

oregon **contraceptive** care

Oregon Health Authority
Public Health Division

Oregon ContraceptiveCare

1115 Demonstration Waiver Renewal Application

Section I – Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

In February 1998, the state of Oregon submitted a Medicaid waiver demonstration proposal titled “Oregon Family Planning Expansion Project” (FPEP), 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 three years, beginning January 1, 2016 and ending December 31, 2018.

The program, now named Oregon ContraceptiveCare or 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 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 (Appendix X). 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.

Oregon ContraceptiveCare has met the budget neutral requirements of the 1115 waiver and continues to realize substantial cost savings by reducing unintended pregnancies across the state.

2) Include the rationale for the Demonstration.

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

¹Women 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.

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 specifically 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 Massachusetts² shows 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.

- *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 especially at 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.

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.

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.

- *Confidentiality:* Although many above 138% FPL will gain private insurance coverage through ACA-generated subsidies, some individuals, especially those needing confidential care, may have coverage that they feel they cannot use 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 private insurance being billed. 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 .

3) Describe the hypotheses that will be tested/evaluated during the Demonstration’s approval period and the plan by which the State will use to test them.

Oregon ContraceptiveCare’s hypotheses 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. The hypotheses used to test them are described in that order below:

(A) Immediate Outcomes

- Hypothesis 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
- Hypothesis 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

- Hypothesis 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)

- Hypothesis 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

- Hypothesis 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)
- Hypothesis 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
- Hypothesis 7: The program will result in a decrease in teen pregnancy rates in Oregon.
 Data source: Oregon Center for Health Statistics

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.

Oregon ContraceptiveCare will operate statewide.

5) Include the proposed timeframe for the Demonstration.

Oregon is requesting a three-year (3) extension of the program for January 1, 2016 through December 31, 2018.

6) Describe whether the Demonstration will affect and/or modify other components of the State’s current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

The program will not affect and/or modify other components of the State’s current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

Section II – Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration.

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Women of reproductive age (10-60)	1902(a)(10)(A)(ii)(XXI) 42 CFR 435.218	Income at or below 250% of the federal poverty level (FPL)
Men of reproductive age (10+)	1902(a)(10)(A)(ii)(XXI) 42 CFR 435.218	Income at or below 250% of the federal poverty level (FPL)

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

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. Central to this is on-site enrollment into CCare and the provision of same-day services, as is the practice of all CCare clinics. Utilizing an expedited eligibility process, clients are enrolled in CCare at the point of service but final determinations of eligibility are made by state staff. CCare clinic staff receive extensive training and written guidance to allow them to assist clients with all aspects of enrollment, particularly citizenship documentation requirements, which kinds of income should be counted, and the circumstances necessary to warrant special confidentiality. Rigorous quality assurance procedures and audits, described in **Appendix X**, ensure that eligibility information is collected, reviewed, and documented consistently.

The first step in enrollment screening is the completion of the CCare Enrollment Form, a standardized, one-page document available in English and Spanish. The Enrollment Form must be completed on or before the first date of service, updated annually thereafter, and kept as part of the client's medical record. On the Enrollment Form, clients provide the personal information necessary for screening including residency, citizenship, Social Security Number (SSN), income and household size, insurance coverage, age, and sterilization status. Documentation of citizenship status, if available, is also collected at the time of initial application. Clinic staff review the CCare Enrollment Form for completeness and enter the client information into a web-based eligibility database developed by the state specifically for CCare. The CCare eligibility database automatically checks for duplicate records, performs FPL calculations and conducts other routine data validation steps. If the applicant's information is acceptable, the client is assigned a unique CCare ID number. All CCare providers have access to the eligibility database, so enrolled clients can be served without delay at any CCare clinic. Once the client's enrollment information is entered into the CCare eligibility database, state staff make a final eligibility determination.

Oregon was granted approval in its 2009 waiver renewal to permit CCare enrollment of individuals who meet eligibility requirements and who have creditable health insurance. Oregon proposes to continue this practice. Given the Affordable Care Act's aim to expand health insurance coverage, this eligibility provision remains essential, particularly for women choosing a birth control method not covered by their insurance plan or because of confidentiality concerns related to billing communications. During 2014, approximately 34% of clients enrolling in CCare indicated they had private insurance at the time of enrollment. Consistent with standard Medicaid policy (42 CFR 433.138), third party reimbursement is pursued, and CCare is the payer of last resort. As part of the program's ongoing program integrity processes, CCare state staff monitor insurance billing practices to ensure that clinics pursue third party payment prior to billing CCare for services (when special confidentiality has not been requested).

As a final eligibility verification step, every CCare claim received is matched against the regular Medicaid (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.

As in the past, CCare eligibility will be effective for one year once established. Eligibility re-determination will occur annually, sooner if a client has lost CCare eligibility for some reason (e.g., acquired regular Medicaid coverage) and is seeking to reestablish it.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

There are no enrollment limits that apply for expansion populations under the Demonstration.

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

Projected number of individuals enrolled during renewal period, based on current average monthly enrollments:

CY16 – 33,000

CY17 – 33,000

CY18 – 33,000

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

Long terms services and supports are not applicable to Oregon ContraceptiveCare.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

Per CMS S59, Oregon proposes to determine eligibility for adults age 20 and over by counting all of the members in the household. The state also proposes to establish a classification of children under this group defined as individuals under the age of 20 whereby only the applicant is included in the household. For both eligibility groups (i.e. adults age 20 and over and individuals under the age of 20), the state will consider only the income of the applicant.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards

applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

The state will plan to align eligibility methodologies and standards with the Medicaid and CHIP State plan, including adoption of MAGI financial methodologies for determining eligibility.

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan.

- Yes No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan.

- Yes No (if no, skip questions 8 – 11)

Individuals enrolled in CCare exempt from premiums and copayments, like Medicaid State plan family planning services.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that eligibility group will receive under the Demonstration.

Eligibility Group Name	Benefit Package
Women of reproductive age (10-60)	Demonstration-only benefit package
Men of reproductive age (10+)	Demonstration-only benefit package

The Demonstration benefit package includes:

- All FDA-approved methods of contraception, excluding female sterilization procedures
- Sexually transmitted disease testing and treatment
- Cervical cancer screenings, including Pap tests and colposcopies, and pelvic exams
- Limited laboratory services
- Family planning counseling and education
- Drugs, supplies, or devices related to the reproductive health services described above

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used.

Oregon ContraceptiveCare does not use benchmark-equivalent coverage.

5) In addition to the Benefit Specifications and Qualifications form:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider->

[Qualifications.pdf](#), please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

BENEFITS CHART		
Benefit	Description of Amount, Duration, and Scope	Reference
Inpatient Hospital	Not covered.	Mandatory 1902(a)(1)
Outpatient Hospital	Not covered.	Mandatory 1902(a)(2)
Rural Health Agency	Only family planning and family planning-related services are covered. Comprehensive rural health agency services are not covered.	Mandatory 1905(a)(2)
FQHC	Only family planning and family planning-related services are covered. Comprehensive FQHC health agency services are not covered.	Mandatory 1905(a)(2)
Laboratory and X-Ray	Only family planning and family planning-related services are covered. Comprehensive laboratory and x-ray services are not covered.	Mandatory 1905(a)(3)
Nursing Facility Services Age 21 and Older	Not covered.	Mandatory 1905(a)(4)
ES PDT	Not covered.	Mandatory 1905(a)(4)
Family Planning Services	Covered if both the procedure code and diagnosis code are on the approved list of waiver covered services. This restriction does not apply to Medicaid family planning services.	Mandatory 1905(a)(4)
Tobacco Cessation for Pregnant Women	Not covered. Ineligible for CCare waiver if pregnant.	Mandatory 1905(a)(4)
Physician's Services	Only family planning and family planning-related services are covered. Comprehensive physician services are not covered.	Mandatory 1905(a)(5)
Medical or Surgical Services by a Dentist	Not covered.	Mandatory 1905(a)(5)
Medical Care and Remedial Care-Podiatrist Services	Not covered.	Optional 1905(a)(6)

BENEFITS CHART		
Benefit	Description of Amount, Duration, and Scope	Reference
Medical Care and Remedial Care-Optometrist Services	Not covered.	Optional 1905(a)(6)
Medical Care and Remedial Care-Chiropractor Services	Not covered.	Optional 1905(a)(6)
Medical Care and Remedial Care-Other Practitioners	Only family planning and family planning-related services are covered. Comprehensive services are not covered.	Optional 1905(a)(6)
Home Health Services- Intermittent or Part-time	Not covered.	Mandatory for certain individuals 1905(a)(7)
Home Health Services-Home Health Aide	Not covered.	Mandatory for certain individuals 1905(a)(7)
Home Health Services-Medical Supplies, Equipment, and Appliances	Not covered.	Mandatory for certain individuals 1905(a)(7)
Home Health Services-Physical, Occupational, Speech Therapy, and Audiology	Not covered.	Optional 1905(a)(7), 1902(a)(10)(D), 42CFR 440.70
Private Duty Nursing	Not covered.	Optional 1905(a)(8)
Agency services	Only family planning and family planning-related services are covered. Comprehensive agency services are not covered.	Optional 1905(a)(9)
Dental Services	Not covered.	Mandatory 2105(c)(5), Optional 1905(a)(10)
Physical Therapy	Not covered.	Optional 1905(a)(11), Optional 2110(a)(22)
Occupational Therapy	Not covered.	Optional 1905(a)(11), Optional 2110(a)(22)
Services for Individuals with Speech, Hearing and Language Disorders	Not covered.	Optional 1905(a)(11), Optional 2110(a)(22)
Prescribed Drugs	Only family planning and family planning-related services are covered. Comprehensive drug therapy for all diagnoses and medical needs are not covered.	Optional 1905(a)(12)
Dentures	Not covered.	Optional 1905(a)(12)
Prosthetic Devices	Not covered.	Optional 1905(a)(12)
Eyeglasses	Not covered.	Optional 1905(a)(12)

BENEFITS CHART		
Benefit	Description of Amount, Duration, and Scope	Reference
Diagnostic Services	Covered if both the procedure code and diagnosis code are on the approved list of waiver covered services. This restriction does not apply to Medicaid family planning services.	Optional 1905(a)(13)
Screening Services	Covered if both the procedure code and diagnosis code are on the approved list of waiver covered services. This restriction does not apply to Medicaid family planning services.	Optional 1905(a)(13)
Preventive Services	Covered if both the procedure code and diagnosis code are on the approved list of waiver covered services. This restriction does not apply to Medicaid family planning services.	Optional 1905(a)(13)
Rehabilitative Services	Not covered.	Optional 1905(a)(13)
Services for Individuals Over 65 in IMDs-Inpatient Hospital	Not covered.	Optional 1905(a)(14)
Services for Individuals Over 65 in IMDs-Nursing Facility	Not covered.	Optional 1905(a)(14)
Intermediate Care Facility for Services for Individuals in a Public Institution for the Intellectually Disabled	Not covered.	Optional 1905(a)(15)
Inpatient Psychiatric Service for Under 22	Not covered.	Optional 1905(a)(16)
Nurse-Midwife Services	Not covered.	Mandatory 1905(a)(17)
Hospice Care	Not covered.	Optional 1905(a)(18)
Case Management Services	Not covered.	Optional 1905(a)(19), 1914(g)
Special TB Related Services	Not covered.	Optional 1905(a)(19), 1902(z)(2)
Respiratory Care Services	Not covered.	Optional 1905(a)(20)
Certified Pediatric or Family Nurse Practitioner's Services	Covered if both the procedure code and diagnosis code are on the approved list of waiver covered services. This restriction does not apply to	Mandatory 1905(a)(21)

BENEFITS CHART		
Benefit	Description of Amount, Duration, and Scope	Reference
	Medicaid family planning services.	
Home and Community Care for Functionally Disabled Elderly	Not covered.	Optional 1905(a)(22)
Personal Care Services	Not covered.	Optional 1905(a)(24), 42CFR 440.170
Primary Care Case Management	Not covered.	Optional 1905(a)(25)
PACE Services	Not covered.	Optional 1905(a)(26)
Sickle-Cell Anemia Related Services	Not covered.	Optional 1905(a)(27)
Free Standing Birth Centers	Not covered.	Optional 1905(a)(28)
Transportation	Not covered.	Optional 1905(a)(29), 42CFR 440.170, administrative required 42CFR 421.53
Services Provided in Religious Non-Medical Health Care Facilities	Not covered.	Optional 1905(a)(29), 42CFR 440.170(b)
Nursing Facility Services for Patients Under 21	Not covered.	Optional 1905(a)(29), 42CFR 440.170(d)
Emergency Hospital Services	Not covered.	Optional 1905(a)(29), 42CFR 440.170(e)
Expanded Services for Pregnant Women-Additional Pregnancy-Related and Postpartum Services for a 60-day Period After the Pregnancy Ends	Not covered.	Optional 1905(e)(5)
Emergency Services for Certain Legalized and Undocumented Non-Citizens	Not covered.	Mandatory 1903(v)(2)(A)
Home and Community Based Services for Elderly or Disabled	Not covered.	Optional 1915(i)
Self-Directed Personal Assistance	Not covered.	Optional 1915(k)
Community First Choice	Not covered.	Optional 1905(a)(29)
Well-Baby and Well-Child Care, Including Age Appropriate Immunizations	Not covered.	Mandatory 2103(c)(1)(D)
Emergency Services	Not covered.	Mandatory 457.410(b)
Physicians Surgical and Medical Services	Not covered.	Mandatory for benchmark equivalent 2103(c)(1)(B)

BENEFITS CHART		
Benefit	Description of Amount, Duration, and Scope	Reference
Clinic Services (Including Health Center Services)	Not covered.	Optional 2110(a)(5)
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Only family planning and family planning-related services are covered. Prenatal care is not covered.	Optional 2110(a)(9)
Inpatient Mental Health Services	Not covered.	Optional 2110(a)(10)
Outpatient Mental Health Services	Not covered.	Optional 2110(a)(11)
Durable Medical Equipment	Not covered.	Optional 2110(a)(12)
Disposable Medical Supplies	Not covered.	Optional 2110(a)(13)
Home and Community-Based Health Care Services	Not covered.	Optional 2110(a)(14)
Nursing Care Services	Not covered.	Optional 2110(a)(15)
Abortion Only if Necessary to Save the Life of the Mother or if Pregnancy is the Result of an Act of Rape or Incest	Not covered.	Optional 2110(a)(16)
Inpatient Substance Abuse Treatment Services	Not covered.	Optional 2110(a)(18)
Outpatient Substance Abuse Treatment	Not covered.	Optional 2110(a)(19)
Care Coordination Services	Only family planning and family planning-related services are covered.	Optional 2110(a)(21)
Hospice Care	Not covered.	Optional 2110(a)(23)
Any Other Medical, Diagnostic, Preventative, Restorative, Remedial, Therapeutic, or Rehabilitative Services	Not covered.	Optional 2110(a)(24)
Premiums for Health Insurance Coverage	Not covered.	Optional 2110(a)(25)
Medical Transportation	Not covered.	Optional 2110(a)(26)
Enabling Services	Not covered.	Optional 2110(a)(27)

6) Indicate whether Long Term Services and Supports will be provided.

Yes (if yes, please check the services that are being offered) No

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

- Yes (if yes, please address the questions below) No (if no, please skip this question)

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

Not applicable.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan.

Not applicable.

10) Indicate if there are any exemptions from the proposed cost sharing.

Not applicable.

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan.

- Yes No (if no, please skip questions 2 – 7)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration’s expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

Oregon’s public family planning provider network is made up of 50 agencies—the administrative units of programs or providers—and 140 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, Planned Parenthood 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, meaning that they have agreed to the CCare Standards of Care and may bill CCare as appropriate. In addition, some agencies and clinics receive Title X grant funding, which entails an extensive set of requirements. Title X-supported clinics must offer a wide range of reproductive health services including contraceptive management, gynecological care, and infertility and pregnancy services. They are mandated to serve all clients regardless of citizenship, residency, or ability to pay. Very little funding is available to meet these conditions; Oregon Title X sub-recipients receive an average of \$100 per client per year. However, Title X clinics have wide discretion over expenditure of their grant funds. Monies may be used to support staff positions and continuing

education, community outreach, clinic infrastructure, and development of educational materials, as well as the provision of gynecological and contraceptive health services. Because very little other funding is available for general operations, clinics that receive Title X funds tend to allocate their grant to infrastructure rather than to client services.

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 populations who are most impacted by health disparities (e.g. communities of color, justice system, alternative schools), all of which increase the likelihood of acquiring care. Furthermore, CCare providers are well-positioned to assist and facilitate client enrollment into full-benefit health coverage. 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.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- Managed care
 - Managed Care Organization (MCO)
 - Prepaid Inpatient Health Plans (PIHP)
 - Prepaid Ambulatory Health Plans (PAHP)
- Fee-for-service (including Integrated Care Models)
- Health Homes
- Other (please describe)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option.

Not applicable; Oregon ContraceptiveCare only uses a fee-for-service delivery system.

5) If the Demonstration will utilize a managed care delivery system:

Not applicable; Oregon ContraceptiveCare only uses a fee-for-service delivery system.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

No services are excluded under the proposed delivery system.

- 7) **If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.**

Yes No

- 8) **If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.**

CCare reimburses providers on a fee-for-service (FFS) basis. Providers are reimbursed a bundled encounter rate of \$150 for office visits (which includes all labs/services performed within the visit), \$13.55 for gonorrhea/Chlamydia tests, \$800 for vasectomy procedures, and acquisition cost for contraceptive devices and pharmaceutical supplies.

- 9) **If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.**

No payments are made through managed care entities on a capitated basis.

- 10) **If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.**

No quality based supplemental payments are made to providers.

Section V – Implementation of Demonstration

- 1) **Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.**

The proposed implementation date for this renewal is January 1, 2016.

- 2) **Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.**

Oregon will continue to use the current enrollment process and approach with this renewal.

- 3) **If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.**

Not applicable.

Section VI – Demonstration Financing and Budget Neutrality

See Attachment X for the Demonstration Financing form and Attachment X for the Budget Neutrality calculations.

Section VII – List of Proposed Waivers and Expenditure Authorities

- 1) Provide a list of proposed waivers and expenditure authorities; and
- 2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Oregon is requesting waiver of selected Medicaid requirements to enable the operation of Oregon ContraceptiveCare as a Demonstration that will effectively meet the program’s objectives as well as budget neutrality expectations. All Medicaid requirements apply, except for those listed in the below table.

List of Proposed Waivers and Expenditure Authorities		
Medicaid Requirement	Expenditure Authority	Waiver Request
Amount, Duration, and Scope of Services	Section 1902(a)(10)(B)	To the extent necessary to allow the State to offer the Demonstration population a benefit package consisting of family planning and family planning-related services.
Comparability	Section 1902(a)(17)	To the extent necessary to enable the State to not require reporting of changes in income or household size for 12 months, for a person found income-eligible upon application or annual redetermination when determining eligibility for Demonstration.
Retroactive Eligibility	Section 1902(a)(34)	To the extent necessary to enable the State to not provide medical assistance to the Demonstration population for any time prior to when an application for the Demonstration is made.
Ex Parte Eligibility Redetermination	Section 1902(a)(19)	To the extent necessary to enable the State to require that a separate Demonstration application be filed by an applicant who is no longer eligible for regular Medicaid prior to being determined eligible for the Demonstration; and to require a

List of Proposed Waivers and Expenditure Authorities		
Medicaid Requirement	Expenditure Authority	Waiver Request
		Demonstration member to file a separate Medicaid application in order to receive benefits under any other Medicaid program.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Section 1902(a)(43)(A)	To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the Demonstration population.
Methods of Administration: Transportation	Section 1902(a)(4) insofar as it incorporates 42CFR 431.53	To the extent necessary to enable the State to not assure transportation to and from providers for the Demonstration population.
Prospective Payment for Federally Qualified Health Centers and Rural Health Agencies	Section 1902(a)(15)	To the extent necessary to enable the State to establish reimbursement rates to these agencies that will compensate them solely for family planning and family planning-related services provided to the Demonstration population.

Section VIII – Public Notice

1) Start and end dates of the state’s public comment period.

Oregon’s public comment period for the waiver renewal application begins on August 17, 2015 and ends on September 18, 2015.

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 was posted to the state website for public notices on August 14, 2015, and will be published in the Secretary of State September Bulletin on their website at: <http://arcweb.sos.state.or.us/pages/rules/bulletin/past.html>.

A copy of the public notice is included as Attachment X, and a screen print of the notice as it appeared on the Oregon website is included as Attachment X.

A copy of the initial draft of the state waiver renewal application was posted on August 13, 2015 on the Oregon CCare website at:

<http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Pages/CCareProviders.aspx>. A copy of the final application that includes modifications following the public and tribal input process will also be posted to this website.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Two public hearings have been scheduled for the public to comment on the waiver renewal on the following dates and locations:

- | | |
|-----------------------------------|---------------------------------------|
| 1. Friday, Sept. 4, 2015, 1:00 pm | 2. Wednesday, Sept. 9, 2015, 10:00 am |
| Portland State Office Building | Portland State Office Building |
| 800 NE Oregon Street, Room 368 | 800 NE Oregon Street, Room 368 |
| Portland, OR 9732 | Portland, OR 97232 |

Teleconference access will be available for both meetings. Written comments concerning the waiver renewal will be accepted on or before 5:00 pm on September 18, 2015 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 here: xxxxx, 2) in the Oregon Secretary of State September Bulletin here:

<http://arcweb.sos.state.or.us/pages/rules/bulletin/past.html>, and 3) on the Reproductive Health

Program website here:

<http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Pages/CCareProviders.aspx>.

Additionally, public notice will also be published in the Reproductive Health Program's electronic newsletter, RH Update, dated August 14, 2015. 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 here:

<https://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Pages/updates.aspx#2015>.

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

To be completed upon completion of 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 upon completion of 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 was sent by email on August 11, 2015 to the tribal health directors and representatives of the nine federally recognized tribes in Oregon. A copy of the notice and the email list is included as **Attachment X**. Further notice will be presented (and tribal consultation requested) in person during the SB 770 Quarterly Health Services Cluster meeting with Tribal Health Directors on August 19, 2015.

Section IX – Demonstration Administration

Please provide the contact information for the state’s point of contact for the Demonstration application.

Name and Title:

Telephone Number:

Email Address: