based student health surveys are used. From 2001-2019 the survey was called Oregon Healthy Teens; starting 2020 the survey is called the Student Health Survey. Both surveys include 8th and 11th grade students. These surveys ask whether students have ever had sex, and if so, which method of contraception they used (if any) the last time they had sex. Those who responded that they didn't know or were not sure about the method used were counted among the "no method" group. Rates of contraceptive use among Oregon students increased steadily through 2019, although in 2020 these rates decreased: in 2020 90.6% of 11th graders and 70.9% of 8th graders reported using contraception at last intercourse (including only those students who reported ever having sex). It is possible that changes in survey methodology between

Oregon Healthy Teens and the Student Health Survey impacted survey results. It is also possible that this decrease is due in part to the COVID-19 pandemic impacting access to contraception through School-Based Health Centers and other youth-friendly clinics, and we will be monitoring this data in the coming years to see if rates return to pre-pandemic levels.



(C) Long-term Outcomes

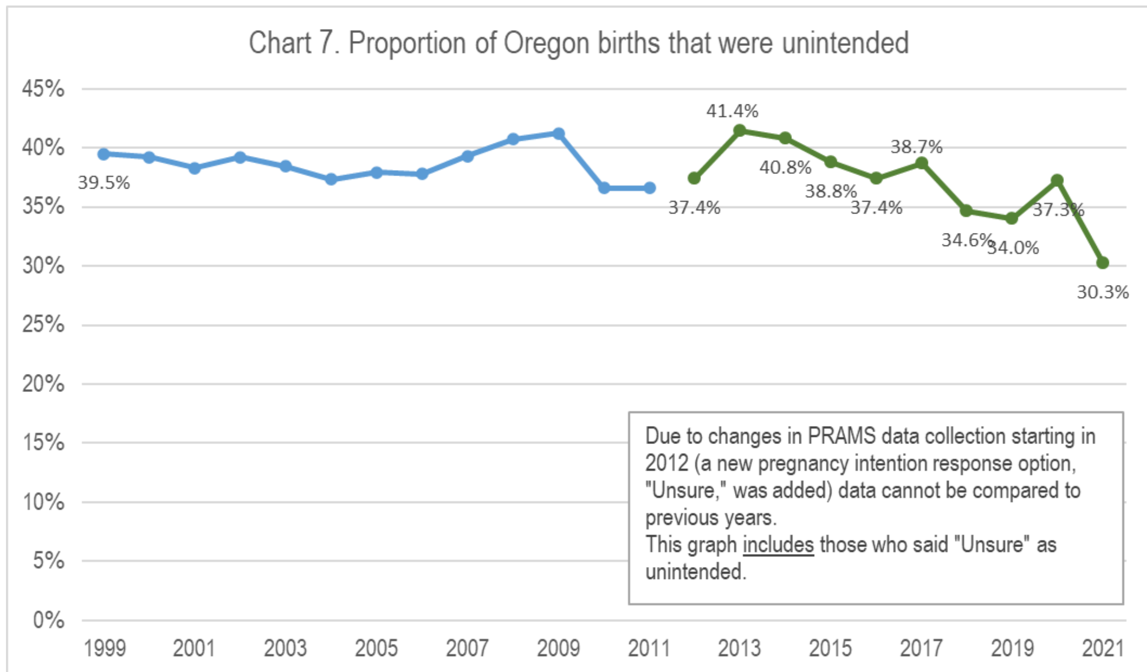
- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.

  Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS)

  Performance target: 36.0%

  Progress: National standard methodology is used to assess pregnancy intent: women are asked to think back before their recent pregnancy and report whether they had wanted to become pregnant at that time, sooner, later, or not at all. Pregnancies that occur too soon are classified as mistimed, those that are not wanted at all are labeled unwanted, and those two categories together form the unintended group. Pregnancies that occur too late or “at about the right time” are considered intended. In 2012, an additional response option was included to the question assessing pregnancy intent:

"unsure". Based on analysis of previous years' response breakdowns, the unsure responses have been grouped as part of the unintended category. Because of this change, results for 2012 and after cannot be compared with data from prior years. Chart 7 below details the proportion of Oregon births that were unintended, starting in 1999. The proportion of births classified as unintended has been declining over the last few years and has reached the performance target as of 2018. Due to a data error, 2021 is the most recent data available for Oregon PRAMS.



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

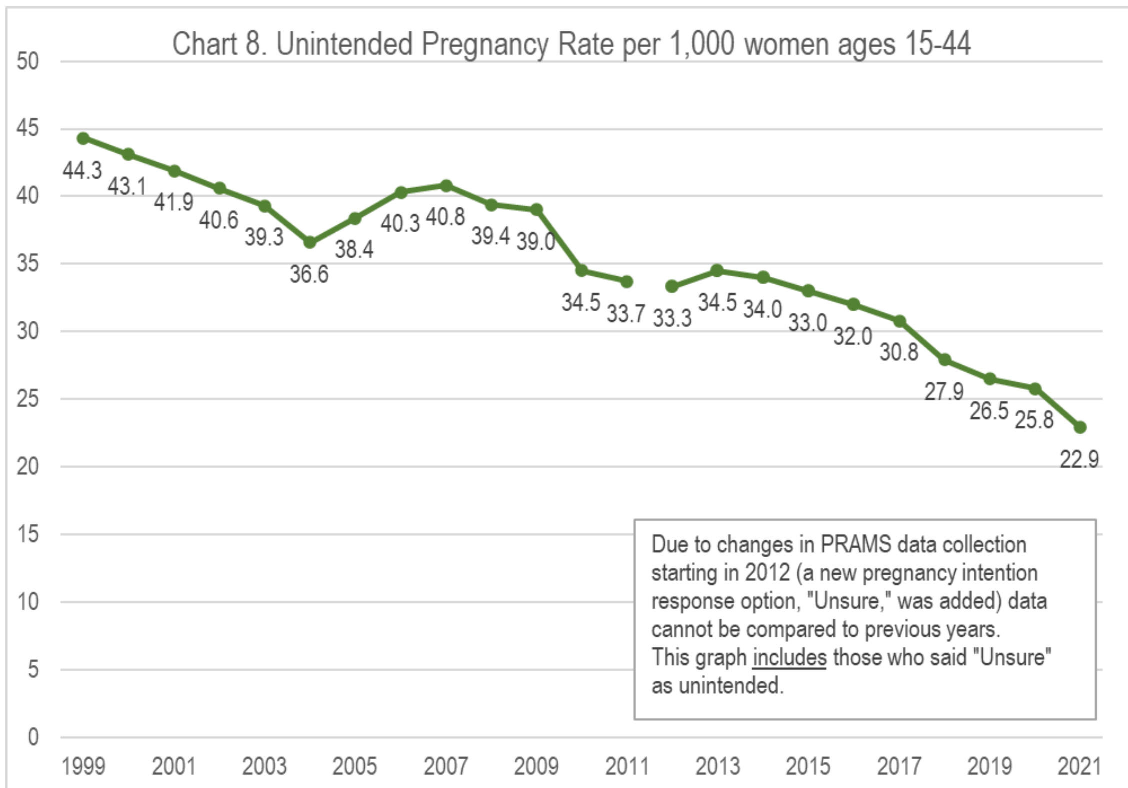
  Data source: Oregon PRAMS and Oregon Center for Health Statistics

  Performance target: 32.0 per 1,000 women 15-44

  Progress: To estimate the unintended pregnancy *rate*, we use a three-step procedure very similar to the one outlined by Stanley Henshaw in his well-known article "Unintended Pregnancy in the United States."[2] In the first step, we estimate the proportion of Oregon's births (not pregnancies) that are unintended using PRAMS data. We then multiply the actual number of births in each year (obtained from the Center for Health Statistics, or CHS) by the unintended proportion to produce an annual number of unintended births in the state. Next, we multiply the annual number of abortions in the state by approximately 0.95 to derive an annual estimate of the number of unintended

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

abortions in the state.[3] Finally, we add the unintended birth and abortion numbers together and divide the result by state population figures to produce an estimated unintended pregnancy rate per 1,000 women aged 15-44. The results of this analysis are shown in Chart 8. Between 2005 and 2007, the unintended pregnancy rate increased slightly to 40.8 per 1,000 women in 2007 but has decreased since then. This decrease can be attributed both to the decline in the total number of pregnancies since 2007 and the drop in the proportion of births classified as unintended. As with the measure above, data for 2012 and after cannot be compared with data from prior years because of the addition of the new response option "unsure" used to calculate the unintended pregnancy rate. However, unintended pregnancies have continued to decrease, with current rates far below the target of 32.0 per 1,000 women aged 15-44. Due to a data error, 2021 is the most recent data available for Oregon PRAMS.



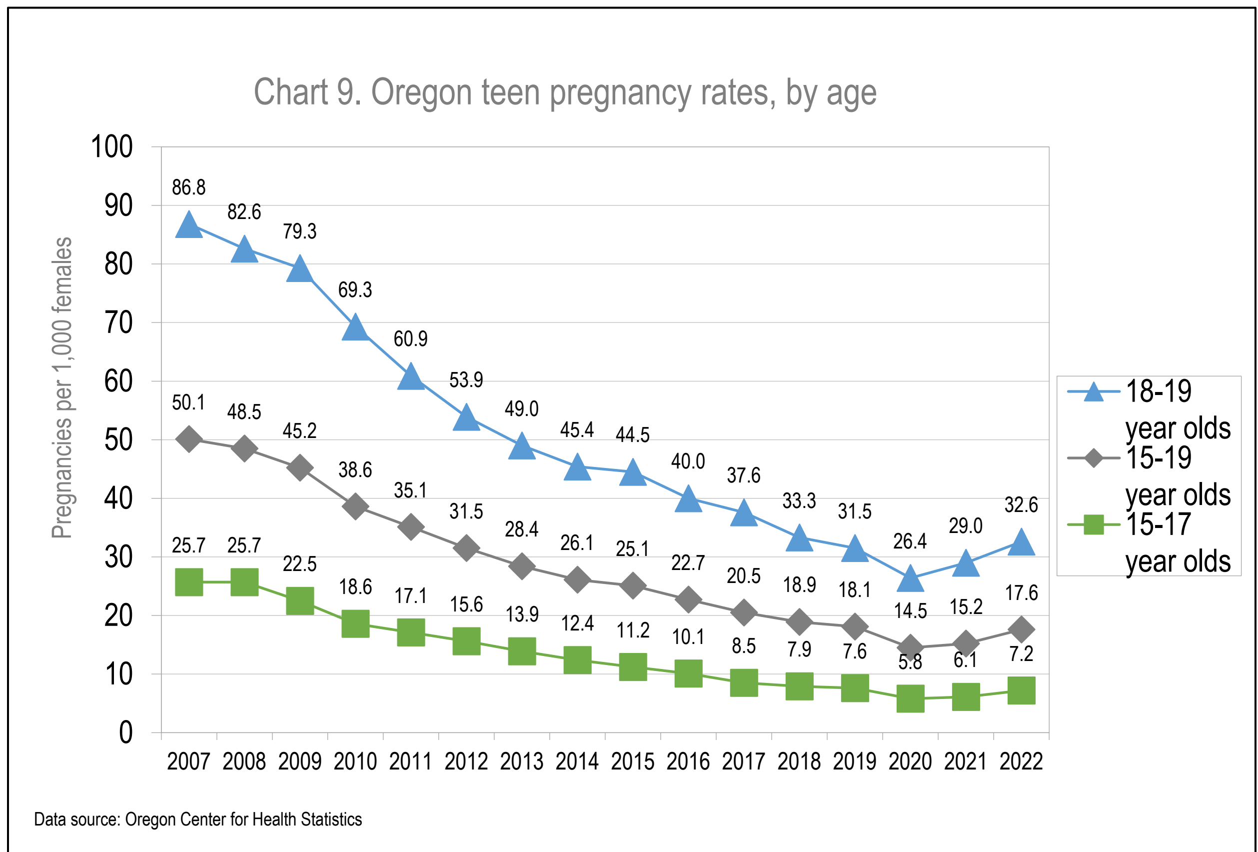
- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.

  Data source: Oregon Center for Health Statistics

  Performance target: 15-17 year olds – 11.0 and 18-19 year olds – 43.5

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

Progress: Teen pregnancy has declined dramatically over the last 20 years. In all three age groups, the drop that occurred in the three years following CCare implementation (1999-2002) was greater than the decline experienced in the previous three-year period (1996 to 1999). Starting in 2005, Oregon teen pregnancy rates increased for the first time in about 10 years, depending on the age group. This trend was reflected nationally, where both teen birth and pregnancy rates rose in 2006, for the first time since 1991.[4] This increase has since reversed, however, with Oregon teen pregnancy rates among all age groups continuing to dramatically decline between 2007 and 2020. The performance targets were reached as of 2016. As shown in the chart below, these rates increased very slightly from 2020 to 2021 but are well below the performance targets.



[4] Guttmacher Institute data report. "U.S. Teenage Pregnancies, Births, and Abortions: National and State Trends and Trends by Race and Ethnicity." January 2010. Accessible at: http://www.guttmacher.org/pubs/USTPtrends.pdf

Expenditures

The below table show the quarterly expenditures through the 4th quarter of DY 25.

TABLE 5. Quarterly Expenditures for DY 25 January 1 – December 31, 2023	
Quarter	**Total Expenditures as Reported on the CMS-64**
1	$1,004,483
2	$1,062,616
3	$1,110,196
4	$758,631
Annual Total	$3,935,926

Budget Neutrality Annual Expenditure Limits

TABLE 6. Demonstration PMPM Ceilings								
Trend	**DY 18 (CY2016)**	**DY 19 (CY2017)**	**DY 20 (CY2018)**	**DY 21 (CY2019)**	**DY 22 (CY2020)**	**DY 23 (CY2021)**	**DY24 (CY2022)**	**DY25 (CY2023)**
.86%	$34.28	$34.57	$34.87	$35.17	$35.47	$35.78	$35.78	$35.78

Budget Limit Calculation:

$35.78 PMPM x 264,117 Member Months = $9,450,106.26

Plus 0.5% per STC 41 = $9,497,356.79

Multiply by 87% (composite federal share admin + direct) = $8,262,700.41

TABLE 7. DY 25 Budget Neutrality Annual Expenditure Limits	
DY 25 Budget Limit	**DY 25 Annual Expenditure**
$8,262,700.41	$3,935,926

Table 7 shows that actual expenditures for DY 25 are well within the budget limit. As noted in Table 2, in DY 25 CCare saw a slight increase in total enrollments as the eligibility extensions implemented as part of the Public Health Emergency ended on April 30, 2023. However, overall enrollment numbers were still below pre-COVID levels. Ongoing efforts to increase access to full benefit coverage through Oregon's Medicaid program may continue to limit enrollment in and utilization of CCare benefits, and we will be tracking these efforts and their impacts moving forward.

Contraceptive Methods

TABLE 8. Number of Contraceptive Methods and Contraceptive Users, CY 2023/DY 25			
	Number of contraceptive methods dispensed	**Number of unique contraceptive users**	**Data source**
Male condom	1238	727	Claims data
Female condom	3	2	
Sponge	0	0	
Diaphragm	3	4	
Pill	3010	2956	
Patch	124	144	
Ring	409	356	
Injectable	1526	826	
Implant	646	765	
IUD	860	1229	
Emergency contraception	1715	0	
Sterilization	136 (vasectomy)	90	

TABLE 9. Contraceptive Care Quality Measures, CY 2023/DY 25						
	Ages 15-20			**Ages 21-44**		
	Percent	**Numerator**	**Denominator**	**Percent**	**Numerator**	**Denominator**
Most and Moderately Effective Methods	88.2%	2184	2477	84.2%	3909	4641
LARC Methods	29.8%	739	2477	25.4%	1181	4641

Activities for Next Quarter

In order to be certified as a CCare clinic, agencies must adhere to a comprehensive set of requirements (Appendix A) which provide the foundation for high-quality contraceptive services. They are based on national standards of care and align with best practices and recommendations for comprehensive client-centered, culturally responsive preventive care. Clinics must also ensure that clinical services are provided in a way that makes it easy and comfortable for youth to seek and receive the services they need.

Oregon's 2024 legislative session begins on February 5, 2024. RH Program staff will track all bills related to reproductive health and provide bill analyses and fiscal impact statements, as

appropriate. RH Program staff will also respond to any questions from legislators and the legislative fiscal office related to state general funding of CCare, though generally budget-related questions do not arise during the state's short legislative session.

Oregon's 1115 family planning Medicaid demonstration waiver renewal was approved November 9, 2023, for the period of January 2024 – December 2029. As part of the waiver renewal, the RH Program will be focusing on implementing NEMT within the next year, developing a mitigation workplan to come into compliance with streamlined application and eligibility determination processes requirements over the waiver renewal period, and establishing a contract with a third-party evaluator to develop an evaluation design and conduct an evaluation for the waiver period.

APPENDIX A: CCare Certification Requirements

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

Section A. Facility, Operations, & Staffing

A.1 Clinic Space

a. Clinics must make efforts to create a welcoming and inclusive environment whereby the clinic space and signage are reflective of all enrollees including but not limited to communities of color, teens, LGBTQ+ individuals, and people with disabilities.
b. The agency's clinic facility(s) must be compliant with ADA requirements.

A.2 Infection Control

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

A.3 Laboratory

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

A.4 Pharmacy and Contraceptive Methods

a. Contraceptive methods covered by CCare must be dispensed onsite following Oregon Board of Pharmacy rules and per appropriate licensure (OAR 855-043).
b. Clinics may offer enrollees the option of receiving their contraceptive methods by mail at no additional cost to the enrollee.
    1. Use of this option is at the discretion of the enrollee; it cannot be offered as the only way the enrollee can receive contraceptive methods.
    2. Clinics must package and mail supplies in a manner that ensures the integrity and confidentiality of the contraceptive packaging and effectiveness of the method upon delivery.

A.5 Medical Emergencies

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

A.6 Reproductive Health Coordinator

a. The agency must designate a staff person as a Reproductive Health Coordinator (RHC) to be the key point of contact in accordance with OAR 333-004-3040. The RHC is

responsible for all the items listed in the RH Coordinator Competencies, including, but not limited to:

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

b. If the agency's designated RHC does not comply with these responsibilities, the RH Program may require the agency to designate a different agency staff person.

c. When an RHC is designated, the designated RHC and a higher-ranking staff member (e.g. agency administrator, the RHC's supervisor) who understands the RHC's workload and job duties must sign the RH Coordinator Competencies.

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

   1. In the case of a leave of absence longer than one month, an interim RHC must be assigned.

A.7 Staff Training Requirements

a. Upon CCare clinic certification or new hire, clinic staff must receive training on the following topics:

   1. CCare certification requirements, policies, and processes (as applicable to staff roles);
   2. Client-centered, nondirective pregnancy options counseling (staff who provide pregnancy options counseling to CCare enrollees); and
   3. Reproductive Justice in the clinical setting (staff who interact with CCare enrollees).

b. Annually, clinic staff must receive one training focused on equity, including topics related to racism, health equity, cultural-responsiveness[5], and/or trauma-informed[6] care in providing sexual and reproductive health clinical services (staff who interact with CCare enrollees).

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

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

Section B. Equitable Access

B.1 Access to Care

a. Clinics must offer the same scope and quality of services to all enrollees regardless of race, skin color, national origin, religion, sex, sex characteristics, sexual orientation, gender identity, age, number of pregnancies, marital status, or disability, in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964, section 1557 of the ACA, the Americans with Disabilities Act (ADA) of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A.
b. All CCare services must be provided without a referral requirement.
c. Enrollees who cannot be provided services within two weeks must be offered information about other reproductive health providers in the area, including whether or not they are RHCare or CCare providers.

B.2 Cultural Responsiveness

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

B.3 Linguistic Responsiveness

a. Clinics must communicate with enrollees in their preferred language and provide interpretation services in the enrollee's preferred language, at no cost to the enrollee.
    1. The clinic must inform enrollees, in their preferred language, both verbally and in writing, that language services are readily available at no cost to them, in accordance with the Civil Rights Act of 1964 and sections 1557, 1331 and 1001 of the Affordable Care Act (ACA).
    2. All persons providing interpretation services must adhere to confidentiality guidelines.
    3. Family and friends may not be used to provide interpretation services, unless requested by the enrollee.
    4. Individuals under age 18 should never be used as interpreters for clinic encounters for enrollees with limited English proficiency or who otherwise need this level of assistance.
b. Clinics must have materials and signage that are easily understandable and in languages commonly used by the populations in the service area.
    1. Medically accurate, culturally, and linguistically responsive, inclusive[7], and trauma-informed appropriate health educational materials must be available for enrollees needing them.

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

2. All print, electronic, and audiovisual materials must use plain language[8] and be easy to understand. An enrollee's need for alternate formats must be accommodated.

Section C. Enrollees' Rights & Safety

C.1 Confidentiality

a. Safeguards must be in place to ensure confidentiality, and to protect enrollees' privacy and dignity throughout the clinic space, during clinic interactions, and in record keeping.
b. Information obtained by staff may not be disclosed without written consent, except as required by law or as may be necessary to provide services to the individual.
c. All aspects of service provision must be compliant with the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and Health Information Technology for Economic and Clinical Health (HITECH) Act.
d. For services provided via telehealth, staff must comply with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (Authority/OHA) Confidentiality and Privacy Rules and security protections for the enrollee in connection with telemedicine technology, communication, and related records.
e. A copy of a patients' bill of rights must be posted in a public area of the clinic in the languages most commonly used by enrollees.
f. Minors (under 18 years)[9] & Confidentiality
    1. Clinic staff are prohibited from requiring written consent from parents or guardians for the provision of reproductive health services to minors.
    2. Clinic staff may not notify a parent or guardian before or after a minor has requested and/or received reproductive health services.

C.2 Noncoercion

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

C.3 Informed Consent

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

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

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

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

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

b. The informed consent process, provided verbally and supplemented with written materials by the clinic, must be presented in plain language.

c. Telehealth

1. Clinics must obtain informed consent from the enrollee for the use of telehealth as an acceptable mode of delivering reproductive health services. The consent must be documented in the enrollee's health record or in each telehealth visit note.

C.4 Mandatory Reporting

a. Agencies must maintain a written policy that requires clinic staff to follow state and federal laws regarding mandatory reporting and assists staff to recognize and acknowledge their responsibility to report suspected abuse or neglect of a protected person pursuant to Federal and State law. The policy must:
    1. Address mandatory reporting obligations regarding sexual abuse, and
    2. Be updated when applicable laws change.

Section D. Services

D.1 Service Delivery

a. Services must be provided using a trauma-informed, inclusive, culturally responsive, and client-driven[10] approach that helps the client clarify their needs and wants, promotes personal choice and risk reduction, and takes into account the cultural and socioeconomic factors of the client and psychosocial aspects of reproductive health.

D.2 Clinical Services

a. Clinics must offer the full scope of services as defined by CCare to all CCare-eligible enrollees. See Appendix A for the detailed list of services. The full scope of services includes:
    1. A broad range of contraceptives, including device insertion and removals;
    2. Core reproductive health services;
    3. Contraceptive services;
    4. Counseling and education services;
    5. Pregnancy testing in context of contraceptive management and counseling on all pregnancy options, including parenting, abortion, and adoption;
    6. Sexually transmitted infection (STI) screening, within the context of a contraceptive management visit; and
    7. Breast and cervical cancer screening, within the context of a contraceptive management visit.

b. Clinics must notify the RH Program within 10 business days if they are unable to provide the full scope of services (e.g. loss of clinical provider) for one month or longer.

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

c. Enrollees must be able to get their first choice of contraceptive method unless there are specific contraindications.
d. Limited exceptions to the clinical services and contraceptive supply requirements as described in D.2.a may be considered. Please see Appendix B for more information.

D.3 Counseling and Education Services

a. Clinics must offer the list of counseling and education topics as detailed in Appendix A.
b. Pregnant people must be offered information and counseling regarding each of the options in a neutral, factual, and non-directive manner: parenting, abortion, and adoption.
c. Clinics must offer/provide written information about all pregnancy options. It must be written in a factual and non-directive manner and include contact information for agencies that give medically accurate, unbiased information about the option(s) for which they are being listed.

D.4 Referrals and Information Sharing

a. Enrollees must be offered information about:
    1. Where to access free or low-cost primary care services,
    2. How to obtain full-benefit health insurance enrollment assistance, public or private, as needed, and
    3. Clinics must provide information to enrollees about resources available in the community to address barriers that might exist for enrollees, including but not limited to transportation, childcare, housing, and food insecurity, as appropriate.
b. Clinics must provide closed-loop referrals[11] for clinical services within the scope of CCare that require follow-up to ensure continuity of care.

D.5 Telehealth Services

a. Enrollees must be given the option to have an in-person visit and informed of the scheduling options, services available, and restrictions of both types of visits.[12]

Section E. Data Collection & Reporting

E.1 Collection and Submission of Claims Data

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

E.2 Other Data and Reporting Requirements

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

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[11] Closed-loop referral means a referral process in which the referring clinic or provider receives information from the entity to which a client was referred about the services they received. This excludes abortion care, as it is considered a self-referral.

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

b. Agencies must provide additional information as requested by the RH Program.

Section F. Reproductive Health Access Fund

F.1 Client Enrollment

a. Clinics must emphasize that alternative programs may be available for clients ineligible for the Reproductive Health (RH) Access Fund.
b. Clinic staff must support clients in completing the RH Access Fund Enrollment Form accurately and to the best of the client's knowledge.
c. Clinics must ensure that all required client enrollment data is collected using the RH Access Fund Enrollment Form, that all fields are completed, and the form is signed and dated appropriately, unless they receive written approval from the RH Program to enter client enrollment data directly into the RH Access Fund Eligibility Database. Enrollment Forms may not be backdated.
    1. If the Enrollment Form is completed remotely, either over the telephone or during a video visit, clinic staff must write the enrollee's name on the signature line and the day's date with a note that consent was obtained verbally, unless the clinic receives written approval from the RH Program to enter client enrollment data directly into the RH Access Fund Eligibility Database.
d. All required enrollment data must be entered into the web-based RH Access Fund Eligibility Database.
e. As part of the enrollment process, clinics must comply with all relevant National Voter Registration Act (NVRA) rules. (OARs 165-005-0060 through 165-005-0070).

F.2 Billing and Payment

a. RH Access Fund enrollees who are eligible for CCare may not be charged for services covered by CCare. See OARs 333-004-3070(3) and 333-004-3090(1)(b) for CCare-covered services and client eligibility, respectively.
b. Enrollees may not be billed for services that would normally be covered by CCare if not for an error on the part of clinic staff.
c. Enrollees may be billed for services that are outside of the CCare scope of services as defined in OAR 333-004-3070(3).
d. Prior to the visit and in a confidential manner, enrollees receiving services not covered by CCare must be informed that they may be expected to pay. See OARs 333-004-3070(3) for CCare-covered services.
e. Clinics may not request a deposit from an enrollee who is eligible for CCare in advance of services covered by CCare.
f. Clinics must submit claims to the RH Program or its claims processing vendor, as directed.
g. Clinics have a legal obligation to seek third party reimbursement, if applicable, prior to billing the RH Access Fund. The clinic:
    1. Must be enrolled with and bill the Oregon Health Plan (OHP);
    2. Must be credentialed with and bill private insurance companies; and
    3. Must assure confidentiality, when indicated.

    i. Including not seeking third party reimbursement if the enrollee requested confidentiality.

h. For services billed to the RH Access Fund, the clinic must accept RH Program reimbursement as payment in full and may not charge the enrollee additional fees for those services.

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

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

2. **Core reproductive health services:**
   - Obtaining a medical history;
   - Clarifying the enrollee's reproductive needs and preferences;
   - Performing a sexual health assessment;
   - Screening for depression;
   - Screening for Intimate Partner Violence (IPV)/contraceptive coercion, counseling, and referring for additional assistance when indicated;
   - Screening for tobacco/illicit substance use, counseling, and referring for cessation assistance when indicated;
   - Screening for immunization status and recommending/offering vaccination when indicated; and
   - Screening for sexually transmitted infections (STIs) per national standards, and offering individualized risk reduction counseling.

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

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

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

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

7. **Breast and cervical cancer screening, within the context of a contraceptive management visit:**
   - Cervical Cytology services include:
     - Cervical cytology screening, per national standards;
     - Referral for abnormal results per national standards; and
     - Referral for additional procedures outside of scope (e.g. colposcopy).
   - Breast Cancer services include:
     - Providing a clinical breast exam when indicated per national standards;
     - Screening for BRCA risk by medical and family history; and
     - Referral for abnormal exam results or positive results on risk assessment tool, per national standards.
   - Mammography referrals include:
     - Recommending mammography per national standards; and
     - Referral for mammography.

REFERENCES:

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

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

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

Centers for Disease Control and Prevention, 2014. Providing Quality Family Planning Services. Retrieved from: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm

Centers for Disease Control and Prevention, 2015. Update: Providing Quality Family Planning Services – Recommendations from CDC and the U.S. Office of Population Affairs. Retrieved from: https://www.cdc.gov/mmwr/volumes/65/wr/mm6509a3.htm

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

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

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

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

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

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

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