Oregon Application Certification Statement - Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes Oregon's application to the Centers for Medicare & Medicaid Services (CMS) to extend the Oregon ContraceptiveCare ("CCare"), Medicaid section 1115 family planning demonstration (Project No. 11-W-00142/0), for a period of 5-years pursuant to section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

__X__ Section 1115(a) extension <u>with no</u> program changes

This constitutes Oregon's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period April 1, 2010 through June 30, 2016.

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

_____ Section 1115(a) extension <u>with</u> minor program changes

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration with minor demonstration program changes. In combination with completing the Section 1115 Extension Template, the state may also choose to submit a redline version of its approved Special Terms and Conditions (STCs) to identify how it proposes to revise its demonstration agreement with CMS.

With the exception of the proposed changes outlined in this application, the state is requesting CMS to extend approval of the demonstration subject to the same STCs, waivers, and expenditure authorities currently in effect for the period [insert current demo period].

The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information requested in Appendices A through E above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the state's whole submission.

1. Section 1115(a) Extension Template
2. Statement of Qualification for Fast Track Process
3. Appendix A
4. Appendix B
5. Appendix C (and Attachment 1)
6. Appendix D
7. Appendix E (and Attachments 1-3)

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature:_____ **Date:_____**

[Governor]

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review. The state will have an opportunity to modify its application submission if CMS determines it does not meet these requirements. If CMS reviews the state's submission and determines that any proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new demonstration.

Oregon Section 1115(a) Application Statement of Qualification for Fast Track Process

The Oregon ContraceptiveCare ("CCare") Medicaid section 1115 family planning demonstration (Project No. 11-W-00142/0), 1115(a) extension application qualifies for the "Fast Track" process. This demonstration does not have any of the policy areas CMS identified as being complex in the guidance issued on July 24, 2015. In addition, the CCare demonstration has been operating for several extension cycles without substantial program changes. Oregon is also in compliance with reporting deliverables and not proposing to implement major or complex changes.

Historical Narrative Summary

In February 1998, the state of Oregon submitted a Medicaid waiver demonstration proposal titled "Oregon Family Planning Expansion Project" (now known as Oregon ContraceptiveCare or CCare), designed to expand the availability of Medicaid-supported contraceptive management services to a wider population base. That proposal was approved in October 1998 by the Centers for Medicare and Medicaid Services (CMS) (previously the Health Care Financing Administration) and the program began in January of 1999. The initial five-year project ran through December of 2003 and three-year extensions were approved in 2003, 2006, and 2009. Temporary extension requests were granted from November 1, 2012 through December 31, 2015. Oregon requests renewal of this waiver for five-years, beginning January 1, 2016 and ending December 31, 2020.

Prior to CCare's inception in 1999, Oregon served an average of 50,000 clients a year, less than 30% of the Women in Need,[1] through approximately 90 publicly funded family planning clinics. Only 82% of sexually active high-school students reported using contraception at last intercourse. The pregnancy rate among 15-17 year olds was 42.1 per 1,000 and the adult unintended pregnancy rate was 44.3 per 1,000. However, with the introduction of the waiver, system capacity and impact increased dramatically. By 2005, Oregon was serving nearly 157,000 clients with all sources of pay at 165 publicly supported clinics – approximately 67% of Women in Need. Ninety percent (90%) of sexually active high-school students reported using contraception at last intercourse and the 15-17 year old pregnancy rate had dropped to 24.2 per 1,000.

Unfortunately, however, these 2005 data represent the height of CCare's client caseload. Waiver utilization and impact diminished significantly beginning in 2006 when federal citizenship documentation requirements and other waiver eligibility restrictions were implemented. In 2008, only 112,000 individuals with all sources of pay (45% of Women In Need) received family planning services. By April of that year, CCare visits had declined from the 2005 peak by 33% overall and by a startling 47% and 49% among teens and African-Americans, respectively. The precipitous drop in these two client groups further demonstrates how the citizenship documentation requirements of the 2005 Deficit Reduction Act (DRA) negatively impacted those who are truly eligible for the program.

Implementation of the Affordable Care Act, including Medicaid expansion and the creation of the health insurance marketplace, have effectively provided coverage to thousands of Oregonians who were previously uninsured, thereby decreasing CCare's client caseload even further. However, the health reform experience of Massachusetts[2] shows that even with greatly expanded

[1] Women in Need is an estimate of the number of fertile, reproductive-age women with incomes under 250% FPL who are neither pregnant nor intentionally trying to become pregnant. It is produced by the Guttmacher Institute.
[2] 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.

health insurance coverage, significant coverage gaps remain for many individuals in need of family planning, and CCare is uniquely positioned to address these gaps.

- *Churning*: A study of the Massachusetts' health care reform efforts demonstrated that nearly 6% of residents reported being uninsured at some point during the past year.[3] These lapses in coverage were more common among young and low-income residents as well as those who were single with no children, all populations at especially high risk of unintended pregnancy. Changing life circumstances, including changes in income, employment status, and marital status, can alter a person's insurance status. Also, rules regarding effective coverage dates, depending upon when during the calendar month an individual enrolls in a qualified health plan may result in significant delays in coverage. CCare will continue to serve as an important bridge to filling these gaps as its point-of-service enrollment provides immediate coverage in the course of a family planning visit. Once the client's immediate family planning needs are met, CCare can assist that client in obtaining longer-term, full-benefit coverage.
- *Confidentiality:* Although many above 138% FPL will gain private insurance coverage through ACA-generated subsidies, some individuals, especially those needing confidential care, may feel they cannot use their insurance to meet their reproductive health care needs. Insurers generally send an "explanation of benefits" (EOB) form to the policy holder which effectively precludes confidentiality for adult dependents of any age whose partner holds the health insurance policy, minors who may consent to health services and are insured through a parent or guardian, and young adults remaining on their parent's health insurance. CCare fills this gap by offering a "good cause exception" which allows individuals to enroll in the program and access confidential services without billing private insurance. Approximately 13% of clients currently enrolled in CCare have indicated a need for special confidentiality (i.e. primary insurance cannot be billed prior to billing CCare).
- *Young People in Transition:* Finally, although many individuals will obtain insurance coverage under ACA coverage provisions, they may be dependents (e.g., high school, college and/or trade school students, young adult women in transition, and youth of undocumented parents) in households that choose not to seek enrollment in full benefit coverage. Access to CCare-funded services allows these individuals to meet their immediate need for family planning services, while at the same time enabling or providing an opportunity for them and their families to initiate a connection to the health insurance system when they are ready.

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

[3] Rachel Benson Gold, "Back to Center Stage: ACA Decision Gives New Significance to Medicaid Family Planning Expansions," *Guttmacher Policy Review*, Fall 2012, Volume 15, Number 4.

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 providers. Participating providers abide by the program's Standards of Care. 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.

Objectives

The waiver's original objectives, including evidence of the state's progress in meeting them, can be found in *Appendix C*. For the next waiver renewal period, CCare's future goals can be 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. Further details regarding these outcomes, and the performance targets established for them, can be found in Appendix C of this application.

(A) Immediate Outcomes

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

(B) Intermediate Outcomes

- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.
  Data source: Oregon Behavior Risk Factor Surveillance System (BRFSS)
- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.
  Data source: Oregon Healthy Teens survey (OHT)

(C) Long-term Outcomes

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.
  Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS)

- Outcome 6: The program will result in a decrease in the unintended pregnancy rate in Oregon.
  Data source: Oregon PRAMS and Oregon Center for Health Statistics
- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.
  Data source: Oregon Center for Health Statistics

Historical Enrollment and Expenditure Data

I. Enrollment

	2010	2011	2012	2013	2014
January	5,254	5,460	5,366	6,110	6,364
February	4,743	4,819	5,023	5,159	3,281
March	5,561	5,374	4,861	5,341	3,287
April	5,491	5,115	5,284	6,026	3,416
May	5,567	5,093	5,406	5,774	3,128
June	5,784	5,198	4,964	5,212	2,905
July	5,341	4,674	4,802	5,295	2,959
August	5,652	5,236	5,172	5,499	2,774
September	5,501	4,992	4,715	4,832	2,958
October	5,820	5,117	5,450	5,481	3,310
November	4,959	4,986	4,683	4,800	2,768
December	4,858	4,365	4,083	3,873	3,310
Average	5,378	5,036	4,984	5,284	3,372

II. Reported Expenditures

	2010	2011	2012	2013	2014
Total	$21,393,956	$20,514,020	$20,757,254	$19,441,234	$12,128,619
Federal	$19,254,560	$18,462,618	$18,681,528	$17,497,110	$10,915,757
Non-Federal	$2,139,396	$2,051,402	$2,075,726	$1,944,124	$1,212,862

Historical Per Member Per Month and Expenditure

	2010	2011	2012	2013	2014
Clients with active eligibility during the calendar year	104,810	101,391	97,653	98,653	84,717
Total number of member months	620,906	607,777	568,261	575,936	490,553
Total expenditures	$21,393,956	$20,514,020	$20,757,254	$19,441,234	$12,128,619
Per Member/Per Month (PMPM) Cost (Total Computable)	$34.46	$33.75	$36.53	$33.76	$24.72
% change in PMPM from year to year		-2%	8%	-8%	-27%

4-year average % change in PMPM from year to year: -7%

As shown above, there were fluctuations in the Per Member/Per Month Costs each year. The greatest change occurred in 2014, which shows a substantial decrease in PMPM Costs compared to previous years. During 2014, many clients enrolled or re-enrolled in CCare who subsequently became enrolled in the Oregon Health Plan, the state's Medicaid program. We did not have a systematic way to check for OHP enrollment for clients who were eligible for CCare, so many clients retained CCare eligibility despite not using CCare services. Thus, the total number of member months for 2014 is inflated compared to the number of member months for which clients actually accessed services. Therefore, the PMPM Cost decreased. It is anticipated that in future years, the shift in client enrollment from CCare to OHP will be less drastic than in 2014, and PMPM costs will likely adjust to be closer to the previous averages.

Projected Number of Enrollments and PMPM Costs:

	2016	2017	2018	2019	2020
Number of clients enrolling or re-enrolling	30,400	29,184	28,308	27,742	27,465
Projected % change in annual enrollments	-5%	-4%	-3%	-2%	-1%
Per Member/Per Month (PMPM) Cost (Total Computable)	$34.28	$35.99	$37.79	$39.68	$41.66
% change in PMPM from year to year	5%	5%	5%	5%	5%

We are projecting that annual enrollments will decrease, but at decreasing rates each year. CCare monthly enrollments have stabilized from 2014 to 2015 and we predict this stabilization will continue. We are projecting a 5% annual increase in the Per Member/Per Month Costs, according to the President's Growth Rate. The PMPM Cost in 2016 is based on a 5% increase over the 5-year average in PMPM costs from 2010-2014. As described above, our PMPM Costs decreased dramatically in 2014 but are expected to stabilize.

Evaluation Plan

As described in Appendix A, the state has developed outcome measures for the next waiver renewal period that reflect the current healthcare landscape and goals of the program. Many of the program's original objectives have been retired due to their limited relevance/applicability to the current program. The program's outcomes can be 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. These proximal, intermediate, and longer-term outcomes are related to the program's overall goal of improving the well-being of children and families by reducing unintended pregnancies and providing assistance in accessing primary health care services and comprehensive health care coverage. Performance targets have been set for each outcome and will be monitored annually to measure progress toward these goals.

(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%
  Current rate (2014): 91.7%
  Notes: Effective contraceptive use, including all Tier 1 and Tier 2 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 pregnancy, seeking pregnancy, or not sexually pregnant.

- 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
  Performance target: 50%
  Current rate (2015): 40%
  Notes: The RH Customer Satisfaction Survey (CSS) is 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. It is not possible to distinguish between clients with CCare and other sources of pay in the CSS data. Therefore, we are unable to assess whether those who did not report receiving assistance are non-CCare clients, and to whom the requirement does not apply, which is why the performance target is set at a low rate.

(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%
  Current rate (2013): 68.7%
  Notes: Effective contraceptive use, including all Tier 1 and Tier 2 methods, among women 18-44 at risk of unintended pregnancy. Women at risk of unintended pregnancy excludes respondents who have a same sex partner, don't know their birth control use, refuse birth control use, have had a hysterectomy, are currently pregnant, reporting being too old, want to get pregnant, and/or don't care if they get pregnant.

- 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%
  Current rates (2013): 8th grade – 77.2% and 11th grade – 84.7%
  Data source: Oregon Healthy Teens survey (OHT)
  Notes: Proportion of sexually experienced, defined as those who have ever had intercourse, 8th and 11th graders who indicated using birth control pills, Depo Provera, condoms, or an "unspecified method"

(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%
  Current rate (2012): 37.2%
  Notes: Proportion of respondents who reported that their most recent pregnancy was either mistimed or unwanted are classified as unintended.

- 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
  Current rate (2012): 33.1 per 1,000 women 15-44
  Notes: The unintended pregnancy rate is derived from multi-step procedure in which the proportion of unintended births are multiplied by the actual number of birth in each year (obtained from the Oregon Center for Health Statistics) to produce an annual number of unintended births in the state. Next, the annual number of abortions in the state are multiplied by .95 (research suggests that approximately 95% of abortions are thought to result from unintended pregnancies) to estimate the number of unintended abortions in

the state. The unintended birth and abortion numbers are added together and divided by state population figures to produce an unintended pregnancy rate per 1,000 women 15-44.

- 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
  Current rate (2014): 15-17 year olds – 12.4 and 18-19 year olds – 45.4
  Notes: Teen pregnancy estimates are based upon the estimated number of teen births and induced terminations among Oregon teens; they do not include the number of fetal deaths or miscarriages (spontaneous abortions) which occur.

Appendix C, Attachment 1: Interim Evaluation Report

Introduction

Oregon ContraceptiveCare, or CCare, (formerly known as FPEP) aims to reduce unintended pregnancies and improve the well-being of children and families in Oregon. Under CCare, a Section 1115(a) waiver is used to expand Medicaid coverage for family planning services to all men and women of reproductive capacity with household incomes at or below 250% of the federal poverty level (FPL). Teens' eligibility is based on their own incomes. The project was authorized for a five-year period beginning in January 1999, was renewed for an additional three years in 2000, 2006 and in 2009. The state is proposing to extend the waiver for additional 5-years. This evaluation report covers the entire lifetime of the waiver, from 1999 to mid-2015. However, data availability varies by measure, 2014 being the most current year for most measures.

It should be noted that the below objectives were developed as part of the state's waiver renewal application to CMS in 2009. The objectives reflected an overarching goal to increase the number of CCare clients enrolled and served. However, as ACA implementation, and most significantly, Medicaid expansion, has served to increase the number of individuals eligible for and enrolled in full-benefit comprehensive coverage, the program's objectives have changed. Instead of focusing on increasing the overall number of CCare clients enrolled and served, the program has shifted its focus to quality of care efforts (e.g. effective contraceptive use) and increasing client access to primary care coverage and services. These new objectives are detailed in the previous pages. Therefore, the below objectives and targets are not reflective of the current health care landscape.

Immediate Outcomes

Objective 1: Increase the number of clients seen at OHA family planning clinics. [2012 target: 70,000 at Title X clinics; 135,000 system-wide.]

Expanding the availability of birth control and reproductive health services is the primary mechanism by which CCare is intended to avert unintended pregnancies and improve child and family well-being. To determine whether improved availability of subsidized services is resulting in increased utilization, we have been tracking the number of clients seen at Oregon Health Authority (OHA) family planning clinics over time. Data for tracking this objective came from the Oregon family planning client data system and are available through 2014.

OHA's public family planning network consists of two types of sites: Title X clinics that existed before CCare and started offering CCare services to eligible clients when the project began; and CCare-only sites, which have joined the network in the years since the project's inception. Currently, there are 140 Title X and CCare clinic sites throughout the state. For Objective 1, we monitor client volume first at Title X sites only and secondly at all sites together. Changes in client volume at Title X sites illustrate how CCare has affected utilization of family planning services under a relatively static level of provider capacity. In contrast, system-wide variations in client volume reflect changes in both utilization and system capacity.

As shown in *Figure 1*, the number of clients seen in OHA Title X clinics has increased since CCare began. Before 1999, the annual number of clients was fairly stable, averaging about 52,000. After 1999, the number of clients served increased each year until 2005, with a net increase of 72% from 1998 to 2004. Client volume increased within each of the sub-groups that are particular foci for CCare: clients at less than 185% of FPL (the FPL limit for the time period of interest); male clients; and teen clients.

The 2005 drop seen in *Figure 1* is a result of one of the largest providers in the state becoming a direct Title X grantee in July of that year; because the provider is no longer a delegate of the state, its clients do not count toward our Title X total. Client numbers continued to decline between 2005 and 2008; this decline can be attributed to three factors: 1) the citizenship documentation requirements of the Deficit Reduction Act (DRA); 2) mandatory collection of Social Security Numbers (SSNs) for teen applicants; and 3) restriction of eligibility to individuals without creditable insurance coverage. These requirements were implemented in 2006. Despite sustained outreach efforts, client numbers continued to decline between 2009 and 2014, with 43,105 clients seen in Title X clinics in 2014.

Changes in client volume system-wide are shown in *Figure 2*, where the impact of the Medicaid waiver is most clearly visible. Total number of clients served at OHA-affiliated clinics grew from an average of 52,000 per year before CCare to almost 157,000 in 2005. However, total client volume declined by 6% in 2006, the first-ever decline in clients served since the waiver began. This decline continued through 2014, as ACA provisions, including Medicaid expansion, went into effect. Examining payment source data implicates the CCare eligibility changes described above as the primary cause of the pre-2014 changes in client volume; the number of CCare clients dropped by 38% between 2005 and 2013.

Further analyses of family planning visits by time period and payer has demonstrated a 33% overall drop in CCare clients since 18 months prior to the 2006 eligibility changes and 18 months after the eligibility changes. Teenage and African American clients have been particularly affected by the eligibility changes, with a 47% decline in visits among teenage clients and a 49% decline in visits among African American clients. The precipitous drop in these two client groups further indicates that the citizenship documentation requirements of the DRA negatively impacted those who are truly eligible for the program.

Between 2009 and 2010, however, client volume increased approximately 27%, with 137,032 clients seen at all agencies, surpassing the 2012 target of 135,000. However, visit data indicate that client numbers have begun to decrease since, to 78,980 in 2014. In particular, there were notable decreases in client numbers among clients with CCare as a source of pay between 2013 and 2014 (59,467 and 35,948, respectively). This decrease can be attributed to Medicaid expansion, in which approximately 38% of clients enrolled in CCare during 2014 transitioned to the state's full-benefit Medicaid program, the Oregon Health Plan (OHP).

Objective 8: Increase the proportion of clients who receive help to access primary care services and comprehensive health coverage. [2012 target: 55%]

Objective 8 was created 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 objective, 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 2013. Results from 2003 (baseline), 2005, 2007, 2009, 2011, 2013, and 2015 are shown in *Figure 3*.

In 2003, 25% of clients reported that they had been offered help to locate a primary care provider. Thirty-six percent (36%) reported that they had been offered a brochure or other help to access comprehensive health coverage. In 2005, these figures climbed to 59% and 48%, respectively. In 2007, 42% of respondents reported receiving help finding a place to go for general health services and 44% reported receiving help accessing health insurance. In 2009, a greater percentage of survey respondents reported receiving help than in any other year. Sixty-four percent (64%) reported receiving information about where to access general health services and 60% reported receiving help accessing health insurance. In 2009, survey participants were also asked about their insurance status. In 2013, 49.9% of clients said they had been offered information on one or more of the following: Medicaid, the Oregon Health Plan, FHIAP (Family Health Insurance Assistance Plan), or other public health insurance and 48.7% of clients said they had been offered information about where to go for general health services. Both of these proportions represent an increase compared to the 2011 survey, in which 37% of respondents said they were offered information about public health insurance and 42% said they were offered information about where to go for general health services.

In 2015, approximately 40% of CSS respondents indicated that they had received help getting primary care services and coverage. This represents a fairly dramatic decline which can be attributed to two factors. First, only 20% of all survey respondents answered these questions, highlighting the need to review the phrasing of these questions and possibly reword them in future iterations of the survey. Second, as more individuals gain comprehensive insurance coverage and access to primary care services, 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 *Figure 4*, those without insurance for primary care were much more likely to have received information about both public health insurance and accessing general health services than those with insurance.

It should be noted that it is not possible to distinguish between clients with CCare and other sources of pay in the CSS data. Therefore, we are unable to assess whether those who did not report receiving assistance are non-CCare clients, to whom the requirement does not apply and which may account for the low figures.

CCare program staff continue to conduct ongoing CCare 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 CCare provider training.

Objective 9: Restore CCare client volume to pre-2006 levels. [2012 target: 100,000 CCare clients served]

This objective was added in 2006 in response to three waiver eligibility changes that occurred that year: documentation of U.S. citizenship in accordance with the DRA; restriction of enrollment to individuals without creditable insurance; and mandatory collection of SSNs from teens. (Note: sub-analyses have been conducted to determine whether minors who voluntarily provided an SSN prior to its being required were more likely to return after the eligibility change than minors who were not able to supply their SSNs. Findings indicate that among those minors who voluntarily provided an SSN prior to its requirement, 52.3% returned to the clinic compared to 37.2% of minors who did not provide an SSN before the requirement.) Anticipating that these changes would increase barriers to family planning services and therefore reduce the number of clients served, Oregon's goal for this measure was to restore client volume to its pre-2006 levels by 2009.

Number of CCare clients served each year is shown in *Figure 5*. As noted above, CCare clients dropped in 2006 for the first time in the waiver's history due to eligibility changes. More recently, a precipitous decline in client volume between 2013 and 2014 can be attributed to Medicaid expansion and the transition of CCare clients into full-benefit Medicaid. This objective will be retired for the next waiver renewal period, as it has been rendered less relevant since implementation of ACA and Medicaid expansion.

Intermediate Outcomes

Objective 2: Increase the proportion of clients who use a highly effective contraceptive method. [2012 target: 75% for adults; 83% for teens.]

Highly effective methods of birth control, such as IUDs or hormonal methods, tend to be more expensive than barrier methods like condoms or diaphragms. For clients who must pay full or partial fees for reproductive health services, the greater cost of highly effective methods may present a barrier to their use. Objective 2 allows us to judge whether CCare, which expanded the number of people eligible to receive contraception at no cost to themselves, has led to increased use of highly effective methods among family planning clients.

The data used to track this objective came from the Region X Title X Information System. In the analysis, we focused on data from Title X-supported clinics; clients who visited CCare-only providers were excluded because of a lack of comparative data for the time period before CCare began. Methods categorized as "highly effective" were: IUDs, oral contraceptives, the Patch (Ortho Evra®), the Ring (NuvaRing®), Depo-Provera®, implants,

sterilization, and abstinence. (Less effective methods include condoms, spermicides, diaphragms, cervical caps, sponges, withdrawal, and the rhythm method.) Women using unspecified "other" methods were excluded from analysis since it was not possible to determine how effective their method might be.

Figure 6 shows what proportion of female clients at Title X-supported sites were using a highly effective method, from 1996 to 2014. Among adults, the proportion increased from 69% to 72% over the first year of CCare and has gradually increased since then, with a slight dip in 2014. Among teen clients, the proportion using highly effective methods has increased by over 22% since CCare began. In 2014, 74.9% of adults and 86.6% of teens used highly effective contraceptive methods. The 1996–2014 increases are statistically significant for both adults and teens, and appear to be continuing on an upward trend. Nevertheless, it is unlikely that the proportion of clients using highly effective methods will ever approach 100%. A significant number of women are unable or unwilling to use methods with high contraceptive efficacy because of contraindications (e.g., oral contraceptives are contraindicated for smokers) or unacceptable side effects (e.g., heavy menstrual bleeding associated with Copper-T IUDs). Family planning services research suggests that women are most likely to use contraception effectively when they are able to choose a method with which they feel comfortable.[4] So while CCare providers are required to provide information about all contraceptive choices, including the effectiveness of each method, the primary message is to "choose the method that's right for you."

Objective 4a: Increase the proportion of reproductive-age Oregonians who use a highly effective contraceptive method. [2012 target: 73%.]

This objective has the same rationale as Objective 2 above but the population of interest in this case is Oregon's adult population of childbearing age rather than family planning clients. To monitor this objective, 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 objective first appeared on the questionnaire in 1998 and asks respondents what method they and/or their partners currently use to prevent pregnancy. Beginning in 2002, both male and female respondents answered this item but we restrict our analysis to female respondents to facilitate year-to-year comparisons. In all other respects, the analysis for this objective mirrors what is conducted for Objective 2.

Figure 7 reveals that the proportion of adult females in Oregon using a highly effective method changed slowly during the first few years of CCare but then climbed to a high of about 74% in 2002. Since then, the proportion has remained fairly consistent. In 2011, the year for which we have most recent data, 73.6% of adult women in Oregon reported using a highly effective method. This represents an increase from 2010 (70.0%). The 2002 figure is a statistically significant improvement from 1999 but none of the other year-to-year differences are statistically significant. *Figure 8* shows effective method use by respondent FPL, split at 185% as a proxy for CCare's target population through 2011, and subsequently split at 250%

[4] Becker et al. (2007). The quality of family planning services in the United States: Findings from a Literature Review. Perspectives on Sexual and Reproductive Health 39(4), 206-215.

starting in 2012 when CCare's eligibility limit increased to 250% FPL. Over the time period shown, the overall trend among women under 185% FPL is toward increased use of effective methods, with an observable increase from 2004 to 2009. In 2011, 73.5% of women under 185% FPL reported using highly effective methods, similar to rates seen during the previous 5 years. Use of more effective methods among women above 185%/250% FPL has remained fairly steady since 2005.

As with any survey data source, however, BRFSS estimates are subject to sampling error. Error bars are included in *Figures 7* and *8* to show the 95% confidence interval around each yearly estimate. Overlapping confidence intervals can be interpreted as evidence of no statistically significant difference between estimates. The sub-analysis by FPL has some additional limitations. The first is that BRFSS respondents report their income in ranges, not exact amounts, so the FPL categorization is approximate at best. In some years, more than 10% of respondents refuse to supply income information at all. Furthermore, FPL can only act as a partial proxy for the CCare target population. U.S. citizenship, a second key CCare eligibility requirement, is not captured in BRFSS data, so the under 185%/250% FPL group used above may include women who were in fact not eligible for CCare because they were not citizens. Finally, the margins of error around estimates of contraceptive use by FPL are quite large: +/- 7% in some cases.

Objective 4b: Increase the proportion of sexually experienced high school students who report using a method of contraception at last intercourse. [2012 target: 90%]

To determine whether expanded availability of subsidized birth control and contraceptive management services is affecting birth control use among teens, we use data from the Youth Risk Behavior Survey (YBRS) and Oregon Healthy Teens Survey (OHT). Both are school-based surveys. The YRBS includes students in grades 9-12 and is conducted every odd year; the OHT focuses on 8th and 11th grade students specifically. Between 2001 and 2009, OHT was conducted annually; it is now administered every odd year. Both the YRBS and OHT questionnaires include an item asking participants what *one* method of contraception they used to prevent pregnancy at last intercourse. In our analysis, we examined responses to this question only among sexually experienced students, defined as those who had ever had intercourse. Students who said they used birth control pills, Depo® shots, condoms, withdrawal, or an unspecified "other" method were counted among contraceptive method users. Those who responded that they didn't know or were not sure about the method used were counted among the "no method" group.

Figure 9 shows the proportion of sexually experienced Oregon high school students who used a method of contraception at last intercourse. (*Note, the YRBS was not conducted after 2007, due to lack of school participation. Only OHT data is reported for this objective after 2007.) YRBS data indicate that the proportion increased by a statistically significant 5 percentage points from 1997 (81.9%) to 2007 (86.9%). Error bars are included for the YRBS figures but may not be visible on the graph because they are fairly small. 2013 OHT data show that 84.7% of 11th graders and 77.2% of 8th graders reported using contraception at last intercourse. It should be noted that starting in 2013, students reporting withdrawal as their

method were no longer included in the numerator, which may account for the slight drop in rates among 11th graders.

Long-range Outcomes

Objective 5a: Decrease the proportion of Oregon births classified as unintended. [2012 target: 37%]

Information on the intendedness of births in Oregon is found in Oregon's Pregnancy Risk Assessment Monitoring System (PRAMS). Launched in 1998, Oregon PRAMS is a population-based, mail and phone survey of women that draws its sample from the state birth certificate file. 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. Using this categorization, the proportion of Oregon births that were unintended was estimated at 39.5% in 1998-99 and decreased to a low of 37.3% in 2004. Between 2005 and 2009, however, this figure has increased each year to a high of 41.2% in 2009. However, 2010 and 2011 data indicate a statistically significant decrease in the rate; 36.6% of Oregon births were unintended in both 2010 and 2011. 2012 data indicate a slight backtracking in the proportion of births that were unintended; we will continue to track this measure closely to assess if this increase persists in coming years *(Figure 10).*

We also examined birth intent by FPL and source of payment for delivery. For the first analysis, PRAMS data on approximate income and number of family members were used to create two groups of women: those whose pre-pregnancy income was at or below 185% FPL (i.e., within the range for CCare eligibility) and those whose income was above that level. For the second analysis, responses to a question regarding payment for labor and delivery were coded to distinguish between Medicaid-paid deliveries and all others. Results of these two sub-analyses are shown in *Figures 11 and 12*.

Figure 11 reveals that women under 185% of FPL (the target population for CCare prior to April 2012) are generally more likely to have an unintended birth than those over 185%. Interestingly, women in the CCare target population experienced a stronger decline in unintended births from 1999-2001 than their counterparts (a reduction of 9.7% vs. 2.5%). While data for 2011 demonstrate a decrease in the unintended birth rate among women under 185% FPL, the rate returned to previous-year levels in 2012. Given the relatively large margins of error around each estimate, these changes are not statistically significant.

Some evidence of the same trends can be seen *Figure 12*. Overall, Medicaid-paid births in Oregon are more likely to be unintended than non-Medicaid paid births; this is consistent

with national data.[5] The proportion of Medicaid paid births that were unintended has fluctuated between approximately 52% -56% since 1998-99, the first year the PRAMS was administered. In contrast, the proportion of non-Medicaid paid births that were unintended has decreased steadily from 33.3% in 2000 to a low of 23.3% in 2005. Both sets of rates have continued to decrease since then, with the exception of unintended births among non-Medicaid-paid births in 2012. It should be noted, however, that all of these changes are well within the margin of error for this measure.

There are several limitations to both of these sub-analyses. The first is that FPL is at best a proxy for the waiver's target population, since income is only one aspect of CCare eligibility. Quality of the income and birth payment data is a second problem. PRAMS respondents give their income in ranges, rather than specific figures, and between 5 and 10% do not provide the information at all. Some women may not know, or may not be able to recall accurately, the source of payment for their child's delivery. Finally, the relatively small number of PRAMS participants (generally around 1,500 each year) means that the margin of error around estimates of birth intent by FPL or delivery source of pay is about +/- 5%.

The delivery payer results, in particular, should be interpreted in the context of demographic and programmatic shifts affecting Oregon's Medicaid population. Since 2000, the group of women with Medicaid-paid deliveries has included a growing proportion of women with Medicaid coverage for emergency services only. (Their Medicaid eligibility status is Citizen/Alien-Waived Emergency Medical, or CAWEM.) Because they are not citizens, these women are ineligible for the CCare services that could have helped them to avoid an unintended childbirth.

Objective 5c: Decrease the unintended pregnancy rate in Oregon. [2012 target: 36.5 per 1,000]

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."[6] In the first step, we estimate the proportion of Oregon's births (not pregnancies) that are unintended using PRAMS data. We then multiply the actual number of births in each year (obtained from the Center for Health Statistics, or CHS) by the unintended proportion to produce an annual number of unintended births in the state. Next, we multiply the annual number of abortions in the state by approximately 0.95 to derive an annual estimate of the number of unintended abortions in the state.[7] 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 *Figure 13*. The state's unintended pregnancy rate declined from 44.3 per 1,000 in 1999 to a low of 36.6 per 1,000 in 2004. The decline between 2000 and

[5] Williams L, Morrow B, Shulman H, Stephens R, D'Angelo D, Fowler CI. PRAMS 2002 Surveillance Report. Atlanta GA: Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 2006.

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

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

2004 is largely attributable to a reduced number of abortions each year. Between 2005 and 2007, the unintended pregnancy rate increased slightly to 40.8 per 1,000 women in 2007, but has since decreased to 33.1 per 1,000 women in 2012, the lowest rate since the measure has been tracked. This recent decrease can be attributed largely to the decline in the total number of pregnancies since 2007 and the drop in the unintended birth rate in 2010 and 2011.

Objective 7: Decrease teen pregnancy rates in Oregon. (2012 target: 23.5 per 1,000 for 15-17 year olds; 80.0 per 1,000 for 18-19 year olds)

Teen pregnancy remains a topic of national concern. In the Oregon Vital Statistics Annual Report, CHS publishes data on the pregnancy rate for a variety of adolescent age groups. *Figure 14* presents these data for 1996 through 2014.

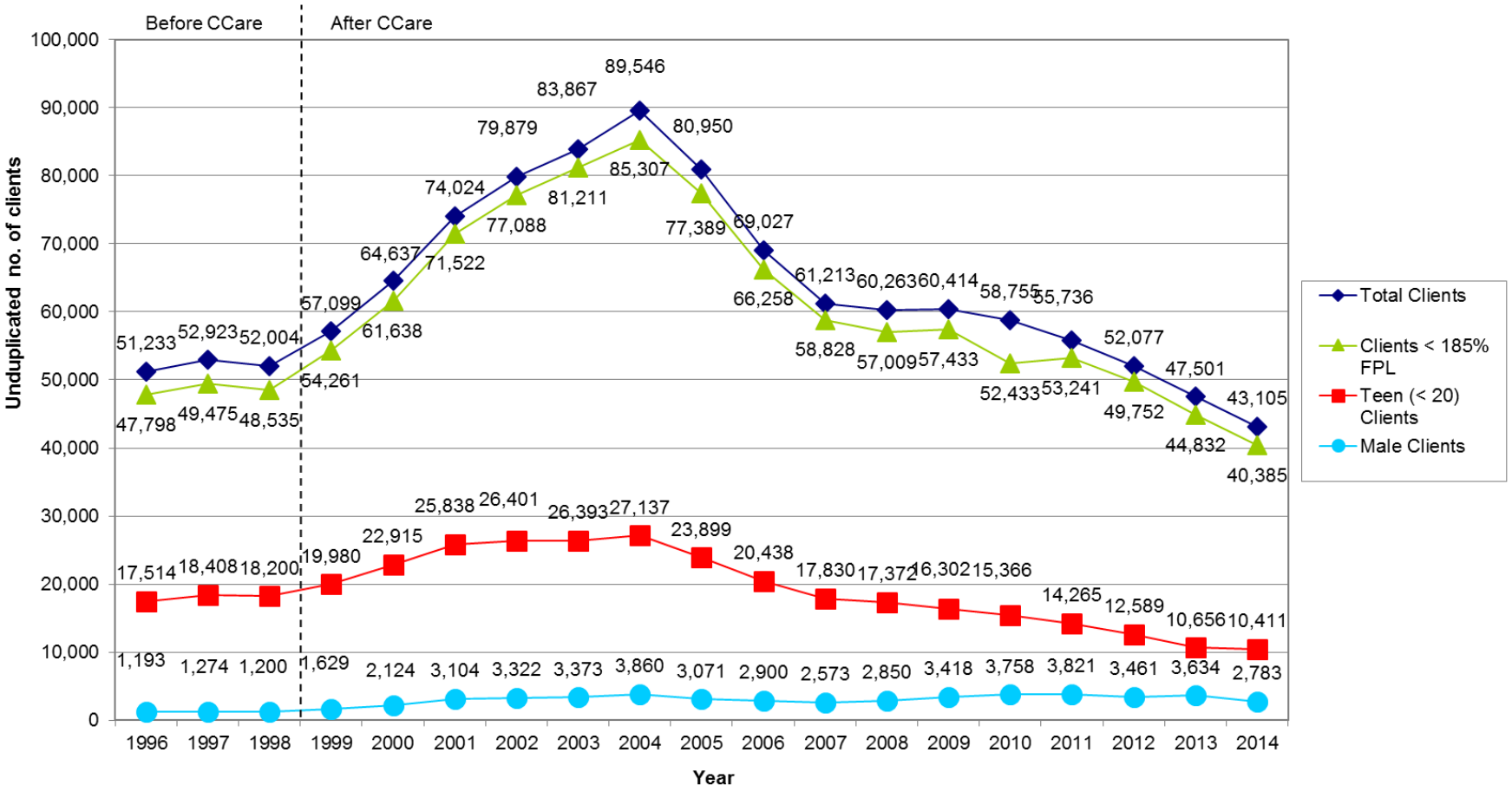
Teen pregnancy declined dramatically between 1996 and 2004: the 18-19 year old rate fell by 35% (122.9 per 1,000 to 79.5 per 1,000); the 15-19 year old fell by 40% (77.1 per 1,000 to 45.8 per 1,000); and the 15-17 rate fell by 50% (47.3 per 1,000 to 23.8 per 1,000). In all three age groups, the drop 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 is reflected nationally, where both teen birth and pregnancy rates rose in 2006, for the first time since 1991.[8] This increase appears to be reversing, however, with Oregon teen pregnancy rates among all age groups continuing to dramatically decline between 2006 and 2014. They are currently at their lowest rates ever since tracking began for this measure (12.4 per 1,000 per 15-17 year olds, 45.4 per 1,000 for 18-19 year olds; and 26.1 per 1,000 for 15-19 year olds).

[8] 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

Appendix C

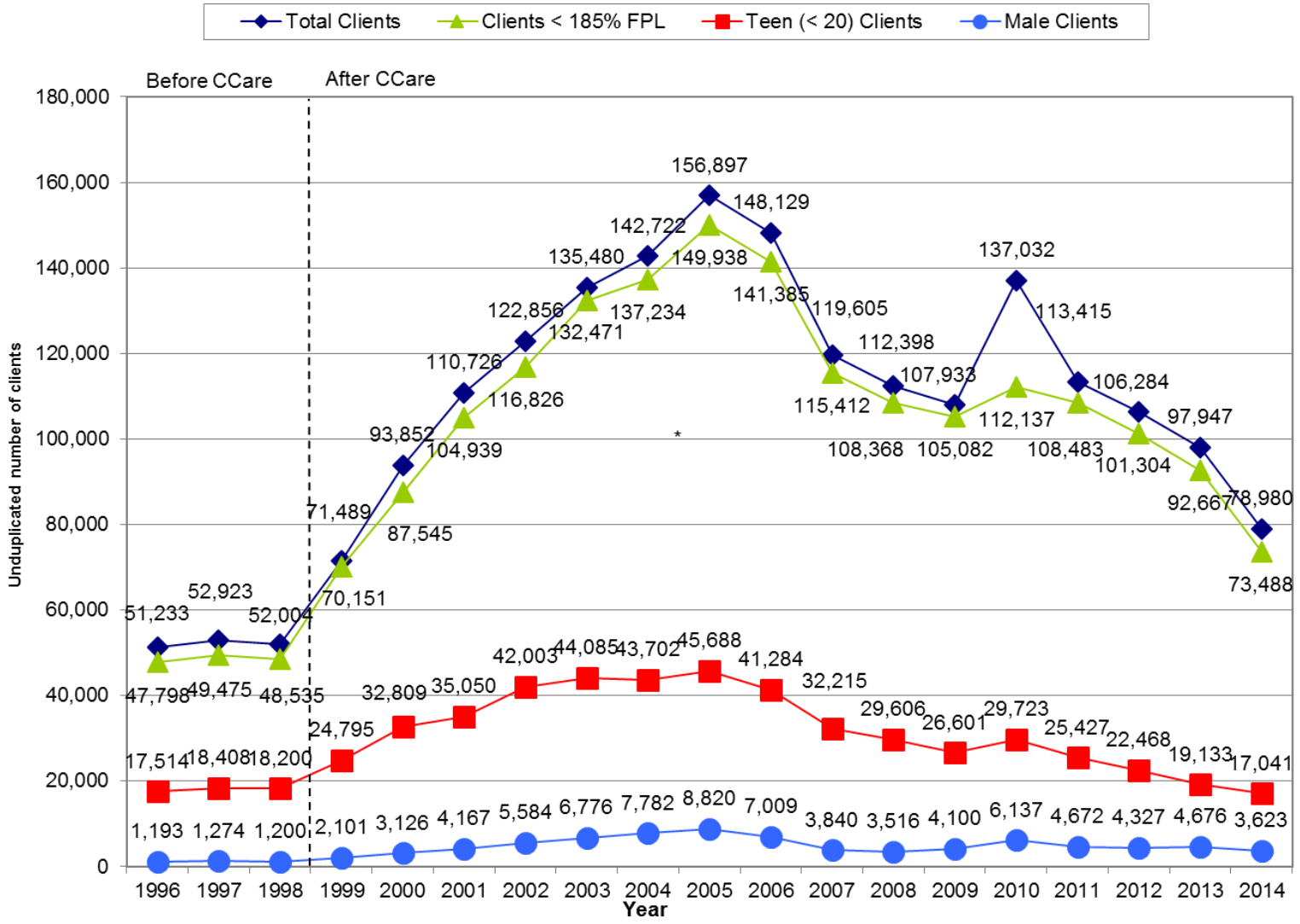
Figures

Figure 1. Clients seen at Oregon *Title X* family planning agencies, 1996-2014. (Objective 1).



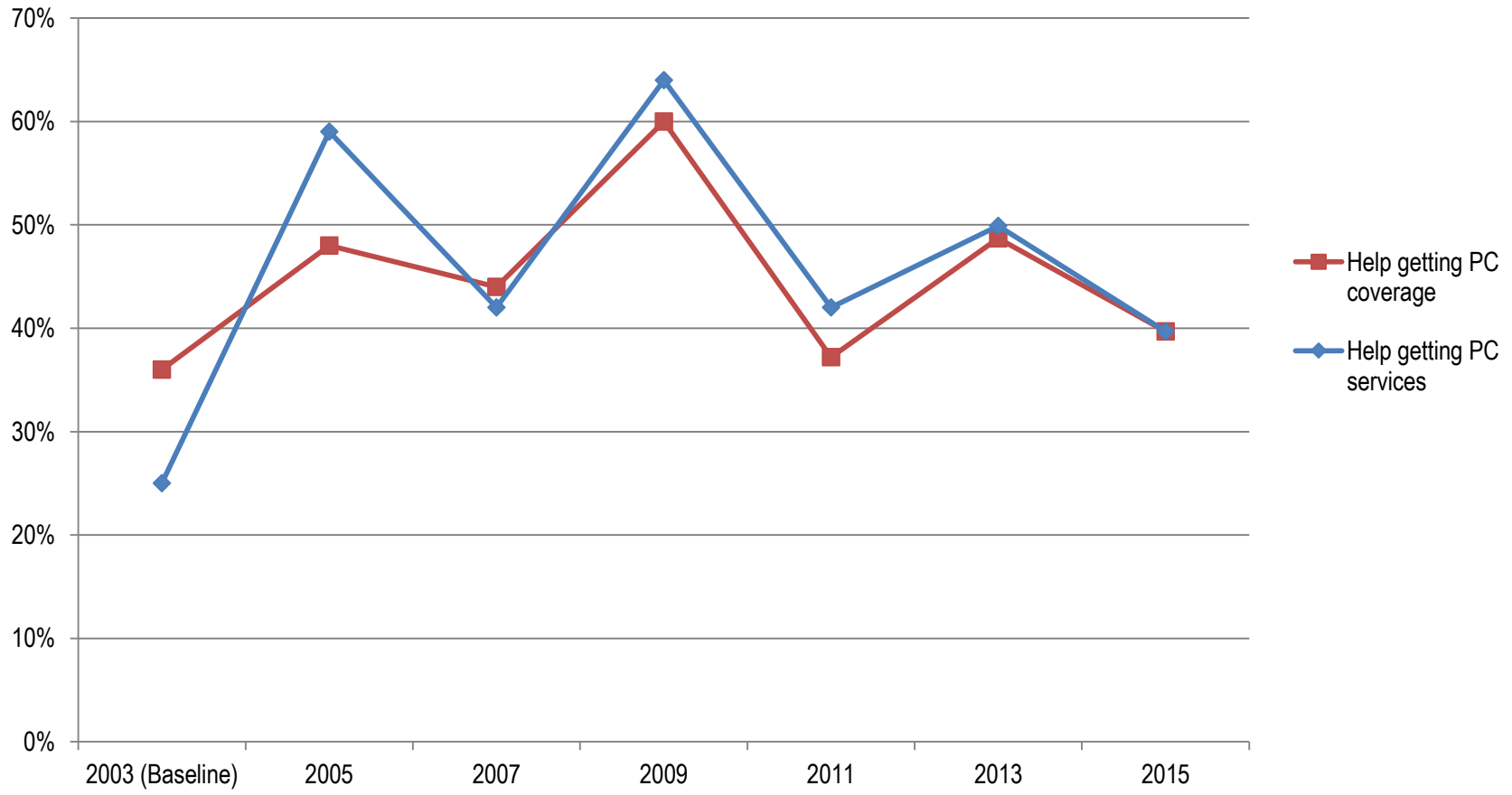
Data source: Oregon Information System

Figure 2. Clients seen at *all* Oregon family planning agencies (Title X and CCare), 1996-2014. (Objective 1).



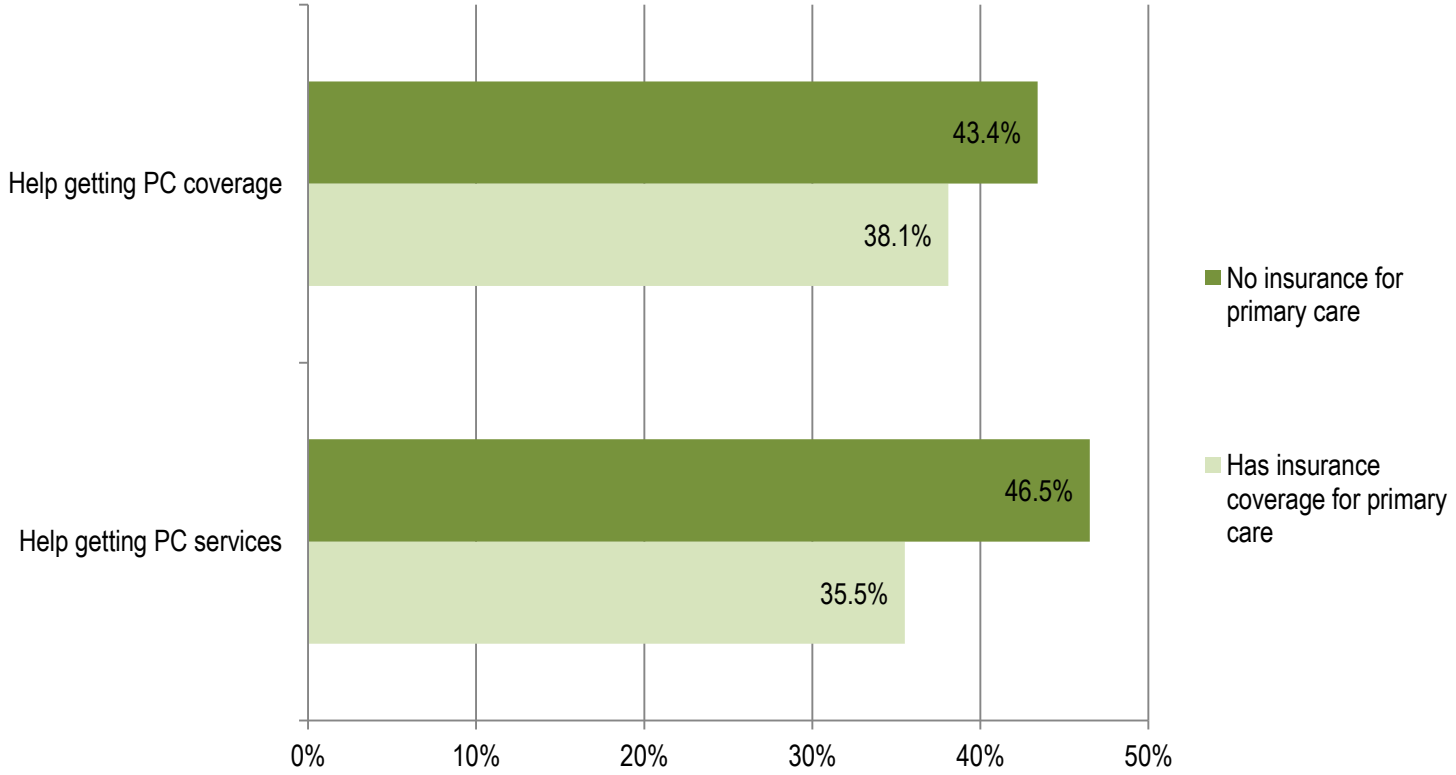
Data source: Oregon Information System

Figure 3. Proportion of Oregon family planning clients who received assistance with accessing primary care services and coverage, 2003, 2005, 2007, 2009, 2011, 2013 and 2015 (Objective 8).



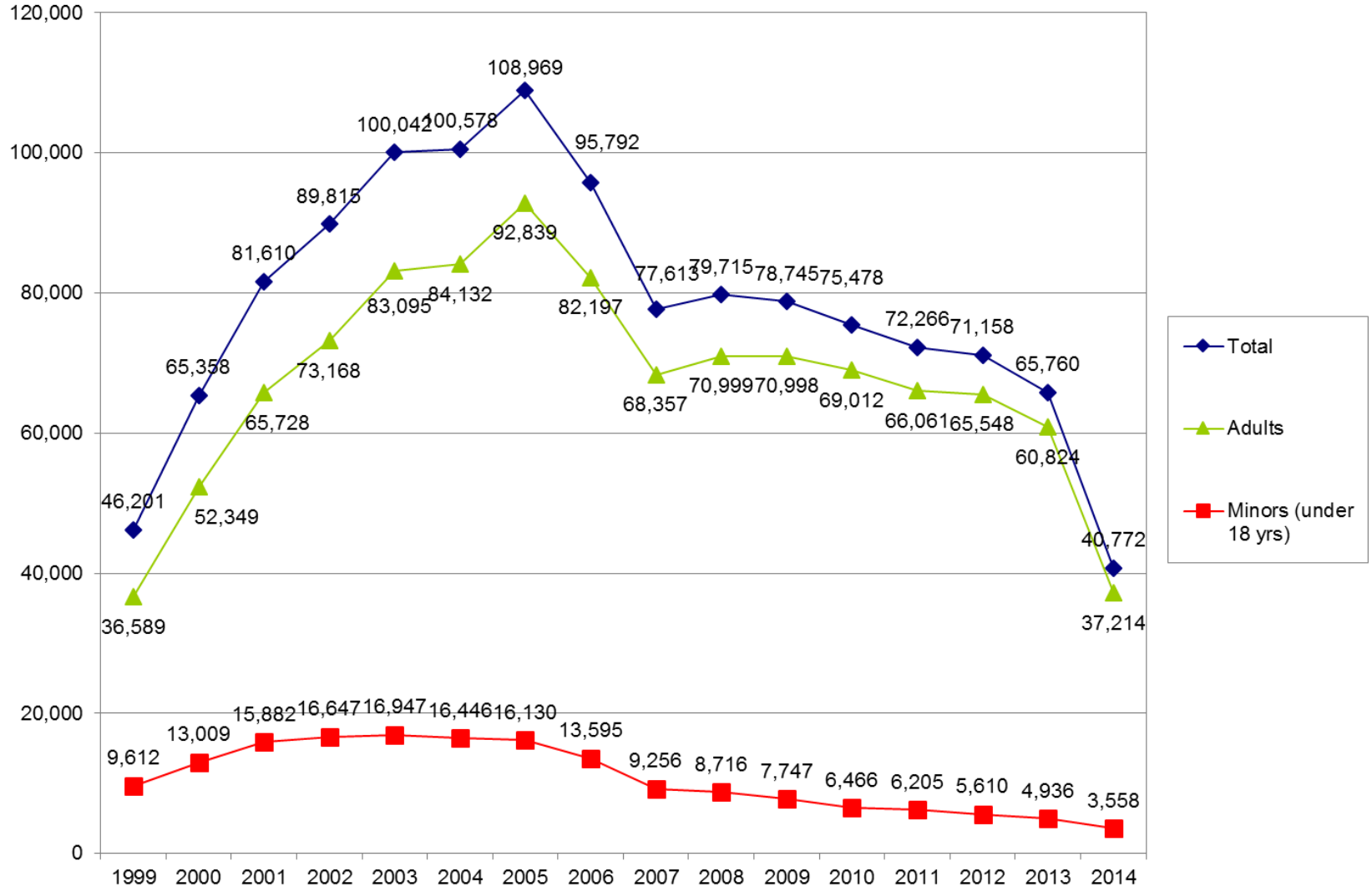
Data source: Oregon Reproductive Health Program, Client Satisfaction Survey

Figure 4. Proportion of Oregon family planning clients who received assistance with accessing primary care services and coverage, by insurance status, 2015.



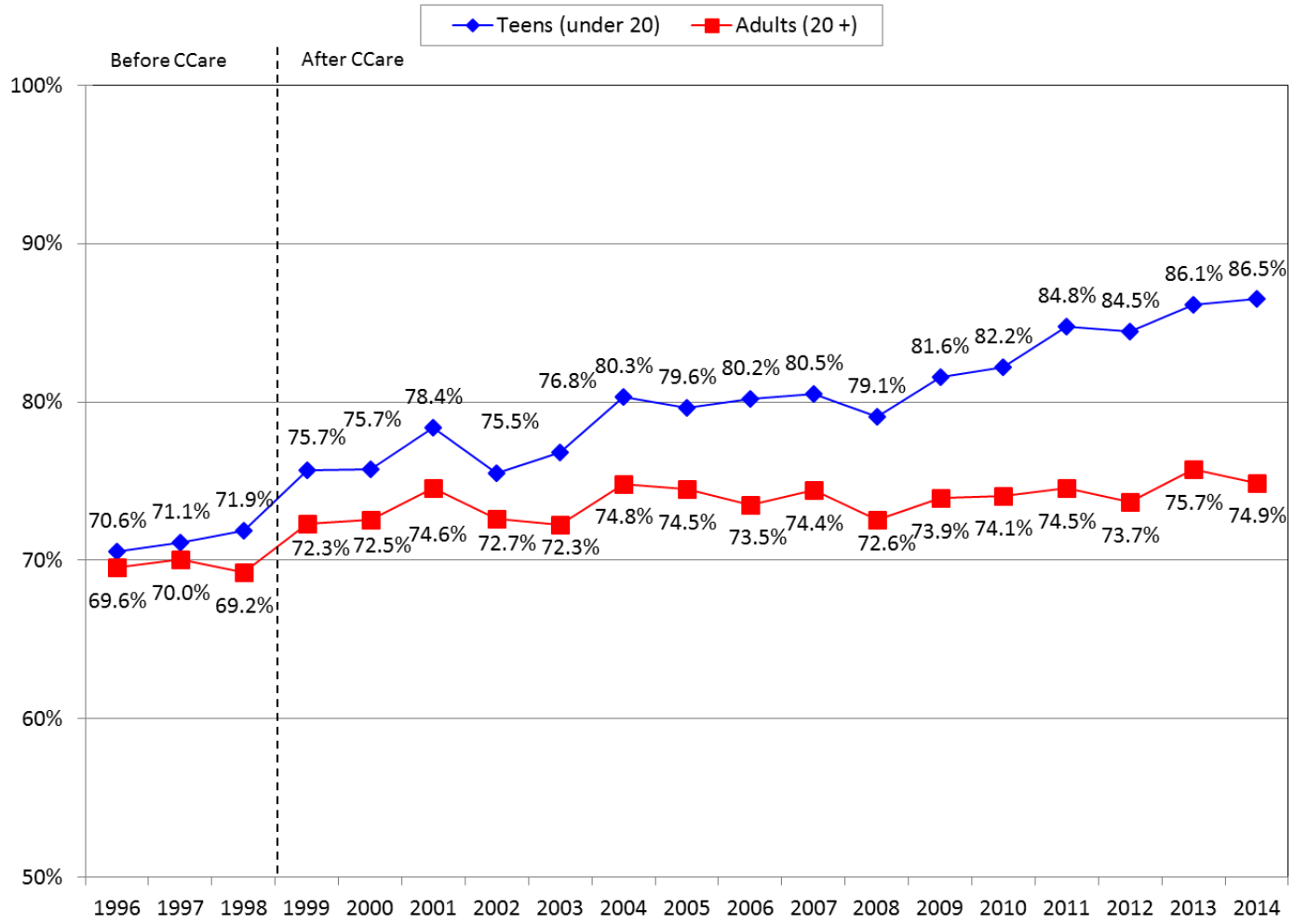
Data source: Oregon Reproductive Health Program, Customer Satisfaction Survey

Figure 5. CCare clients served, 1999 – 2014. (Objective 9).



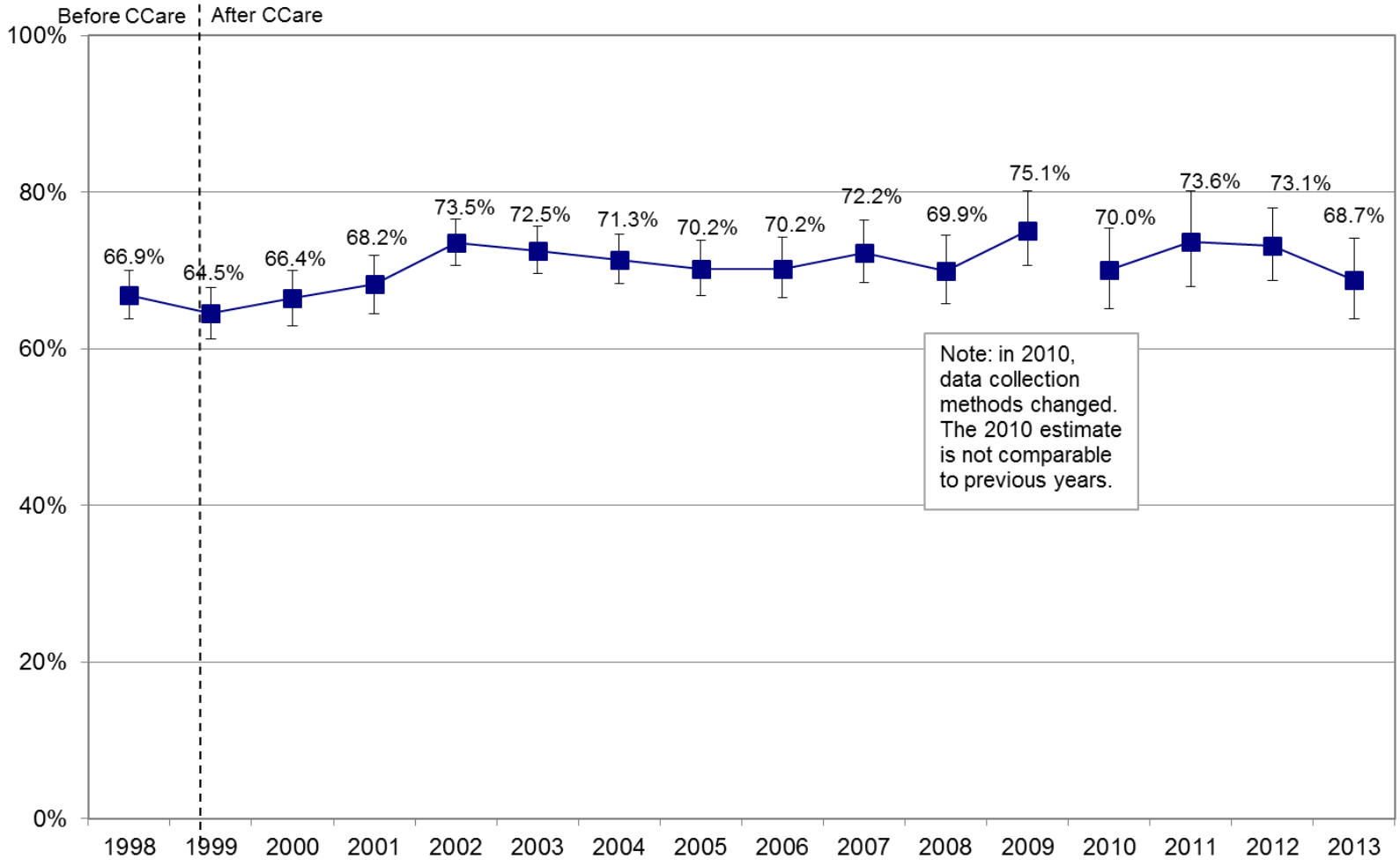
Data source: Oregon Information System

Figure 6. Proportion of female family planning clients at Oregon Title X agencies using highly effective contraceptive methods, 1996 – 2014. (Objective 2).



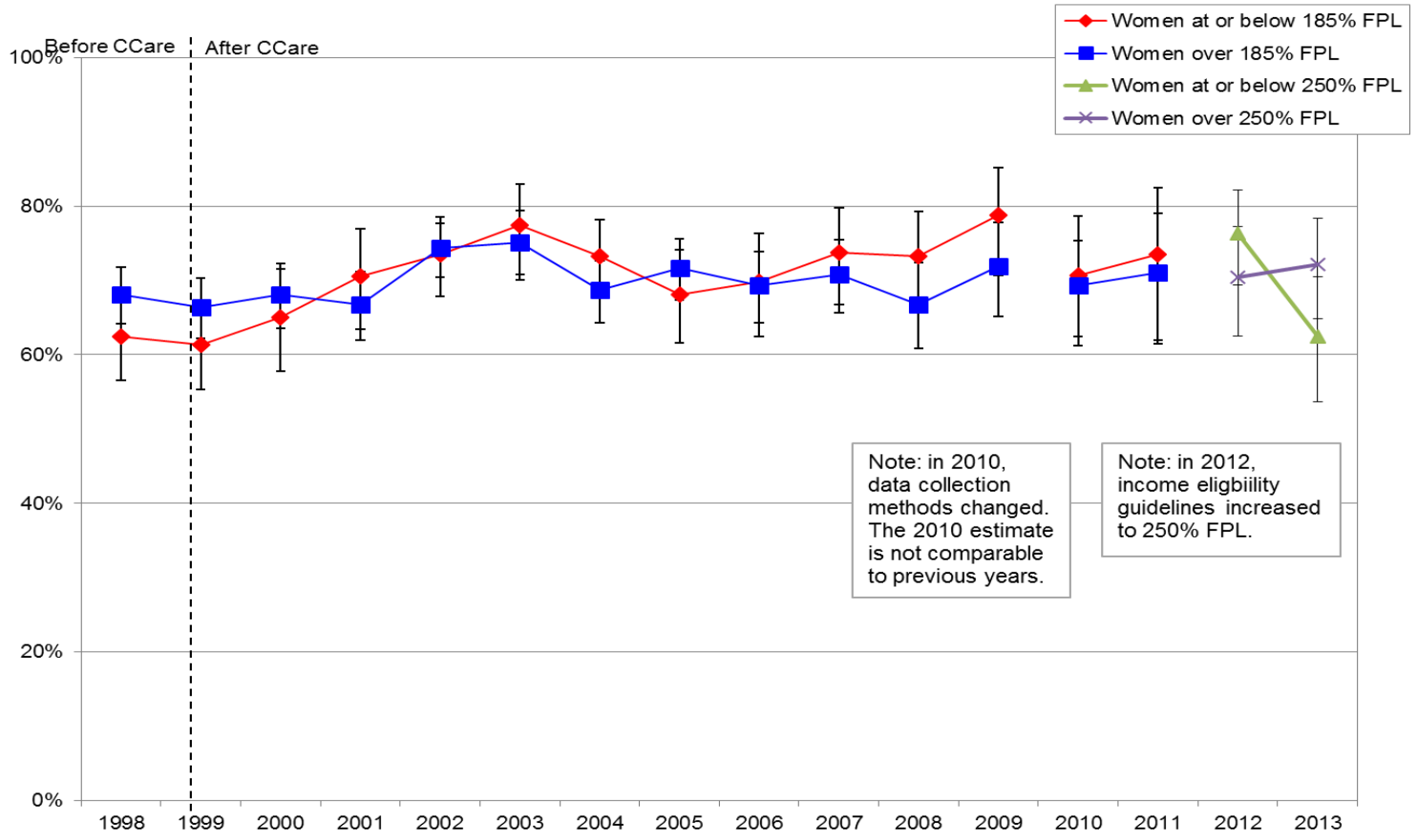
Data source: Region X Information System

Figure 7. Proportion of Oregon's female, reproductive-population using highly effective contraceptive methods, 1998-2013. (Objective 4a).



Data source: Oregon Behavioral Risk Factor Surveillance System (BRFSS). Error bars indicate 95% confidence interval around each estimate.

Figure 8. Proportion of Oregon's female, reproductive-population using highly effective contraceptive methods, by FPL, 1998-2013. (Objective 4a).



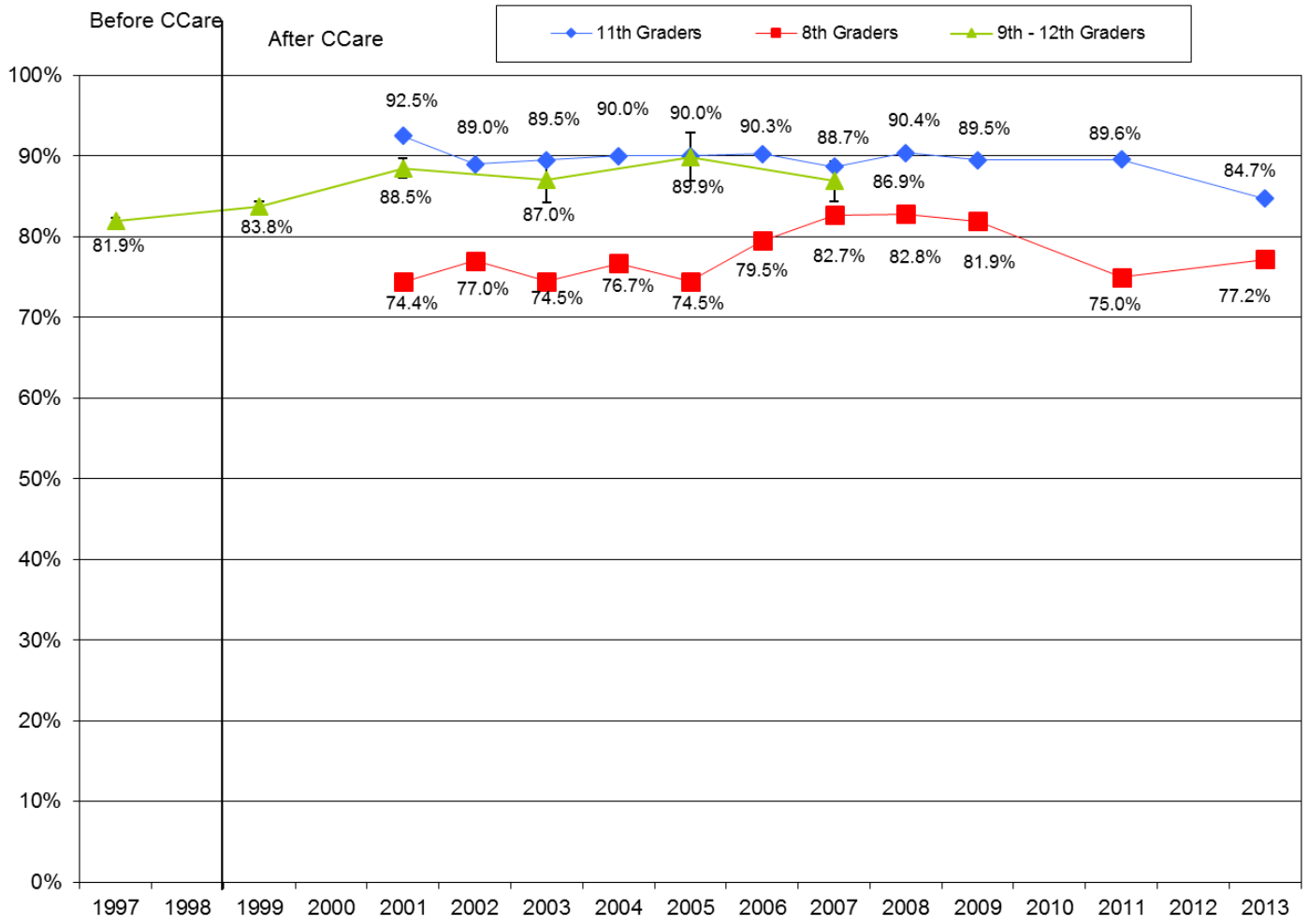
Data Table

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012^	2013^
At/under 185%^	62.4	61.4	65.0	70.5	73.5	77.4	73.3	68.1	69.8	73.8	73.2	78.8	70.7	73.5	76.3	62.4
Over 185%^	68.1	66.4	68.1	66.8	74.3	75.1	68.7	71.7	69.3	70.8	66.8	71.9	69.3	71.0	70.4	72.1

^Data table changes to at/under and over 250% FPL in 2012.

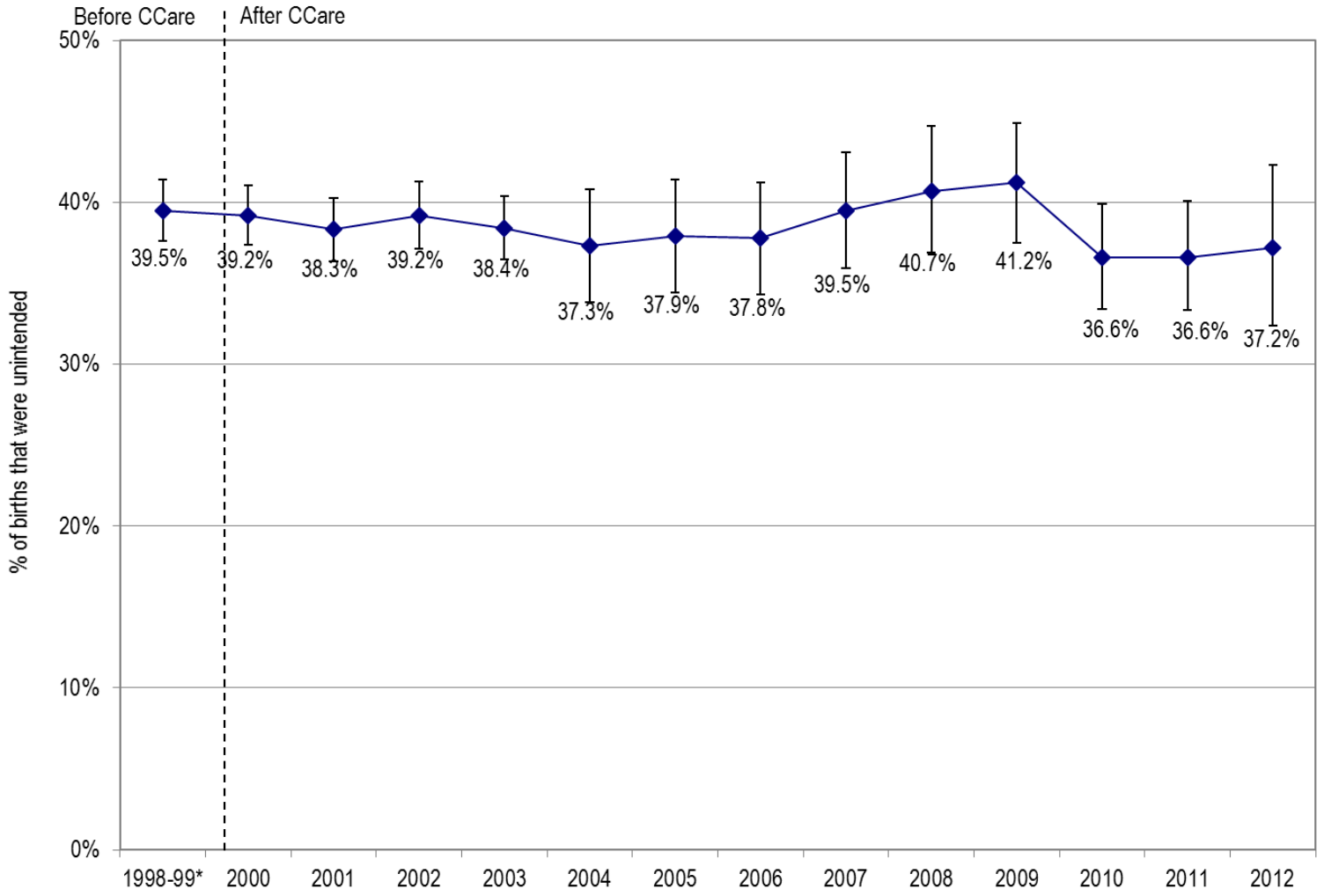
Data source: Oregon Behavioral Risk Factor Surveillance System (BRFSS). Error bars indicate 95% confidence interval around each estimate.

Figure 9. Proportion of Oregon sexually experienced students who used contraception at last intercourse, 1997 – 2013. (Objective 4b).



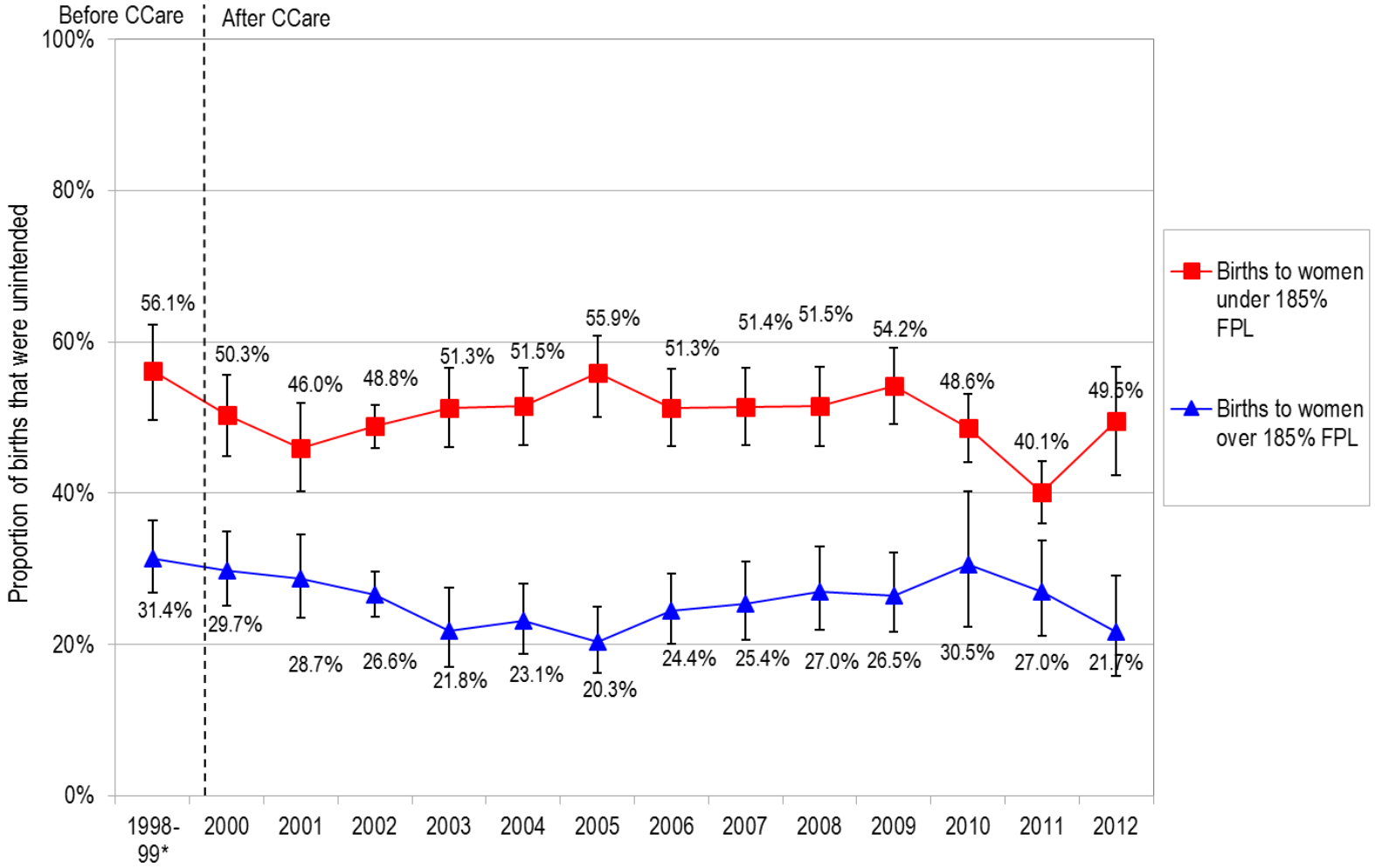
Data source: Oregon Youth Risk Behavior Survey (YRBS) for 9-12th grade and Oregon Healthy Teens survey (OHT) for 8th and 11th grade. Error bars indicate the 95% confidence interval around the YRBS-based estimates. YRBS not conducted after 2007.

Figure 10. Proportion of Oregon births that were unintended, 1998-99 – 2012. (Objective 5a).



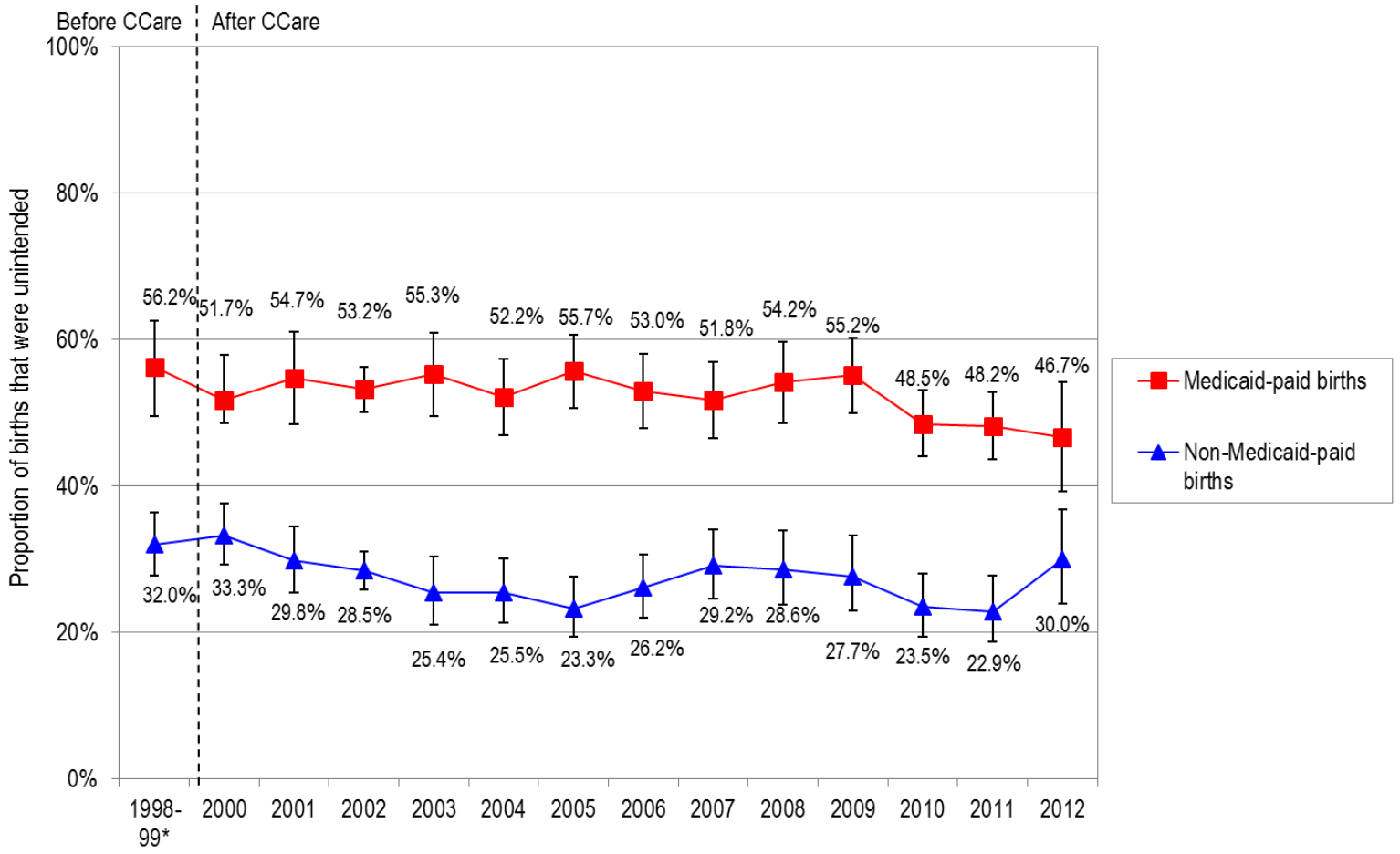
Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS). Error bars indicate 95% confidence interval around each estimate.
*Data for births from August 1998 to August 1999

Figure 11. Proportion of Oregon births that were unintended, by FPL, 1998-99 – 2012. (Objective 5a).



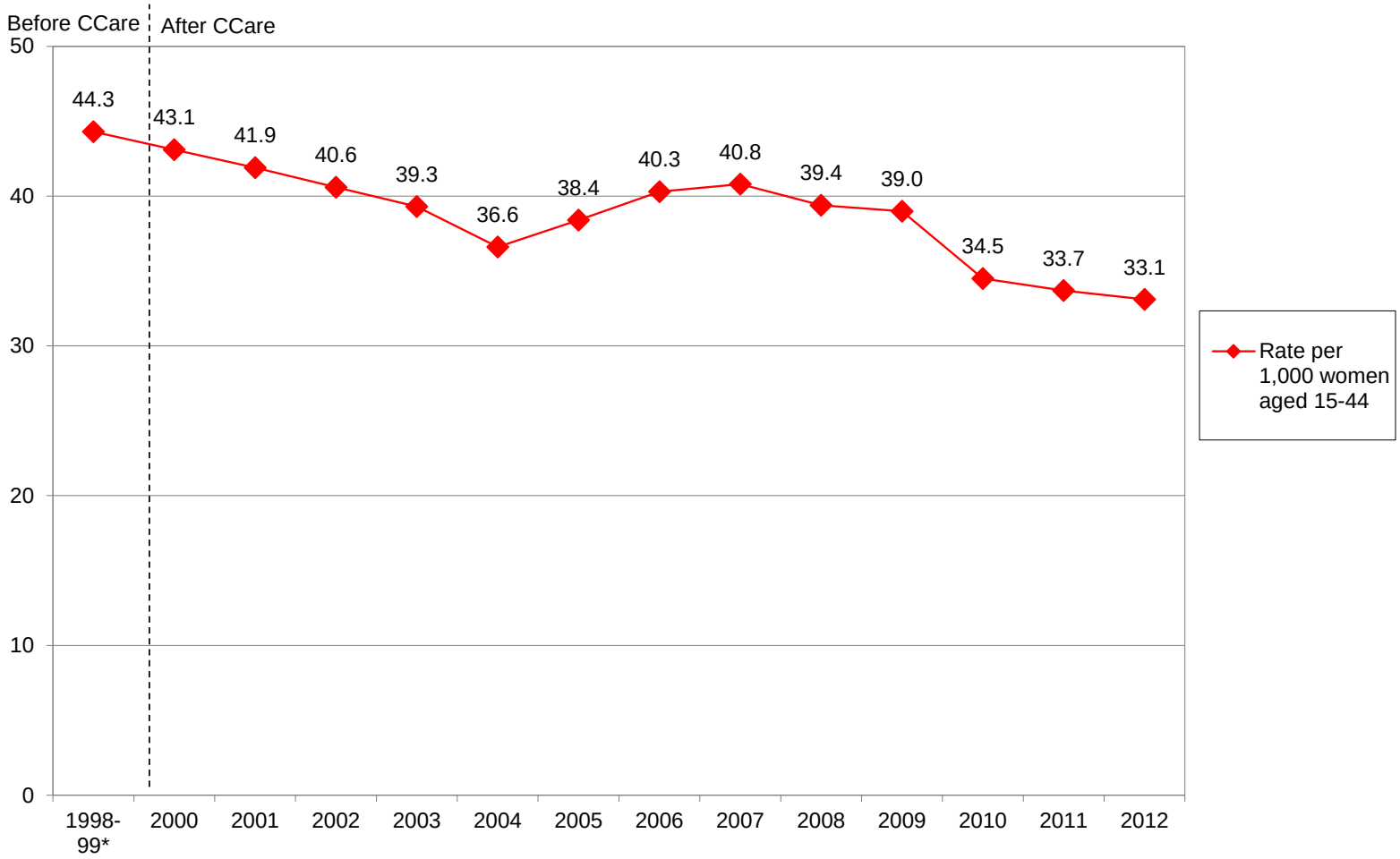
Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS). Error bars indicate 95% confidence interval around each estimate.
*Data for births from August 1998 to August 1999

Figure 12. Proportion of Oregon births that were unintended, by delivery source of pay, 1998-99 – 2012. (Objective 5a).



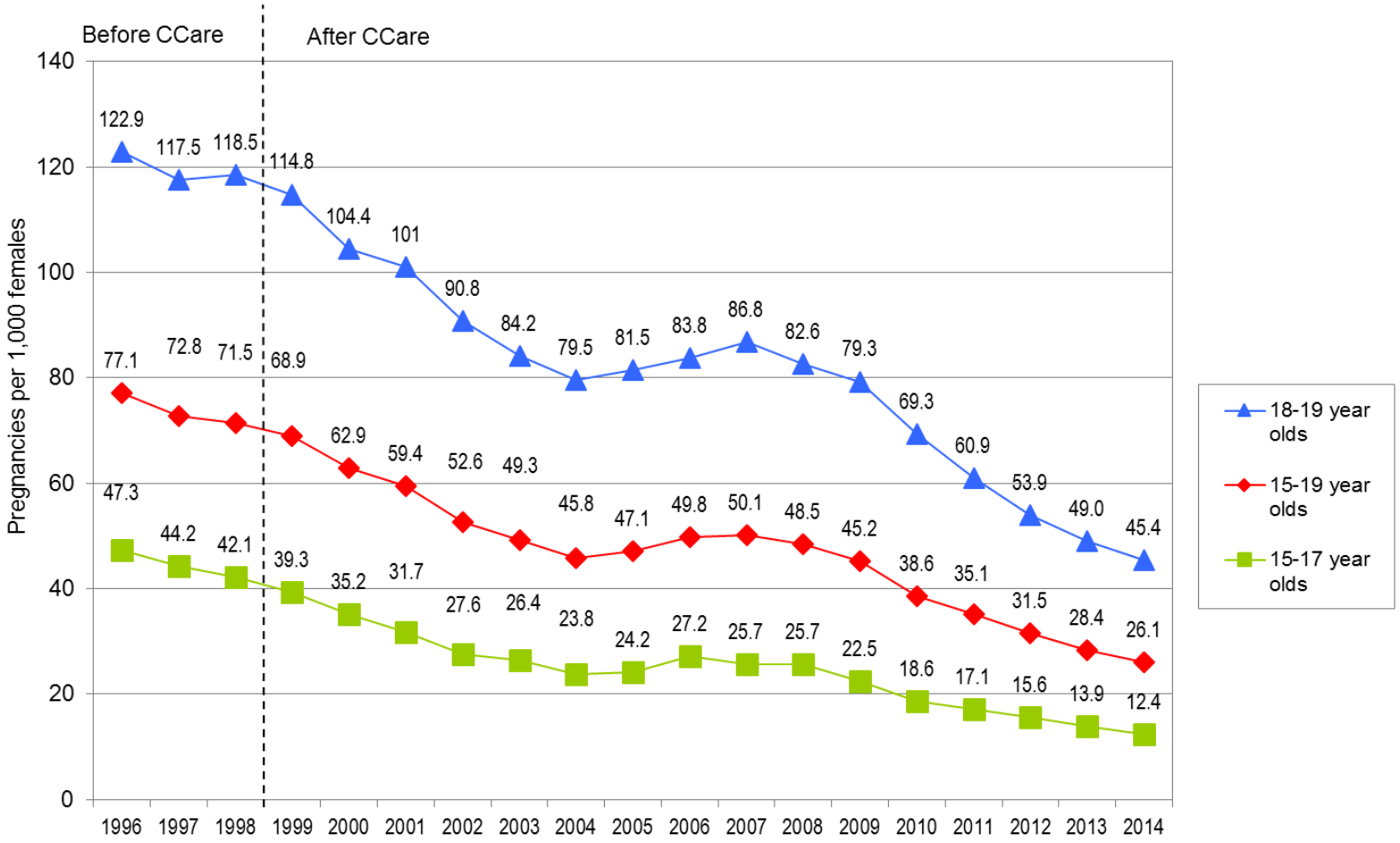
Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS). Error bars indicate 95% confidence interval around each estimate.
*Data for births from August 1998 to August 1999

Figure 13. Unintended pregnancy rate in Oregon (per 1,000 women 15-44), 1998-99 – 2012. (Objective 5c).



Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS) and Oregon Center for Health Statistics.
*Data for births from August 1998 to August 1999

Figure 14. Oregon teen pregnancy rates (per 1,000 females in age group), 1996 – 2014. (Objective 7).



Data source: Oregon Center for Health Statistics.

Oregon ContraceptiveCare: Access to and Quality of Care

Currently, Oregon's public family planning provider network is made up of 54 agencies—the administrative units of programs or providers—and 156 clinic sites, the physical facilities where services are provided. The network includes a broad range of provider types: County Health Departments, Federally Qualified Health Centers and Rural Health Clinics, college/university health services and School-Based Health Centers, and a small number of private providers. Almost every clinic in Oregon's public family planning provider network is an enrolled CCare provider (52 agencies and 141 clinic sites).

The CCare provider network is often the single entry point for many individuals of reproductive age into the health care system. CCare is uniquely positioned at this key entry point to meet the immediate family planning needs of these individuals while also assisting them with obtaining more comprehensive insurance coverage. CCare provides vital access to providers who are uniquely qualified to serve the low-income women, men and teens who need their services: by being available when and where their clients need them; by speaking their languages and understanding their value and perspectives; by discussing sexuality comfortably and without judgment; by offering accurate information and the full range of family planning methods, onsite. Further, these programs have developed relationships within their respective communities that facilitate access to high risk, disenfranchised populations (e.g. justice system, alternative schools), all of which increase the likelihood of acquiring care

All CCare providers, as outlined in the terms of their enrollment, agree to comply with the CCare Standards of Care. The CCare Standards of Care set forth minimum clinical and administrative services that an enrolled CCare provider must offer in order to participate in CCare (the complete CCare Standards of Care may be found here on page 6). In particular, the CCare Standards of Care outline the full scope of clinical and preventive services that must be offered to CCare clients. These services include, but are not limited to: a comprehensive health history; an initial physical exam, as clinical indicated; routine laboratory tests related to the decision-making process for contraceptive choices; provision of a broad range of FDA-approved contraceptive methods, devices, supplies and procedures. The contraceptive methods and their applications, consistent with recognized medical practice standards, as well as fertility awareness methods, must be available onsite at the clinic for dispensing to the client at the time of the visit.

Oregon ContraceptiveCare Integrity Plan

The Oregon Health Authority Reproductive Health Program has an obligation to state and federal funders, as well as to Oregon taxpayers, to oversee funding for family planning services to assure compliance with program regulations. Outlined in this manual are the various screening and audit procedures used to assure CCare program integrity and reduce risk of overpayment.

It is not the goal of the audit process to impose additional fees or penalties, but rather to recover payments that were made in error or to correct practices that are not in keeping with program regulations.

The Oregon Administrative Rules (OARS) pertaining to CCare are 333-004-000 through 333-004-0190.

Types of CCare Audits

1. Monthly Desk Audit

Clinic Visit Records (CVRs) Rejected – Many edits are built into CCare's data collection/billing system, operated by the program's 3rd party administrator Ahlers and Associates (Ahlers). A list of edits to the data and billing system can be found here. These edits cause a Client Visit Record (CVR) to be rejected from the system and therefore not included in the billing summary or data. A report showing the number of CVRs rejected per agency and the associated reasons for rejection is reviewed monthly to help detect systems problems and to determine where training and technical assistance is needed.

Billing Register Review – Ahlers provides a monthly billing summary or "billing register" that details every client transaction by date of service. This summary includes client information, visit purpose, contraceptive method used and costs associated. Review of the monthly billing register by agency and site supplies a wealth of information for audit purposes.

Examples include:

- How much an agency is billing CCare for supplies
- Quantities of methods dispensed
- Revenue received by billing third party resources

Each month the billing register is reviewed and a *Billing Register Desk Audit Chart* is used to track any unusual circumstances or findings. The chart contains a space to document follow-up needed. Generally, follow-up consists of a phone call or e-mail to the specific agency to discuss the issue. It may be easily resolved over the phone or through e-mail.

If the same problem occurs in several agencies at a time, a memo is sent to providers describing the problem and the expected course of action to resolve it. The state Provider Liaison is also notified so that the recurring problem can be addressed in future training. The audit chart is referenced in subsequent months to determine if the identified problem has been resolved.

Additionally, supply billing is monitored against purchasing data and invoices to track changes in supply prices and billing accuracy.

2. Visit Frequency Audit

A visit frequency audit is performed by generating a separate report from Ahlers data showing client visits by date of service for a specific time period (usually one year). Review of this report helps identify clients with a high number of visits, which can indicate the need for a chart audit. A large number of clients with more visits than the statewide average of two per year (or one for males) can be an indicator of incorrect billing practice. Clients who use Depo Provera as a birth control method are not included in the visit frequency report, as the injections are required four times per year.

Agency visit frequency reports are run on a regular basis, or the need may be identified through the monthly desk audit. Review of a visit frequency report can lead to a chart audit of specific clients who have an unusually high amount of repeat visits.

3. Random Sample Chart Audit

The need for a chart audit may be identified by any of the other audit functions described above and is also done a regular rotating monthly schedule. Chart audits are done using a statistically valid random sampling, with sufficient sample size allowing a confidence interval of 95%.

Agencies will be asked to produce either random or specific charts by client number within a time period of 30 days. Usually, photocopies of the charts are sent to the state office for review but in some instances the reviewer(s) may go to the agency site to review the charts. When reviewer(s) come to the agency site a dedicated room/office must be available for the process and entrance and exit discussions are required.

Charts are reviewed by the Reproductive Health Program reviewer(s) and a matrix of findings is developed identifying the results of each chart reviewed. This matrix is provided to the agency for review. Upon receipt of the matrix, the agency has a period of ten days to review and/or challenge the findings.

A primary reason for a chart audit is to substantiate whether or not the visit was appropriately billed to CCare; however, other findings may also be identified. For a visit to be billed to CCare, contraceptive management must be the primary purpose of the visit and it must be accurately supported/documented in the chart notes.

Charts determined to be billed in error are to be voided from the Ahlers system with the next claims submission.

4. Eligibility and Enrollment Form Audit

The CCare enrollment form and its citizenship verification components are also reviewed as part of the chart audit. Examples of what reviewers will be looking for include:

- CCare Enrollment Form is complete
- Date of client signature matches eligibility date in the client database
- Citizenship and identity are verified

Enrollment forms are regularly requested and reviewed for completeness and accuracy. Proof of identify and citizenship are reviewed and monitored against the CCare database in this review.

5. CCare Audits During Regular Title X Review

Agencies receiving Title X funds are reviewed for compliance with all family planning program regulations on a triennial basis. Chart reviews are performed as part of the process. Reviewers will also follow a checklist of components to review CCare charts when reviewing charts for Title X compliance. This review tool is also given to providers to encourage regular self-audit.

6. Vasectomy/Sterilization Consent Form Audit

Vasectomy/sterilization consent forms are sampled and reviewed for completeness and accuracy from clinics that bill both Title X and CCare for this service.

7. Monitoring Agency Insurance Billing

In 2011, a new audit process was implemented to monitor insurance billing for clients who have indicated having insurance on the CCare Enrollment Form. Federal law requires that all reasonable efforts be taken to ensure that CCare is the payer of last resort, unless a client with private insurance also indicates the need for special confidentiality.

The new process matches clients who have marked "yes" to private insurance on the CCare Enrollment Form to subsequent claims to determine if a dollar amount was paid by the insurance carrier or an explanation code was provided. If there is no indication that the insurance carrier was billed, the agency will be contacted for an explanation to be provided within 30 days. This is done on a quarterly basis.

Providers may also be asked to provide copies of client Explanation Of Benefits (EOB) showing the amount paid or the reason for non-payment, as well as copies of client enrollment forms showing the explanation of request for special confidentiality.

Failure to bill a client's private insurance carrier may be grounds for recovery or sanction.

8. Other Requests for Information

The state Reproductive Health Program may request specific information on an as-needed basis.

Types of Findings

1. Administrative

Administrative findings, identified by review or chart audit, are not related to incorrect billing or overpayment, but are program elements not being met. Examples:

- An agency consistently gives only one package of pills per visit
- An agency shows no evidence of billing third party reimbursement
- Items omitted on the CCare Enrollment Form

2. Financial

Financial findings identified by chart audit procedure consist of incorrect billing that resulted in overpayment to the provider. The specific OAR for *Recovery of Over-payments to Providers Resulting from Review or Aud*it is 333-004-1050.

Financial Finding Procedure:

- Overpayment is established through chart audit and documented in the matrix of findings.
- Amount of overpayment may be calculated by extrapolation of the random sample or may be actual overpayment.
- A cover letter and notice of overpayment (invoice) is sent.

- Agency has a 10-day period to review the matrix/chart audit findings and to discuss or refute the findings with the auditor.
- Claims that are determined to be billed in error should be corrected using the void and resubmit process in the Ahlers system during the next monthly billing cycle.
- A repayment agreement may be arranged at the discretion of OHA, using a repayment contract signed by both parties.
- If the audited agency is in disagreement with the findings, the contested case hearing procedure is followed.

3. Excluded Provider Verification

As part of the CCare provider enrollment process, new providers are verified by the Division of Medical Assistance Programs (DMAP), the state's primary Medicaid agency, to ensure they have not been excluded from being a Medicaid provider.

Twice annually, all CCare providers are verified in DMAP's Medicaid Management Information System (MMIS) by state Reproductive Health Program staff to assure active status of the provider.

If the system shows that a CCare provider has been excluded, the provider will also be notified of exclusion from the CCare program, effective the same date as termination by DMAP. Any CCare claims paid after the termination date will be subject to recovery.

Public Notice

1) **Start and end dates of the state's public comment period.**
Oregon's public comment period for the waiver renewal application is scheduled to begin on February 5, 2016 and to end on March 7, 2016.

2) **Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.**
Public notification of the state's intent to apply for renewal of the 1115 Demonstration waiver for Oregon ContraceptiveCare and opportunities for public comment will posted to the state website for public notices on February 5, 2016 and will be published in the Secretary of State February Bulletin on their website.

A copy of the draft of the state waiver renewal application will also be posted on February 5, 2016 on the Oregon CCare website.

3) **Certification that the state convened at least 2 public hearings, of which both hearings included teleconferencing and one hearing included web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.**
Two public hearings will be scheduled for the public to comment on the waiver renewal on the following dates and locations:

1. Tuesday, February 9, 2016
10:30 am to 12:30 pm
Portland State Office Building
800 NE Oregon Street, Room 368
Portland, OR 9732

2. Monday, February 29, 2016
2:00 pm to 4:00 pm
DHS/Child Welfare Benton Branch
555 NW 5th, Room 1B
Corvallis, OR 97330

Teleconference access will be available for both meetings and web capability will be available for the Tuesday, February 9, 2016 public hearing. Written comments concerning the waiver renewal will be accepted on or before 5:00 pm on March 7, 2016 via postal mail or email to:

Emily Elman
Oregon Reproductive Health Program
Public Health Division
800 NE Oregon Street, Room 370
Portland, OR 97232
Email: emily.l.elman@state.or.us

4) **Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)**
   Public notice describing where to access the application and where and how to submit public comment will be posted: 1) in the public notices section of the state website, 2) in the Oregon Secretary of State February Bulletin, and 3) on the Reproductive Health Program website.

   Additionally, public notice will be published in the Reproductive Health Program's electronic newsletter, RH Update. The distribution list for the RH Update includes local providers, local and state community partner agencies and community-based organizations across the state. A copy of the newsletter containing the notice is posted to the state RH website.

5) **Comments received by the state during the 30-day public notice period.**

   To be completed following the public comment period.

6) **Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.**

   To be completed following the public comment period.

7) **Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.**
   Formal notice of tribal consultation regarding the state's intent to submit the waiver renewal application will be sent by email to the tribal health directors and representatives of the nine federally recognized tribes in Oregon.