



House Bill 3391 Reproductive Health Equity Act: Report to the Legislature

Legislation requires a report from the Oregon Health Authority.

This report describes the progress made in carrying out House Bill 3391.

Oregon
Health
Authority

PUBLIC HEALTH DIVISION
Reproductive Health Program

Acknowledgments

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Executive summary

Overview of House Bill 3391

The Reproductive Health Equity Act (House Bill 3391) was passed in the summer of 2017. The basis for this landmark legislation is the idea that everyone deserves access to:

- Client-centered reproductive health education and counseling;
- High-quality clinical care;
- A broad range of contraceptive methods; and
- The right to become pregnant (or become a parent) without stigma or shame.

House Bill (HB) 3391 ensures that Oregonians have access to comprehensive reproductive health care regardless of their income, citizenship or immigration status, gender identity, or insurance coverage.

HB 3391:

- Expands coverage for reproductive health services for some uninsured individuals;
- Provides insured individuals with protections for reproductive health services with no cost sharing, such as co-pays or payments toward deductibles;
- Codifies the legal right to abortion; and
- Bans discrimination in the delivery of reproductive health services.

Oregon has long been a leader in enacting policies and programs that support access to high-quality reproductive health services. However, disparities persist in:

- Unintended pregnancy rates;
- Maternal and birth outcomes;
- Sexually transmitted infections (STIs); and
- Cervical cancer.

These disparities highlight structural and societal inequities that may inhibit

Upon signing, Governor Kate Brown said “To lead productive and thriving lives, Oregonians must have the ability to control their bodies and make informed decisions about their health. I am proud to sign legislation that expands access to basic reproductive health services for all Oregonians — regardless of where they live, where they come from, or how they identify as a person.”

individuals' ability to access services, and to plan and make decisions about their reproductive health goals. It is critical that legislation and policies aimed at improving reproductive health outcomes be wide-reaching and sensitive to the unique circumstances and challenges of different communities. Access to reproductive health care helps individuals reach their life goals and maximize their education, economic, emotional, and physical health outcomes. Furthermore, preventive reproductive health services are cost-effective. Analyses show significant cost savings through funding such services. Nationally, an estimated \$7.09 is saved for every dollar spent on reproductive health services.*

About 40,000 recent immigrants who live in Oregon are women of reproductive age. Of these, roughly 30,000 are:

- At risk of unintended pregnancy;
- Low-income; and
- Uninsured or underinsured.

Two specific provisions within HB 3391 intend to improve this population's access to high-quality reproductive health care:

- Section 5(1): Provides coverage for reproductive health services for low-income individuals who:
 - » Can become pregnant; and
 - » Would be eligible for medical assistance if not for their immigration status.
- Section 5(2): Extends full medical coverage for 60-days postpartum to immigrant women enrolled in the state's prenatal Medicaid program, Citizen Alien Waived Emergent Medical (CAWEM) Plus.

The Reproductive Health (RH) Program, under the Public Health Division of the Oregon Health Authority, administers the coverage of a broad scope of reproductive health services for immigrant women as described in section 5(1) of HB 3391.

This includes:

- Contraceptive management;
- Screening for breast and cervical cancer and STIs;
- Counseling and education; and
- Abortion.

* https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/MQ-Frost_1468-0009.12080.pdf. Accessed Jul. 27, 2018.

The RH Program developed a unique approach to align HB 3391 funds with its two other sources of federal funding: Title X and Oregon ContraceptiveCare (CCare). This integration allows for a streamlined model for both clients and providers. In this model there is no “wrong door” for clients, and providers receive adequate payment for services. This approach also takes advantage of an established and trusted network of providers held to high standards of quality, client-centered care. To become a RH Program provider, agencies must apply for certification. Certification requirements are based on national standards and align with best practices and recommendations for client-centered, culturally responsive, high-quality care. Coverage for services began Apr. 1, 2018. As of Aug. 15, 2018, there were 37 agencies, with 111 clinic sites across the state, with certifications to provide clinical services through the RH Program.

The Health Systems Division (HSD) of OHA administers the expansion of comprehensive medical coverage under section 5(2) of HB 3391. For immigrant women enrolled in CAWEM Plus this includes:

- Primary physical health care;
- Dental care;
- Immediate postpartum female sterilization; and
- Long-acting reversible contraception (LARC).

HSD used postpartum codes and services offered under the full Oregon Health Plan (OHP) benefit package to set coverage guidelines. Coverage for postpartum services began Apr. 1, 2018.

Utilization

Due to the timing of this report, limited client enrollment and claims data are available. Preliminary data indicates that as of Jul. 1, 2018:

- 1,748 HB 3391-eligible individuals were enrolled in the RH Program; and
- 476 women were enrolled in the CAWEM Plus 60-day postpartum benefit package.

Stakeholder engagement and communications

HB 3391 expands coverage for a traditionally underserved population — individuals without eligible immigration status (i.e., immigrants who don't qualify for full Medicaid coverage because of their immigration status.). However, HB 3391 did not provide funds or resources to support outreach, education, or communications efforts. Still, given the importance of connecting with communities not generally engaged or connected to health care, the RH Program, in partnership with the Department of Human Services' Community Partner Outreach Program, took advantage of existing channels and networks to work together and share community- and client-centered information about HB 3391. The RH Program gathered a community partner workgroup to advise and aid with stakeholder engagement and education materials development. The RH Program also used existing sources of funding to produce online and print materials related to HB 3391. Recent federal policy actions around immigration have both heightened awareness of and concerns for immigrant privacy. To address these concerns, and preserve the community's trust, OHA will need to continue to work with partners to communicate transparently and thoughtfully.

Implementation of this legislation has been well received by providers, community partners, and clients. OHA will continue to evaluate and make changes to ensure the effective and efficient use of state resources. At the same time, OHA will safeguard the intent of the legislation. Since its passage, HB 3391 has served as model legislation for other states and reflects Oregon's ongoing commitment to promote the health and well-being of all its residents.

Overview of House Bill 3391

House Bill (HB) 3391, known as the Reproductive Health Equity Act (RHEA), was passed by the Oregon Legislature during the 2017 legislative session. Governor Brown signed it into law Aug. 15, 2017 (see Appendix A for the enrolled bill). The bill:

- Expands coverage for reproductive health services for some uninsured individuals;
- Provides insured individuals with protections for reproductive health services with no cost sharing, such as co-pays or payments toward deductibles;
- Establishes a legal right to receive and provide abortions; and
- Bans discrimination in the delivery of reproductive health services.

Relevant provisions of the bill include:

Section 2

Requires health benefit plans regulated by the state to provide coverage for a broad range of reproductive health services, like those defined in the Affordable Care Act's preventive services guidelines, without any cost-sharing requirements. Services, as outlined in section 2(2) of the bill, include:

- Well-woman care;
- Counseling and screening for STIs and various health conditions (e.g. gestational diabetes, cervical cancer);
- Screening and counseling for various health risk behaviors;
- Comprehensive breastfeeding support;
- Genetic counseling and screening;
- Abortion;
- Counseling on and the provision of any FDA-approved contraceptive drug, device, or product; and
- Any other preventive services for women under 42 U.S.C. 300gg-13 as identified after the effective date of this 2017 bill.

Most services are for women's reproductive health. However, there are some provisions for men, as indicated. This includes voluntary sterilization (i.e., vasectomy).

Section 3

Requires the Department of Consumer and Business Services to report on the degree of compliance by insurers with section 2, by Sept. 15, 2019. This report is to be made to the interim committees of the Legislative Assembly related to health.

Section 5

Requires the Oregon Health Authority (OHA) to administer a program to reimburse all services described in section 2 for individuals who:

- Can become pregnant; and
- Who are not otherwise eligible for medical assistance (i.e., those not eligible for Medicaid because of their immigration status).

Expands full medical coverage under the Citizen Alien Waived Emergent Medical (CAWEM) benefit package for pregnant women (CAWEM Plus) for 60-days immediately postpartum.

Section 6

Requires OHA to report to the legislature, by Sept. 15, 2018, on implementation of section 5.

Section 7

Bans discrimination of individuals in the receipt of benefits or medical assistance because of actual or perceived race, color, national origin, sex, sexual orientation, gender identity, age or disability.

Section 8

Provides protections for women to obtain abortion services by establishing an affirmative right to provide and receive abortion information and services.

Section 9

Requires the Health Evidence Review Commission (HERC) to review the coverage described in section 2. By November 1 of each even-numbered year, HERC must report to the interim committees of the Legislative Assembly related to health any recommended changes to coverage described in section 2, based on the latest clinical research.

Section 10

Requires OHA, in consultation with the Department of Consumer and Business Services, to design a program to provide for statewide access to abortion coverage for Oregonians enrolled in health benefit plans described in section 2.

The purpose of this report is to fulfill the requirement outlined in section 6 of the bill and to report on the progress of OHA in implementing section 5 of the bill.

Overview of House Bill 3391, section 5

Section 5 of HB 3391 contains four subsections, all of which fall to OHA for implementation:

1. The creation of a program to reimburse the cost of medical appropriate services, drugs, devices, products, and procedures described in section 2 for individuals who can become pregnant and would otherwise be eligible for medical assistance if not for 8 U.S.C. 1611 or 1612. This program is overseen by the Reproductive Health Program, within the Public Health Division, of OHA.
2. Provision of medical assistance for pregnant women authorized by Title XXI, section 2112, of the Social Security Act (42 U.S.C. 139711) is for 60 days immediately postpartum. Extended medical coverage for women enrolled in the CAWEM Plus program is administered by the Health Systems Division of OHA.
3. The collection and analysis of data on the cost-effectiveness of the services, drugs, devices, products and procedures paid for under section 5. Staff from OHA's Health Policy and Analytics Division and Public Health Division are responsible for this work. This is outlined in an evaluation matrix and described in more detail in the utilization section of this report.
4. The identification, in collaboration with the Department of Consumer and Business Services, of opportunities to obtain federal financial participation in the costs of implementing section 5, including but not limited to waivers or demonstration projects under Title X of the Public Health Services Act or Title XIX or XXI of the Social Security Act. Both the Reproductive Health Program, the state's Title X grantee, and the Health Systems Division, the office that administers the state's Medicaid (Title XIX) and CHIP (Title XXI) programs, continue to leverage these sources of funding wherever and whenever possible.

A summary of the coverage requirements outlined in section 5, including the OHA Divisions responsible for administering the coverage and the timeline for implementation, is detailed in Table 1 below.

Table 1. Summary and implementation timeline

Coverage requirement	Covered population	Administered by	Implementation date
Coverage for outpatient abortion services	Individuals who can become pregnant and would be eligible for medical assistance if not for their immigration status	Reproductive Health Program (Public Health Division)	Jan. 1, 2018
Coverage for broad range of reproductive health services	Individuals who can become pregnant and would be eligible for medical assistance if not for their immigration status	Reproductive Health Program (Public Health Division) and Health Systems Division	Apr. 1, 2018
Extension of medical coverage 60-days postpartum	Individuals enrolled in CAWEM Plus	Health Systems Division	Apr. 1, 2018

Agency coordination

Multiple state agencies are responsible for the implementation of HB 3391. This includes the Department of Consumer and Business Services and OHA. Section 5 of the bill is unique in that more than one OHA program administers the coverage expansion programs. This has called for a coordinated approach across the agency, bringing together programs that have not typically worked together. To support this coordination, staff from the below convened an HB 3391 interagency workgroup with a focus on planning and implementation:

- OHA's Reproductive Health (RH) Program;
- Office of Government Relations;
- Health Systems Division (HSD);
- Health Policy and Analytics Division; and
- Communication Office.

Staff from the Department of Human Services' (DHS) Community Partner Outreach Program (CPOP) also took part in the workgroup. CPOP's primary focus was to leverage existing community partner engagement and outreach efforts. Early on, the workgroup identified key staff leads and set a timeline for implementation. Monthly workgroup meetings allowed staff to track progress, address challenges and barriers, identify opportunities for expanded collaboration and highlight successes.

The workgroup will continue to meet to establish quality assurance and improvement activities and refine a framework for ongoing evaluation. The workgroup's efforts should serve as a successful model for future interagency work.

Reproductive health services as described in section 5(1)

Program structure

One of the key provisions of section 5 is the expansion of coverage for reproductive health services for individuals who can become pregnant and would be eligible for medical assistance if not for their immigration status. This includes undocumented individuals, those with Deferred Action for Childhood Arrivals (DACA) status, and lawful permanent residents of less than five years.

These services are administered by the RH Program, housed in OHA's Public Health Division. The RH Program's existing structure and capacity to provide reproductive health services to underserved individuals across the state serves as a strong foundation for new programming, as part of HB 3391. The RH Program was effectively and efficiently able to incorporate the new coverage requirements outlined in section 5(1). This is because of the program's already established network of providers, high-quality standards of clinical care and a focus on serving all individuals regardless of citizenship or immigration status.

For nearly five decades, the RH Program has developed and supported programs focused on the delivery of client-centered reproductive health services to low-income individuals across the state. The RH Program has been the state's Title X grantee since 1970. The program distributes federal Title X funds to its network of agencies (primarily local public health authorities) and their clinic sites to support a broad range of reproductive health services. Individuals seeking services at Title X clinics may not be denied access to services based on inability to pay, residency status, or citizenship status.

In addition to the Title X grant, the RH Program administers the state's family planning Medicaid waiver, Oregon ContraceptiveCare (CCare). Implemented in 1999, CCare expands Medicaid coverage to U.S. citizens or eligible immigrants who have household incomes at or below 250 percent of the federal poverty level (FPL). CCare provides fee-for-service (FFS) reimbursement to CCare enrolled providers. Many of these providers also receive Title X funds for family planning services to prevent unintended pregnancy.

The RH Program's network of clinic sites includes:

- Local public health authorities (LPHAs);
- Federally-qualified health centers (FQHCs);
- Rural health centers (RHCs);
- Planned Parenthood clinics;
- School-based health centers (SBHCs); and
- University student health centers.

Almost every county in the state has at least one RH Program provider, often with multiple clinic sites per provider. In 2017, the RH Program served nearly 60,000 unduplicated clients.

To leverage its longstanding structure and network of clinics, to the benefit of both clients and providers, the RH Program aligned its three sources of funds: Title X, CCare, and HB 3391. This integration of funds makes for a simplified model in which there is “no wrong door” for clients seeking services. In addition, agencies have access to FFS reimbursement for a broad scope of reproductive health services. This model contributes to a sustainable network of clinics and access to essential reproductive health services for more individuals.

Program planning

The RH Program began planning for implementation shortly upon passage of the bill. In mid-August 2017, the RH Program set up multiple sub-committee workgroups, comprised of existing providers, new providers, community partners, and external stakeholders.

The purpose of the workgroups was to ask for input and feedback on multiple topics related to:

- Implementation;
- Scope of services;
- Program requirements;
- Client forms;
- Data and billing; and
- Provider trainings.

While most of the workgroups met only two to three times, a few continue to meet on an ad hoc basis. A primary focus during planning was to ensure the new program structure reflects the needs of both clients and providers. Key stakeholder involvement was essential so that the program could consider the existing delivery system, increase access for underserved clients, and support the financial sustainability of safety-net providers.

Oregon Administrative Rule making

During the fall of 2017, the RH Program drafted Oregon Administrative Rules (OARs) to reflect integration of the RH Program's three funding sources. This includes all relevant HB 3391 provisions. The OARs concern:

- Provider enrollment;
- Client enrollment and eligibility;
- Covered services;
- Program requirements;
- Compliance and monitoring;
- Agency sanctions; and
- Agency appeals.

The RH Program convened a Rules Advisory Committee (RAC), which met twice in November 2017, to review and provide comment on the draft rules. In late December 2017, the RH Program filed temporary rules to certify RH Program agencies under the newly integrated program structure by the Apr. 1, 2018 implementation date. A public hearing was held on Feb. 22, 2018 and the public was invited to file written comments on the proposed permanent rules between Jan. 16, 2018 and Feb. 23, 2018. A copy of the Hearing Officer's Report on Rulemaking Hearings and Public Comment Period can be found in Appendix B. The permanent RH Program rules, [OARs 333-004-2010 through 333-004-2190](#), were filed on Mar. 14, 2018.

The RH Program requested and received approval for a Rules Advisory Committee (RAC) exception to make rules related specifically to the coverage of abortion services, as detailed in section 5 of HB 3391, effective Jan. 1, 2018. Apart from abortion coverage, the RH Program already provided low- and no-cost coverage for a broad array of reproductive health services for the specified population under the state's Title X grant. However, abortion services were not covered for this specific population. Under recommendation from external stakeholders and advocates, the RH Program implemented coverage for abortion services Jan. 1, 2018. The RH Program drafted rules specific to the coverage of abortion services and held a public hearing Dec. 6, 2017. Members of the public

were invited to provide written comment between Oct. 18, 2017 and Dec. 7, 2017. A copy of the Hearing Officer's Report on Rulemaking Hearings and Public Comment Period can be found in Appendix C. Rules specific to the coverage of abortion services were filed Dec. 19, 2017. These OARs were then incorporated under permanently adopted rules that apply to the full RH Program (333-004-2010 through 333-004-2190) on Mar. 14, 2018.

Program implementation

Clinic-based reproductive health services — To meet legislative intent and ensure the provision of high-quality care, participating clinical service providers must adhere to robust standards of care defined by the RH Program. Interested agencies must apply for certification to become an RH Program provider and receive reimbursement for the broad range of reproductive health services under CCare, Title X, and HB 3391. Using the Oregon School-Based Health Center Program's Standards for Certification as a model and based largely on federal Title X, requirements, the RH Program developed a set of [Certification Requirements for Reproductive Health Services](#) (Appendix D). Certification requirements provide the foundation for high-quality services based on national standards of care and align with best practices and recommendations for client-centered, culturally-responsive care. As part of RH Program certification, agencies are required to offer:

- Core reproductive health services, including pregnancy testing and options counseling;
- Counseling and education to assist with achieving or preventing pregnancy;
- Basic infertility;
- STI screening and treatment;
- Preconception health; and,
- Breast and cervical cancer screening.

To be certified, agencies must also offer a broad range of FDA-approved contraceptive methods, and clients must be able to get their first choice of contraceptive method, unless there are specific contraindications, at the clinic site. Once an agency applies for certification, the RH Program decides whether to approve or deny the agency based on its application. Upon approval and final execution of the contract between the RH Program and the agency, the RH Program then conducts regularly scheduled verification and compliance reviews.

The RH Program finalized the Certification Requirements for Reproductive

Health Services, which are also referenced in the RH Program's OARs, in early January 2018. (Information about the application process and associated materials, can be found here: healthoregon.org/rhcertification). While any agency is eligible to apply, the RH Program worked strategically to prioritize certification of its existing provider network, including Title X and CCare agencies, in advance of the Apr. 1, 2018 implementation date.

Leveraging its existing model of FFS claims-based reimbursement through CCare, the RH Program developed three bundled reimbursement rates. These rates were calculated using a weighted average of the different office visits and laboratory services conducted within typical reproductive health visits. Based on Medicaid FFS reimbursement rates they are intended to accommodate the range of typical visits provided for both new and established clients. Clinics select the appropriate visit type for each encounter. The visit type triggers the corresponding reimbursement rate. Using a set of system rules based on each funding source's eligibility and coverage requirements, the RH Program determines the appropriate fund source to draw from. This ensures that funding is maximized based on each fund source's unique eligibility and coverage requirements.

To access services through the RH Program and its network of clinics, clients must complete an RH Program Enrollment Form (Appendix E). The RH Program revised the CCare Enrollment Form to incorporate the data elements necessary to determine eligibility for one or more of its three funding streams. To establish eligibility for HB 3391 coverage specifically, questions were added to determine whether the applicant can become pregnant and holds an immigration status that doesn't qualify for Medicaid coverage (e.g. DACA, undocumented, etc.). All information on the RH Program Enrollment Form is self-attested. Unlike the OHP application, it is completed at the clinic site, on the day of the client's visit. This process facilitates easy and timely access to services. Once RH Program eligibility has been established, clients are conferred a year's worth of eligibility.

On Apr. 1, 2018, 20 agencies were certified to provide and receive reimbursement for services under each of the RH Program's three funding sources. As of Aug. 15, 2018, 37 agencies, with 111 clinic sites, were certified to provide clinical services. The RH program will continue to work with its existing provider network in addition to a diverse set of community partners to identify gaps in and barriers to access. Based on identified need, the RH Program will reach out and encourage providers that serve as key access points for the HB 3391 target population to participate in the RH Program.

Clinic-based abortion services — Coverage for abortion services began Jan. 1, 2018. To ensure services were available Jan. 1, 2018, the RH Program set up short-term contracts with three providers of abortion services: Planned Parenthood of Southwestern Oregon; Planned Parenthood of the Columbia Willamette; and Lovejoy Surgicenter. Prior to Apr. 1, 2018, these providers were asked to apply for certification for abortion services. Based in large part on the certification requirements for reproductive health services, the [Certification Requirements for Abortion Services](#) (Appendix F) were developed with input from subject matter experts in the medical field.

All three providers originally contracted with the RH Program were certified under the new process in early April 2018. This allowed them to continue to provide abortion services under HB 3391 without interruption. Like agencies that contract with the RH Program for reproductive health services, providers of abortion services are subject to robust compliance and monitoring processes. The RH Program maintains rigorous controls to ensure that state funds used for abortion services are kept distinctly separate from the RH Program's federal funding sources — CCare and Title X. Claims for abortion services are submitted on a specific claims form and are processed separately from claims for reproductive health services. Clients who access abortion services under HB 3391 must complete an RH Program Enrollment Form prior to receiving services. Once enrolled, the client has access to the full range of reproductive health services at any RH Program clinic to ensure continuity of care.

Specialized services — Coverage is administered through several different mechanisms for highly specialized reproductive health services, including:

- Screening mammograms;
- Female sterilization;
- Inpatient abortion services; and
- Complex contraceptive management.

These services and the mechanisms for their administration are described in more detail below:

- The RH Program is relying on its sister program, ScreenWise, in the Public Health Division, to administer coverage for breast cancer screening services. This includes mammography for individuals who can become pregnant and would be eligible for medical assistance if not for their immigration status. The ScreenWise Program oversees a statewide network of providers, including imaging facilities and labs, that offer breast and cervical cancer screening services. Leveraging ScreenWise's existing network of providers and trusted connections with communities, individuals eligible for HB 3391 coverage may access breast cancer screening services in a timely and efficient manner. The RH Program will continue to work with ScreenWise to further integrate programming and prioritize the most appropriate use of both HB 3391 and ScreenWise funds.
- The RH Program expanded its network of providers and contracting processes to facilitate outpatient abortion services. However, the RH Program has not historically contracted with entities or facilities that provide services performed in non-outpatient clinic settings, including female sterilization, hospital-based inpatient abortion services, and complex contraceptive management. To facilitate access to these services for HB 3391-eligible individuals, the RH Program, in collaboration with HSD, leveraged existing provider contracts with the Oregon Health Plan (OHP). HSD added the service-specific diagnosis and procedure codes already established under OHP to the CAWEM (Citizen Alien Waived Emergent Medical) benefit package. To reflect these changes, [OAR 410-120-1210\(4\)\(c\)](#) was amended to include the subset of state-funded benefits under HB 3391 available to CAWEM-covered individuals.

Clients seeking these specialized services first must enroll and be determined eligible for CAWEM. Once eligible, the client may access any specialized service without prior authorization. Providers can use OHP FFS (open card) billing to submit claims and receive reimbursement. Unlike CAWEM-covered services eligible for federal matching funds, all HB 3391-covered services added to the CAWEM benefit package draw from state funds only.

Postpartum services as described in section 5(2)

Program structure

The Health Systems Division (HSD) is responsible for administering the coverage outlined in section 5(2). HSD, with a diverse set of partners, providers, and health systems across the state, works to build and advance a system of care to assure the health of all Oregonians. HSD's primary responsibility is to manage OHP, the state's Medicaid program. In addition to OHP, HSD administers CAWEM Plus, a slightly reduced version of the OHP Plus benefit package that provides prenatal Medicaid services to pregnant women ineligible for full OHP benefits because of their immigration status (i.e., non-qualified aliens not eligible for other Medicaid programs according to OAR 461-135-1070). Using sophisticated systems and contracts already in place for OHP, HSD was able to effectively and efficiently expand benefits for CAWEM Plus-enrolled recipients for 60-days immediately postpartum.

Program planning

Staff from multiple programs within HSD began planning for implementation alongside the RH Program's efforts. To implement state-funded postpartum coverage, HSD determined programming changes needed in Oregon's Medicaid Management Information System (MMIS). These changes ensured that appropriate codes and fund sources are applied. Additionally, eligibility policy staff in both HSD and DHS' integrated eligibility policy program confirmed what updates were necessary to Oregon's Eligibility (ONE) system to confer 60-days of extended eligibility to CAWEM Plus recipients in the postpartum period.

Oregon Administrative Rule making

Temporary rules relating to the set of state-funded postpartum benefits offered to CAWEM Plus recipients were established in [OAR 410-120-1210\(4\)\(g\)](#) on Mar. 15 through Jun. 29, 2018. The rules were made permanent Jun. 1, 2018. These rules establish a benefit package under the name of RHEF (Reproductive Health Equity Act Fund) for eligible clients. Eligible recipients are:

- CAWEM pregnant women not eligible for Medicaid based on immigration status; with
- Income at or below 185 percent of the Federal Poverty Level (FPL).

Immigrants eligible for the CAWEM Plus prenatal program are also eligible for a state-funded benefit pursuant to ORS 414.432 and includes postpartum care delivered outside of the global obstetric package not included under the CAWEM Plus benefit, 60 days following the pregnancy end date. Furthermore, [OAR 410-200-0240\(2\)\(b\)](#), which outline the eligibility requirements for individuals who do not meet citizen and alien status requirements, were amended temporarily from Apr. 29 through Oct. 25, 2018 to include RHEF eligibility. These rules will go through the permanent rulemaking process prior to Oct. 25, 2018.

Program implementation

Coverage for 60-day postpartum services began Apr. 1, 2018. HSD used the postpartum codes and services offered under the full OHP benefit package to establish coverage. All HB 3391-covered services added to the CAWEM Plus benefit package draw from state funds only. The OHP Notice of Eligibility (NOE) has been updated so that CAWEM Plus recipients entering their postpartum eligibility period will be accurately informed of their OHP Plus-level coverage during that time. Members who were amid their postpartum eligibility period as of Apr. 1, 2018 were sent a notice informing them of their Plus-level coverage effective Apr. 1 through the remainder of their postpartum eligibility period.

Stakeholder engagement and communications

HB 3391 does not provide any funds or resources to support outreach, education, or communication efforts related to the expanded coverage detailed in section 5. Understanding how critical these efforts are to the success of newly implemented programs, the RH Program worked in collaboration with DHS' Community Partner Outreach Program (CPOP) to capitalize on existing channels and networks to engage in meaningful ways and share community- and client-centered information about HB 3391.

Stakeholder engagement

Using the model established by Senate Bill 558 (otherwise known as Cover All Kids) as a guidepost, the RH Program convened a community partner workgroup to advise and assist with community stakeholder engagement and educational materials development. The community partner workgroup was established in December 2017 and is scheduled to meet through December 2018. Providers, community-based organizations, and advocacy organizations are all represented on the workgroup. Regular participants of the workgroup include Western States Center, Planned Parenthood, NARAL Pro-Choice Oregon, Oregon Health Equity Alliance, Latino Network and 211.

The workgroup's primary objectives are to:

- Create continual, bi-directional communication mechanisms;
- Advise the RH Program's strategies on outreach, education, and engagement;
- Help identify gaps and create solutions; and
- Ensure that HB 3391 is implemented with fidelity.

The workgroup's efforts include:

- Developing a toolkit for community partners to conduct outreach around newly expanded services;
- Executing a contract with Latino Network to conduct focus groups throughout the state to solicit feedback on materials, messaging and branding; and
- Supporting Western States Center to recruit a Reproductive Health Equity Fellow focused on developing quality, culturally-appropriate reproductive health information and messages to families with mixed immigration status.

In addition to the above efforts, the RH Program has shared information about expanded coverage under HB 3391 with:

- Community members, providers and partners during regional community forums;
- OHP providers in two electronic OHP Provider Matters newsletters (an example is in Appendix G);
- Members of the Oregon Perinatal Collaborative during a conference presentation; and
- Maternal and Child Health (MCH) Title V grantees in a webinar.

The RH Program also leveraged CPOP's efforts related to SB 558 implementation to engage with a diverse set of partners and shared HB 3391-specific information through several mechanisms, including:

- Email blasts reaching nearly 15,000 individuals;
- In-person updates at 21 county collaboratives and population-specific collaboratives (Justice-Involved, Latino, and Tribal); and,
- Two DHS Provider Collaborative webinars with 150-200 participants in each.

Communications

Despite having no dedicated funding for outreach and promotional materials, the RH Program leveraged other existing sources of funding to produce online and print materials related to HB 3391.

Electronic:

The Reproductive Health Equity Act webpage, healthoregon.org/rhea, was created to provide a basic overview of HB 3391. This webpage is located on the RH Program's website. It was launched Oct. 1, 2017 and has over 2,700 unique page views, approximately 30 percent are from out of state. The RH Program also initiated a bi-monthly newsletter for community partners informing them of HB 3391 and RH Program-related information. Over 65 partners receive the email.

Print:

The RH Program, with input from both internal and external subject matter experts, developed four unique documents and brochures related to HB 3391. These materials are in Appendix H and include:

- A Frequently Asked Questions (FAQ) dual-sided, one-page document in both English and Spanish provides an overview of HB 3391. It also provides answers to commonly asked questions.
- A client-facing brochure called, “What you need to know!” about the services available at RH Program clinics. The brochure is for clinics, providers, and community-based organizations to share with community members and clients. In addition to an extensive review of the draft brochure by key stakeholders, a focus group was held with eight bi-cultural youth to solicit feedback. Participating youth were Latinx and spoke Spanish.
- A poster titled “Pathways to Care: Helping Your Clients Access Free Reproductive Health Care” is for social service organizations that don’t provide direct clinic care to use with clients. Created with input from community partners and other referring providers, the poster is available in English and Spanish.
- A digital fact sheet that can be downloaded and printed, is called “What is the Reproductive Health Equity Act (RHEA)?” This fact sheet is for clinical service providers, primarily primary care and perinatal providers. It provides a basic overview of HB 3391 and where clients can receive covered services. There is an accompanying business card with both a weblink and quick response (QR) digital code to promote easy access for providers.

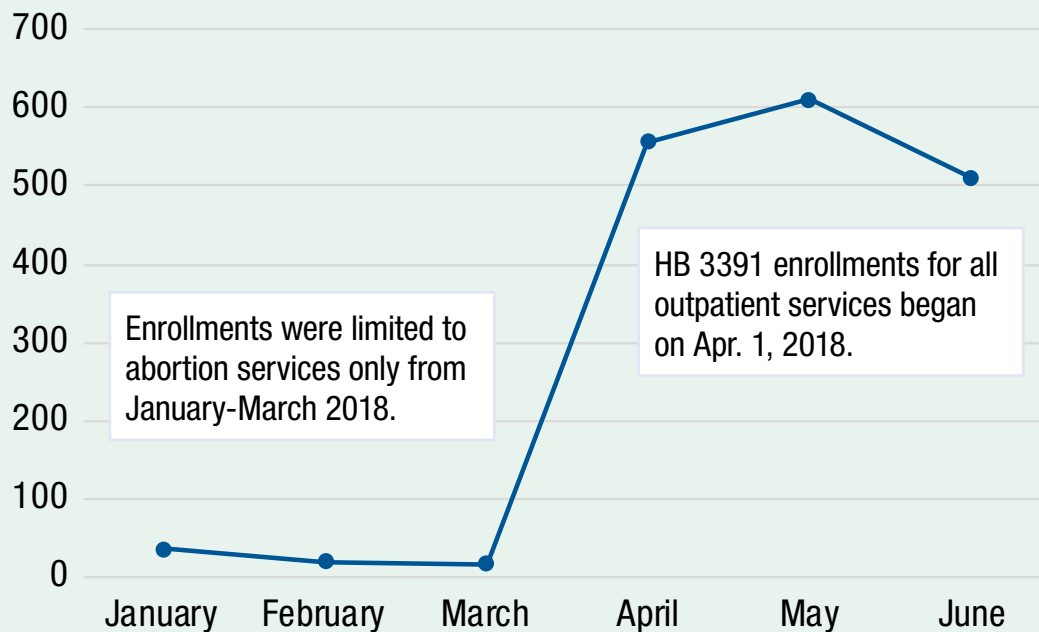
Utilization

Due to the timing of this initial report, limited utilization data are available. The RH Program has developed a vigorous evaluation matrix for long-term evaluation of HB 3391 (Appendix I).

Enrollment for clinic-based services

Enrollment for clinic-based abortion services began January 2018. Enrollment for the full suite of clinic-based reproductive health services began April 2018. As of Jul. 1, 2018, a total of 1,748 HB 3391-eligible individuals were enrolled in the RH Program (see Graph 1 below).

Graph 1. HB 3391 enrollments into RH Program, 2018



Outpatient clinic-based reproductive health services

Coverage for clinic-based reproductive health services began April 2018. In the first two months of claims processing for clinic-based services under HB 3391 (excluding abortion services), the RH Program paid 879 claims. These claims include visits for services such as:

- Cervical cancer screenings;
- STI screenings;
- Well-woman visits; and
- Contraception services.

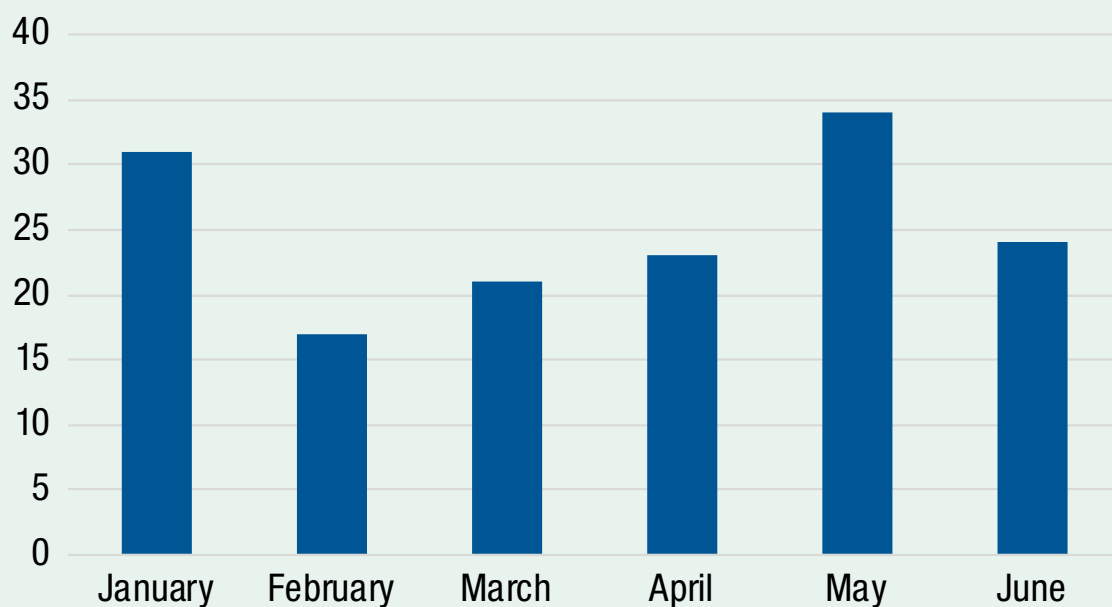
The RH Program has a 12-month timely filing deadline and thus these data are very preliminary.

Abortion services

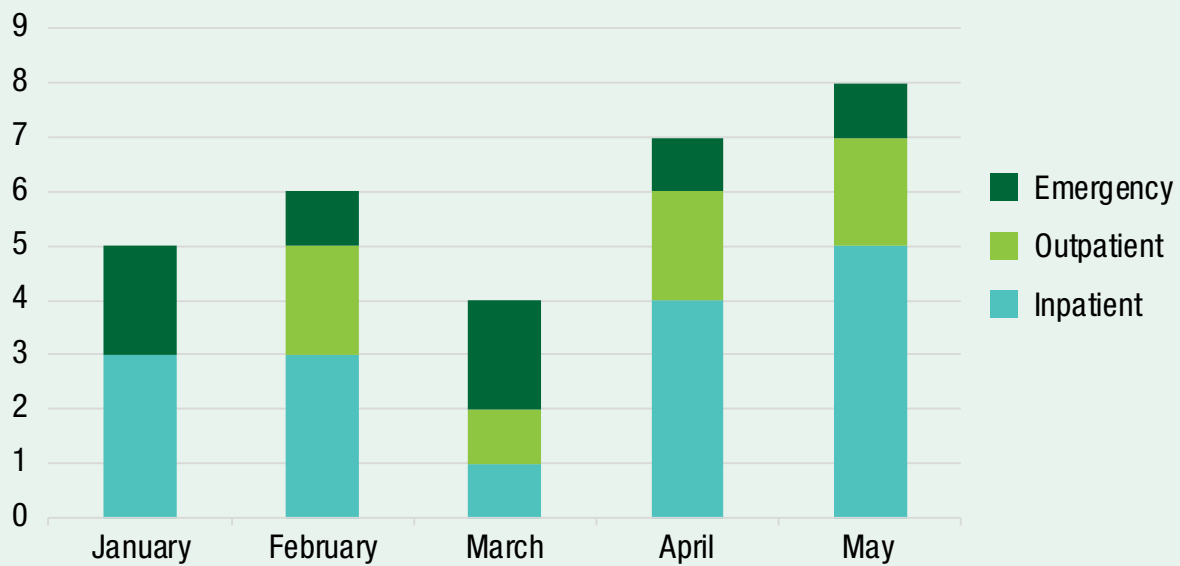
The RH Program has paid 260 claims for dates of service Jan. 1, 2018 through Jun. 30, 2018. This includes:

- 151 claims for abortion procedures;
- 25 claims for pre-abortion visits; and
- 84 claims for post-abortion follow-up visits.

Graph 2. Clinic-based abortion procedures billed to the RH Program under HB 3391, 2018



Graph 3. Hospital-based abortion procedures billed through CAWEM Plus under HB 3391, 2018

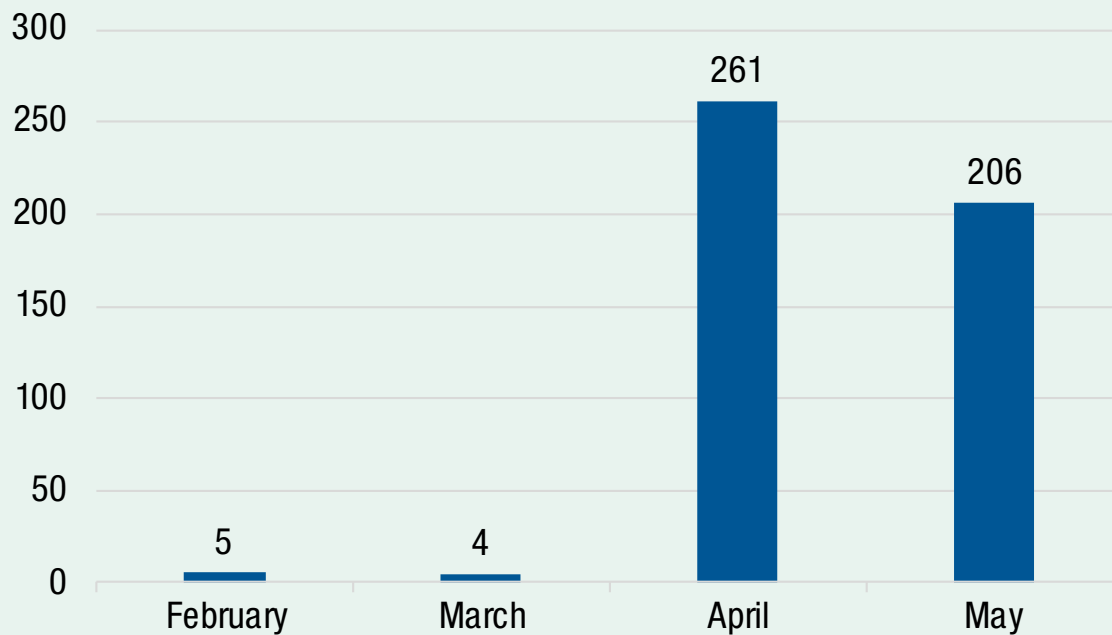


Please note that the RH Program has a 12-month timely filing deadline. Therefore, these figures are preliminary and won't necessarily align with client enrollment figures. Graph 2 shows the number of abortion procedures billed to the RH Program (excluding other abortion-related visits). Hospital-based abortion procedures are billed through CAWEM Plus and are shown separately in Graph 3 below.

Postpartum services

Postpartum full benefit coverage for CAWEM Plus recipients began April 2018. 476 women have been enrolled in this postpartum benefit package, thus far. OHA will monitor the receipt of postpartum visits and postpartum contraception, including immediate postpartum LARC services.

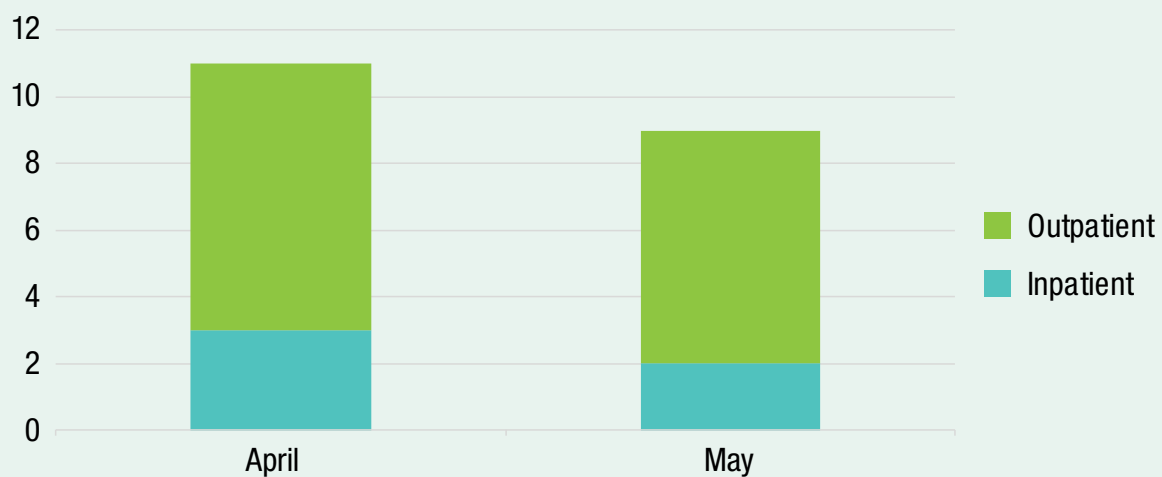
Graph 4. HB 3391 60-day postpartum coverage enrollments, 2018



Female sterilization services

Coverage for female sterilization services began April 2018. Thus far, 20 sterilization procedures have been billed through CAWEM and CAWEM Plus for HB 3391-eligible individuals. Submitted claims can take 90-180 days to complete processing, so these data are preliminary.

Graph 5. Female sterilization services under HB 3391, 2018



Challenges and opportunities

As one of the first states to comprehensively expand access to reproductive health care through legislative action, HB 3391 has served as a model for other states. Oregon's implementation efforts provide useful lessons for ongoing efforts within the state to ensure access to high-quality, client-centered health care and for other states embarking on a similar path.

HB 3391 lacked any language or funding related to outreach, education, and community partner engagement. Section 5 expanded coverage for a traditionally underserved population – individuals without eligible immigration status. Given the importance of connecting with communities not generally engaged with or connected to health care, it is essential to do active, multi-component messaging that is community-specific, and culturally and linguistically responsive. The RH Program, in collaboration with DHS' Community Partner Outreach Program, has been able to leverage small amounts of existing funds and partnership networks to convene stakeholders, share information and develop materials.

The RH Program has also relied on staff time and resources from community-based partner and provider organizations already stretched thin by competing needs. To make measurable progress in reaching and connecting immigrant populations with newly expanded coverage, there needs to be significant investments in education and awareness campaigns that are conducted at the local level.

Section 5 of the bill expands coverage specifically for individuals who are eligible for medical assistance, if not for their immigration status. This includes, but is not limited to undocumented individuals, those with DACA status and those with lawful permanent resident status of less than five years. Recent federal policy actions around immigration have both heightened awareness and concerns for immigrant privacy. In 2017, the RH Program contracted with two Regional Health Equity Coalitions (RHECs) to conduct focus groups for a Latino sexual health needs assessment with community members in Linn, Benton and Jackson Counties.

One of the predominant themes in each of the focus groups was fear around immigration enforcement. Below are examples of immigration concerns shared by focus group participants:

“I think that whenever you have to go somewhere that you sign forms, you’re scared if you’re not legal. No matter what.”

“When you go to the clinic they always ask your information, name, where do you live [...] and I believe that the excess of information is something that intimidates people, for those without papers.”

“Now people think that if they go to some places [these places] will provide information to Immigration.”

Anecdotal evidence suggests that fear for the safety of their families and themselves prevents individuals without eligible immigration status from seeking care. Further concerns about sharing personal information, such as address and social security number, on the RH Program Enrollment Form and OHP Application have also been reported as deterrents for enrolling in coverage. Similar fears and concerns have been expressed with regards to the implementation efforts of SB 558 (Cover All Kids) which extends full OHP benefit coverage to children and teens younger than 19 who have DACA or undocumented status. Staff from OHA, DHS, and the Department of Justice (DOJ) have been working closely to address concerns and questions related to data privacy and immigration status. Over the past six months they have worked on the development of processes for data collection and sharing related to HB 3391 and SB 558, as well as education for community partners and providers. The DOJ provided guidance regarding the legal limits of data privacy and information sharing. Meanwhile, both OHA and DHS are engaged in ongoing discussions and decision-making to be able to provide both transparent and accurate information to the public. It is essential that state agencies continue to work to address this issue in a thoughtful, coordinated manner to preserve the community’s trust.

Conclusion

With HB 3391, Oregon has the opportunity to serve as a national model for the provision of comprehensive reproductive health services. By integrating services across state agencies and leveraging existing funding streams, Oregon is assuring access to timely, client-centered preventive reproductive health services. This will save state resources by reducing unintended pregnancies and supporting the life-long health of Oregonians.

Appendix A: House Bill 3391

79th OREGON LEGISLATIVE ASSEMBLY--2017 Regular Session

Enrolled House Bill 3391

Sponsored by Representatives BARKER, WILLIAMSON, FAHEY, Senators DEVLIN, MONNES ANDERSON; Representatives ALONSO LEON, BOONE, GOMBERG, HELM, HERNANDEZ, HOLVEY, KENY-GUYER, LININGER, MALSTROM, MARSH, MCLAIN, MEEK, NOSSE, PILUSO, POWER, RAYFIELD, REARDON, SANCHEZ, SMITH WARNER, SOLLMAN, WITT, Senators BEYER, DEMBROW, FREDERICK, GELSER, MANNING JR, PROZANSKI, RILEY, STEINER HAYWARD, TAYLOR

CHAPTER

AN ACT

Relating to reproductive health care; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2017 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a) “Contraceptives” means health care services, drugs, devices, products or medical procedures to prevent a pregnancy.

(b) “Enrollee” means an insured individual and the individual’s spouse, domestic partner and dependents who are beneficiaries under the insured individual’s health benefit plan.

(c) “Health benefit plan” has the meaning given that term in ORS 743B.005, excluding Medicare Advantage Plans and including health benefit plans offering pharmacy benefits administered by a third party administrator or pharmacy benefit manager.

(d) “Religious employer” has the meaning given that term in ORS 743A.066.

(2) A health benefit plan offered in this state must provide coverage for all of the following services, drugs, devices, products and procedures:

(a) Well-woman care prescribed by the Department of Consumer and Business Services by rule consistent with guidelines published by the United States Health Resources and Services Administration.

(b) Counseling for sexually transmitted infections, including but not limited to human immunodeficiency virus and acquired immune deficiency syndrome.

(c) Screening for:

(A) Chlamydia;

(B) Gonorrhea;

(C) Hepatitis B;

(D) Hepatitis C;

(E) Human immunodeficiency virus and acquired immune deficiency syndrome;

(F) Human papillomavirus;

(G) Syphilis;

(H) Anemia;

(I) Urinary tract infection;

(J) Pregnancy;

- (K) Rh incompatibility;
- (L) Gestational diabetes;
- (M) Osteoporosis;
- (N) Breast cancer; and
- (O) Cervical cancer.

(d) Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated.

(e) Screening and appropriate counseling or interventions for:

- (A) Tobacco use; and
- (B) Domestic and interpersonal violence.
- (f) Folic acid supplements.
- (g) Abortion.

(h) Breastfeeding comprehensive support, counseling and supplies.

(i) Breast cancer chemoprevention counseling.

(j) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, subject to all of the following:

(A) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, a health benefit plan may provide coverage for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(B) If a contraceptive drug, device or product covered by the health benefit plan is deemed medically inadvisable by the enrollee's provider, the health benefit plan must cover an alternative contraceptive drug, device or product prescribed by the provider.

(C) A health benefit plan must pay pharmacy claims for reimbursement of all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(D) A health benefit plan may not infringe upon an enrollee's choice of contraceptive drug, device or product and may not require prior authorization, step therapy or other utilization control techniques for medically appropriate covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(k) Voluntary sterilization.

(L) As a single claim or combined with other claims for covered services provided on the same day:

(A) Patient education and counseling on contraception and sterilization.

(B) Services related to sterilization or the administration and monitoring of contraceptive drugs, devices and products, including but not limited to:

- (i) Management of side effects;
- (ii) Counseling for continued adherence to a prescribed regimen;
- (iii) Device insertion and removal; and
- (iv) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the enrollee's provider.

(m) Any additional preventive services for women that must be covered without cost sharing under 42 U.S.C. 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services as of January 1, 2017.

(3) A health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage required by this section. A health care provider shall be reimbursed for providing the services described in this section without any deduction for coinsurance, copayments or any other cost-sharing amounts.

(4) Except as authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required by this section.

(5) This section does not exclude coverage for contraceptive drugs, devices or products prescribed by a provider, acting within the provider's scope of practice, for:

(a) Reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause; or

(b) Contraception that is necessary to preserve the life or health of an enrollee.

(6) This section does not limit the authority of the Department of Consumer and Business Services to ensure compliance with ORS 743A.063 and 743A.066.

(7) This section does not require a health benefit plan to cover:

(a) Experimental or investigational treatments;

(b) Clinical trials or demonstration projects, except as provided in ORS 743A.192;

(c) Treatments that do not conform to acceptable and customary standards of medical practice;

(d) Treatments for which there is insufficient data to determine efficacy; or

(e) Abortion if the insurer offering the health benefit plan excluded coverage for abortion in all of its individual, small employer and large employer group plans during the 2017 plan year.

(8) If services, drugs, devices, products or procedures required by this section are provided by an out-of-network provider, the health benefit plan must cover the services, drugs, devices, products or procedures without imposing any cost-sharing requirement on the enrollee if:

(a) There is no in-network provider to furnish the service, drug, device, product or procedure that is geographically accessible or accessible in a reasonable amount of time, as defined by the Department of Consumer and Business Services by rule consistent with the requirements for provider networks in ORS 743B.505; or

(b) An in-network provider is unable or unwilling to provide the service in a timely manner.

(9) An insurer may offer to a religious employer a health benefit plan that does not include coverage for contraceptives or abortion procedures that are contrary to the religious employer's religious tenets only if the insurer notifies in writing all employees who may be enrolled in the health benefit plan of the contraceptives and procedures the employer refuses to cover for religious reasons.

(10) If the Department of Consumer and Business Services concludes that enforcement of this section may adversely affect the allocation of federal funds to this state, the department may grant an exemption to the requirements but only to the minimum extent necessary to ensure the continued receipt of federal funds.

(11) An insurer that is subject to this section shall make readily accessible to enrollees and potential enrollees, in a consumer-friendly format, information about the coverage of contraceptives by each health benefit plan and the coverage of other services, drugs, devices, products and procedures described in this section. The insurer must provide the information:

(a) On the insurer's website; and

(b) In writing upon request by an enrollee or potential enrollee.

(12) This section does not prohibit an insurer from using reasonable medical management techniques to determine the frequency, method, treatment or setting for the coverage of services, drugs, devices, products and procedures described in subsection (2) of this section, other than coverage required by subsection (2)(g) and (j) of this section, if the techniques:

(a) Are consistent with the coverage requirements of subsection (2) of this section; and

(b) Do not result in the wholesale or indiscriminate denial of coverage for a service.

SECTION 3. No later than September 15, 2019, the Department of Consumer and Business Services shall report to the interim committees of the Legislative Assembly related to health on the degree of compliance by insurers with section 2 of this 2017 Act and of any actions taken by the department under ORS 731.988 to enforce compliance with section 2 of this 2017 Act.

SECTION 4. Section 5 of this 2017 Act is added to and made a part of ORS chapter 414.

SECTION 5. (1) The Oregon Health Authority shall administer a program to reimburse the cost of medically appropriate services, drugs, devices, products and procedures described in section 2 of this 2017 Act, for individuals who can become pregnant and who would be eligible for medical assistance if not for 8 U.S.C. 1611 or 1612.

(2) The authority shall provide the medical assistance for pregnant women that is authorized by Title XXI, section 2112, of the Social Security Act (42 U.S.C. 1397ll) for 60 days immediately postpartum.

(3) The authority shall collect data and analyze the cost-effectiveness of the services, drugs, devices, products and procedures paid for under this section.

(4) The authority, in collaboration with the Department of Consumer and Business Services if necessary, shall explore any and all opportunities to obtain federal financial participation in the costs of implementing this section, including but not limited to waivers or demonstration projects under Title X of the Public Health Service Act or Title XIX or XXI of the Social Security Act. However, the implementation of this section is not contingent upon the authority's receipt of a waiver or authorization to operate a demonstration project.

SECTION 6. Not later than September 15, 2018, the Oregon Health Authority shall report to the interim committees of the Legislative Assembly related to health on the implementation of section 5 of this 2017 Act.

SECTION 7. (1) An individual may not, on the basis of actual or perceived race, color, national origin, sex, sexual orientation, gender identity, age or disability, be excluded from participation in, be denied the benefits of or otherwise be subjected to discrimination by any health benefit plan issued or delivered in this state, in the receipt of medical assistance as defined in ORS 414.025 or in the coverage of or payment for the services, drugs, devices, products and procedures described in section 2 of this 2017 Act.

(2) Violation of this section is an unlawful practice under ORS 659A.403.

(3) Nothing in this section shall be construed to invalidate or limit the rights, remedies, procedures or legal standards available to individuals under ORS 659A.820 or 659A.885 or to supersede state or local laws that provide additional protections against discrimination on any basis described in subsection (1) of this section.

SECTION 8. A public body as defined in ORS 174.109 or, except as provided in ORS 435.225, an officer, employee or agent of a public body may not:

(1) Deprive a consenting individual of the choice of terminating the individual's pregnancy;

(2) Interfere with or restrict, in the regulation or provision of benefits, facilities, services or information, the choice of a consenting individual to terminate the individual's pregnancy;

(3) Prohibit a health care provider, who is acting within the scope of the health care provider's license, from terminating or assisting in the termination of a patient's pregnancy; or

(4) Interfere with or restrict, in the regulation or provision of benefits, facilities, services or information, the choice of a health care provider, who is acting within the scope of the health care provider's license, to terminate or assist in the termination of a patient's pregnancy.

SECTION 9. The Health Evidence Review Commission shall review the coverage described in section 2 (2) of this 2017 Act and, no later than November 1 of each even-numbered year, report to the interim committees of the Legislative Assembly related to health any recommended changes to the coverage described in section 2 (2) of this 2017 Act based upon the latest clinical research.

SECTION 10. (1) As used in this section, "health benefit plan" has the meaning given that term in section 2 of this 2017 Act.

(2) In consultation with the Department of Consumer and Business Services, the Oregon Health Authority shall design a program to provide statewide access to abortion coverage for

Oregon residents enrolled in health benefit plans described in section 2 (7)(e) and (9) of this 2017 Act.

(3) In developing the design of the program described in subsection (2) of this section, the authority and the department shall consult with consumer advocates, insurers transacting insurance in this state that offer the health benefit plans described in section 2 (7)(e) and (9) of this 2017 Act and other stakeholders.

(4) The authority, in collaboration with the department, shall:

(a) If funding is available, take any actions authorized by state law to implement the program described in subsection (2) of this section; and

(b) Not later than November 1, 2017, report to the Speaker of the House of Representatives, the President of the Senate and the interim committees of the Legislative Assembly related to health:

(A) Any actions taken by the authority under paragraph (a) of this subsection; and

(B) Recommendations for legislative changes necessary to fully implement the program described in subsection (2) of this section.

SECTION 11. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2017, out of the General Fund, the amount of \$10,195,935, which may be expended for carrying out the provisions of section 5 of this 2017 Act.

SECTION 12. Section 2 of this 2017 Act applies to health benefit plan policies or certificates issued, renewed, modified or extended on or after January 1, 2019.

SECTION 13. (1) Sections 5 and 9 of this 2017 Act become operative on January 1, 2018.

(2) The Oregon Health Authority shall take any action before January 1, 2018, that is necessary for the authority to implement the provisions of sections 5 and 9 of this 2017 Act on or after January 1, 2018.

SECTION 14. Section 10 of this 2017 Act is repealed on January 2, 2019.

SECTION 15. This 2017 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2017 Act takes effect on its passage.

Passed by House July 1, 2017

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Koteck, Speaker of House

Passed by Senate July 5, 2017

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2017

Approved:

.....M.,....., 2017

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2017

.....
Dennis Richardson, Secretary of State

Appendix B: Hearing officer's report for administrative rules for reproductive health services

PUBLIC HEALTH DIVISION
Center for Health Protection
Kate Brown, Governor



800 NE Oregon Street
Portland, OR 97232
Voice: (971) 673-1222
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DATE: March 1, 2018

TO: Hearing Attendees and Commenters –
Oregon Administrative Rules chapter 333, division 4 – "Oregon
Reproductive Health Program Coverage of Reproductive Health Services"

FROM: Jana Fussell, Hearing Officer

cc: Helene Rimberg, Manager
Adolescent, Genetic and Reproductive Health Section

Brittany Hall
Administrative Rules Coordinator

SUBJECT: Presiding Hearing Officer's Report on Rulemaking Hearings and Public
Comment Period

Hearing Officer Report

Date of Hearing: February 22, 2018

Purpose of Hearing: The Oregon Health Authority (OHA), Public Health Division is permanently adopting OAR 333-004-2000 through 333-004-2190 related to coverage of reproductive health services.

Oregon Laws 2017, chapter 721 requires the Oregon Health Authority (OHA) to administer a program to reimburse for the cost of medically appropriate services, drugs, devices, products, and procedures, including abortion, for individuals who can become pregnant and would be eligible for medical assistance if not for 8 U.S.C. 1611 or 1612. This program will be administered by the Reproductive Health (RH) Program, and is to be implemented April 1, 2018. In light of this new program, the RH Program is re-organizing its structure to reduce administrative burden on both enrolled providers and clients. In order to implement the new structure on April 1, 2018, the RH Program, as part of the OHA, proposes to adopt permanent rules for the coverage of all services provided under the RH Program, including those detailed in Oregon Laws 2017, chapter 721, those covered by the state's family planning Medicaid waiver program Oregon ContraceptiveCare or CCare, and the state's Title X grant. These rules mirror, in their

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Oregon Reproductive Health Program
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entirety, temporary rules under the same rule numbers filed with the Secretary of State effective December 22, 2017.

The rules pertain to client eligibility and enrollment procedures; covered and excluded services; agency (provider) enrollment, responsibilities, and termination; billing and claims; payment; compliance with federal and state statutes; and agency audits and appeals processes.

Hearing Officer: Jana Fussell

Testimony Received: One individual provided oral and written comments at the hearing. These comments are briefly summarized as follows:

Kalpana Krishnamurthy, National Field and Policy Director, Forward Together

Ms. Krishnamurthy's written comments are attached to this report as "Exhibit 1".

Ms. Krishnamurthy noted her organization's support of the Oregon Reproductive Health Equity Act (RHEA), HB 3391, but expressed concern about hearing "some lawmakers voice opposition to the legislation using racial stereotypes about Asian women and abortion" during the floor debate. She disputed the stereotype that Asian communities are more likely to have sex-selective abortion and noted efforts to "introduce sex-selection abortion bans into law in Oregon and across the country." Her written testimony sets out six principles that Forward Together, along with its partners at the Asian Pacific American Network of Oregon, believes will help the agency develop administrative rules to implement RHEA fairly and to "ensure access without judgment and racial stereotyping."

Agency response: The Reproductive Health (RH) Program appreciates the written testimony submitted by Forward Together in response to proposed OARs 333-004. The RH Program will take under consideration the six principles proposed by the organization in its operationalization of the rules in order to ensure access to high-quality, patient-centered, and culturally-appropriate care.

Other Comments: One additional individual submitted written comments to the Authority within the period allotted for public comment. These comments are briefly summarized as follows:

Jennie Hawthorn Mayes, Programs Director, Daisy C.H.A.I.N. Mothering

Ms. Mayes' written comments are attached to this report as "Exhibit 2". The comments identify specific proposed rule provisions where she recommends the inclusion of language that addresses lactation or a trauma informed care training requirement.

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Agency response: The RH Program appreciates the written testimony submitted by Daisy C.H.A.I.N. in response to proposed OARs 333-004. In her testimony, Ms. Mayes suggests the inclusion of comprehensive lactation support, including consultation and education, as a covered service in the rules. However, it should be noted that the funding streams administered by the RH Program do not cover lactation services. Lactation support services under the Reproductive Health Equity Fund (HB 3391) are included under the 60-day post-partum medical coverage for women enrolled in the state's CAVEM Plus program.

Ms. Mayes also suggests adding training on trauma informed care to the administrative requirements as part of the certification requirements for reproductive health services. The RH Program appreciates the suggestion and will consider ways to incorporate training and technical assistance related to trauma informed care to agencies through a variety of mechanisms, including the RH Program orientation and annual Reproductive Health Coordinators' meeting.

received 2/22/18

Thank you for having me here today. My name is Kalpana Krishnamurthy and I am the national field and policy director at Forward Together. We work in Oregon and nationally to win rights, recognition and resources so all families can thrive. We focus on issues of healthcare, family recognition and building safe communities. We are here today to talk about the rulemaking process for the Oregon Reproductive Health Equity Act, HB 3391.

As part of the coalition that supported HB 3391, Forward Together was thrilled when RHEA passed last year. RHEA is the first legislation in the US to comprehensively address systemic barriers to accessing reproductive health care, expanding coverage to thousands of Oregonians throughout the state – regardless of income, citizenship status or gender identity.

During the floor debate around RHEA, Forward Together was concerned to hear some lawmakers voice opposition to the legislation using racial stereotypes about Asian women and abortion. We come here today to share our belief that racial stereotypes have no place in healthcare. Forward Together believes the rulemaking process of RHEA is an important step in ensuring reproductive healthcare access for all communities.

The idea that Asian families prefer boys over girls is the stereotype that underlies the belief that Asian communities are more likely to have a sex-selective abortion. In reality, studies show immigrant Indian, Chinese, and Korean American women actually have more girls overall than Whites in the United States. But legislators opposed to abortion access don't care about the facts and have tried to introduce sex-selective abortion bans into law in Oregon and across the country.

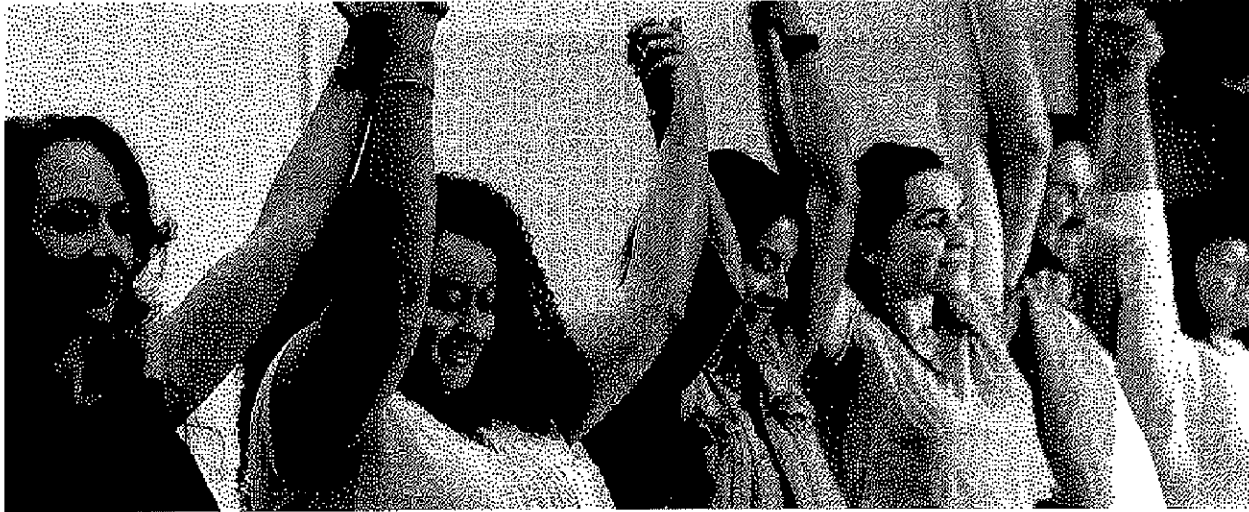
Forward Together, along with our partners at the Asian Pacific American Network of Oregon, developed key principles that we believe can help the Oregon Health Authority public health division in developing the rules to implement RHEA fairly. We believe that rules to govern the program should be based in the following principles:

1. Racial profiling has no place in the provision of health care.
2. Abortion is a part of reproductive health care.
3. The reasons why a patient is seeking an abortion are private. All rules and processes should reinforce patient confidentiality.
4. Throughout a pregnancy, pregnant individuals must have accurate information to be able to make decisions about what is best for them and their family, with the advice of a health care professional they trust.
5. It's important that patients can talk to their doctors about their healthcare options without politicians restricting or intruding with mandatory information or required documentation about those conversations.
6. No guidelines should implicitly or explicitly encourage or mandate healthcare providers to inquire about the reason someone is seeking an abortion.

We believe that if the rules to administer and implement RHEA follow these simple principles, they will help ensure access without judgement and racial stereotyping. Given the many barriers that Asian communities face in getting health care—from language access and translation, to affordability, to cultural competency of the provider—the last thing we need is racial profiling at the doctor's office.

Thank you.

300 Frank H. Ogawa Plaza, Suite 700, Oakland, CA 94612 510 663 8300 www.forwardtogether.org @fwdtogether



The coalition working to pass the Reproductive Health Equity Act (HB 3391) included organizations working with communities of color, immigrants and refugees, LGBTQ organizations, reproductive health and rights groups, and more.

Implementing RHEA

What is HB 3391, the Oregon Reproductive Health Equity Act?

The passage of HB 3391, also known as the Reproductive Health Equity Act (RHEA), ensures that Oregonians, regardless of income, citizenship status, gender identity or type of insurance, have access to the full range of preventive reproductive health services, including family planning, abortion and post-partum care.

The Reproductive Health Equity Act was supported by a diverse coalition of organizations; Forward Together and Asian Pacific American Network of Oregon (APANO) served as members of the coalition steering committee.

What has happened so far with RHEA and what is next?

The part of RHEA that addresses discrimination went into effect in August 2017, and coverage for abortion services for undocumented community members began in January 2018. By April 2018, all other reproductive health services for undocumented individuals

Reproductive justice is achieved when all people have the social, economic and political power and resources to make healthy decisions about our bodies, gender and sexuality for ourselves and our families.

will be piloted. Changes to cost sharing requirements for private insurance plans will take effect in January 2019.¹ Over the next year, RHEA will be fully implemented.

What are sex-selective abortion bans and how do they impact RHEA?

Sex-selective abortion bans are a ruse. Sex-selective abortion bans require healthcare providers to refuse to provide abortion if they think the patient is making a decision based on the sex of the fetus. **These bans actually target and attack abortion care providers and are built on racial stereotypes about Asian American communities.** Sex-selective abortion bans assume

1. What is the Reproductive Health Equity Act (HB 3391)? Public Health Division of the Oregon Health Authority. Accessed 1/24/2018.
2. Replacing Myths with Facts: Sex Selective Abortion Laws in the United States. NAPAWF, International Human Rights Clinic, University of Chicago Law School, and Advocating New Standards in Reproductive Health (ANSRH). June 2014.

that specific Asian American communities have sex-selective abortions because they prefer boys. In reality, studies show that in the United States immigrant Indian, Chinese and Korean American women actually have more girls overall than White women do.³

Each year since 2013, legislators opposed to abortion have introduced sex-selective abortion legislation in our state. Already in 2018, legislators have introduced HB 4101, while in 2017, Oregon saw the introduction of HB 2588 and SB 541, all bills that would have prohibited a person from performing a “late-term” sex-selective abortion. As organizations that work with Asian-Pacific Islander (API) families, both APANO and Forward Together opposed the 2017 legislation and all previous versions.

In addition to the introduction of sex-selective abortion legislation in Oregon, **APANO and Forward Together were very concerned to see sex-selective abortion rhetoric creep its way into the fight for RHEA**, both through statements made by Sen. Knopp and by Sen. Thatcher during the Senate floor debate, as well as in media coverage of RHEA that quoted anti-abortion lawmakers’ talking points.

During the Senate floor debate on RHEA, anti-abortion lawmakers used phrases like “protecting baby girls from being killed” as a way to cue stereotypes about Asian communities. In addition, media coverage of RHEA evoked the myth of sex-selective abortion through statements like: “If a woman wants to kill her unborn daughter because she wanted a son, her insurer has no choice but to cover that.”⁴

Neither the statements made in the media nor by those opposed to RHEA about so-called sex-selective abortions are true. Rather, they are part of a larger narrative built on harmful stereotypes that criminalize Asian and Asian American communities seeking care. Opponents of abortion use sex-selective abortion rhetoric as a tool to chip away at abortion access.

3. Oregon’s Radical, Grisly Law Abortion Law, *National Review*, July 13, 2017.

Shared Principles for Reproductive Health Access in Rulemaking

Given the way that the myth of sex-selective abortion showed up in the fight for RHEA, APANO and Forward Together want to ensure that implementation of RHEA does not rely on any false assumptions and stereotypes that create conditions for racial profiling. The rulemaking process is a critical step in ensuring that access to these services is guided by fact.

The following principles can help ensure that stereotypes and false assumptions are not part of implementation of RHEA.

- ✓ Racial profiling has no place in the provision of healthcare.
- ✓ Abortion is a part of reproductive healthcare.
- ✓ The reasons why a patient is seeking an abortion are private. All rules and process should reinforce patient confidentiality.
- ✓ Throughout a pregnancy, pregnant individuals must have accurate information to be able to make decisions about what is best for them and their family, with the advice of a healthcare professional who they trust.
- ✓ It’s important that patients can talk to their doctors about their healthcare options without politicians restricting or intruding with mandatory information or required documentation about those conversations.
- ✓ No guidelines should implicitly or explicitly encourage or mandate healthcare providers to inquire about the reason someone is seeking an abortion.

FORWARD TOGETHER works in Oregon and nationally to ensure all families have the rights, recognition and resources they need to thrive. We change culture and policy as a multi-racial organization working at the intersection of race, gender and sexuality. For more information, contact Michele Ruffin at michele@forwardtogether.org, @FwdTogether, FB /fwdtogether.

THE ASIAN PACIFIC AMERICAN NETWORK OF OREGON (APANO) is a statewide, grassroots organization, uniting Asians and Pacific Islanders to achieve racial justice. We use our collective strengths to advance equity through empowering, organizing and advocating with our communities. For more information, contact Kara Carmosino, kara@apano.org, @APANONews, FB/APANONews.

Exhibit 2



990 W. 7th Ave Eugene, Oregon 97402 * info@daisychainmothering.org * (541)505-1139



Board of Directors

Gabby Darzi, BS
Postpartum Doula
President

Sophia Ricci
Relief Nursery
Secretary

Lysa Songermano, BS, IBCLC
Relief Nursery

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Paul Wagner, RN

Staff

Jadlyn A Mahoney
Executive Director

Jennie Hawthorn Mayes
Programs Director

Key Volunteers

Susie Ralls, CPA
Volunteer Accountant

Mare Sippel, RN
Volunteer IBCLC

Angela Hoertkorn, RN
Volunteer IBCLC

Simone Schnablor, MS
Eval Coordinator,
Univ. of Oregon
Volunteer Data Entry

Shae Donnelly, BA
4J Young Parent Program
Volunteer Lactation Educator,
Vroom Advisor

February 21, 2018

To whom it concerns,

Included are written comments for proposed rules of Reproductive Health Program.

Comments are in blue.

Thank You,

Jennie Hawthorn Mayes, MA IBCLC
Programs Director

Daisy C.H.A.I.N. Mothering
990 W 7th Ave Eugene 97402
541 505-1139
programs@daisychainmothering.org

Daisy C.H.A.I.N. Mothering is a 501c3 nonprofit charitable organization providing the community with research and evidence-based support services and education for new-mothers and their families. Federal Tax ID #46-1007539

From Human Resources and Service Administration (HRSA): The Women's Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding.

333-004-2010

(30) "Reproductive health services" means preventive services, including family planning, and related drugs, devices, and supplies, to support the healthy reproductive processes, functions and system.

- Suggest including comprehensive lactation support

333-004-2040

(2) Title X covers family planning services that assist individuals in determining the number and spacing of their children, and related preventive health services.

- Suggest including comprehensive lactation support

Section B: Administrative Requirements for Reproductive Health Services

B.7 Required Training

c. At minimum, the agency/RIIC is responsible for providing annual training to staff on the following:

- Suggest trauma informed care training requirement

Section C: Clinical Requirements for Reproductive Health Services

C.1 Collaborative Agreements and Partnerships

b. The agency must maintain current collaborative agreements or partnerships with relevant providers of other health care services, including:

- Suggest adding comprehensive lactation support services

C.3 Clinical and Preventive Services

d. Core services must be offered to clients, as appropriate. Core services are defined as:

- suggest including comprehensive lactation support services

C.7 Education and Counseling Services

b. Clients should be offered client-centered counseling and education on the following:

5. Preconception

A. Pregnancy intention

- Suggest adding Lactation Consultation/Education

c. Pregnant women must be offered information and counseling regarding each of the following options in a neutral, factual and non-directive manner:

- Suggest adding Lactation Consultation/Education

Appendix C: Hearing officer's report for administrative rules for abortion services

PUBLIC HEALTH DIVISION
Center for Health Protection
Kate Brown, Governor



800 NE Oregon Street
Portland, OR 97232
Voice: (971) 673-1222
FAX: (971) 673-1299
TTY: 711

DATE: December 15, 2017

TO: Hearing Attendees and Commenters –
Oregon Administrative Rules chapter 333, division 4 – "Reproductive Health Program Coverage of Pregnancy Termination Services"

FROM: Jana Fussell, Hearing Officer

cc: Helene Rimberg, Manager
Adolescent, Genetic and Reproductive Health Section

Brittany Hall
Administrative Rules Coordinator

SUBJECT: Presiding Hearing Officer's Report on Rulemaking Hearings and Public Comment Period

Hearing Officer Report

Date of Hearing: December 6, 2017

Purpose of Hearing: HB 3391 (Oregon Laws 2017, chapter 721) requires the Oregon Health Authority (Authority) to administer a program to reimburse for the cost of medically appropriate services, drugs, devices, products and procedures, including abortion, for individuals who can become pregnant and would be eligible for medical assistance if not for 8 U.S.C. 1611 or 1612. At this time, the Reproductive Health Program, as part of the Authority, proposes to adopt rules applying to the coverage of pregnancy termination services to be effective January 1, 2018. Additional rules applying for the coverage of the remainder of services detailed in statute will be effective April 1, 2018 and will be adopted under a separate permanent rulemaking. These current proposed rules applying to coverage of pregnancy termination services would be subsumed by the rules to be effective April 1, 2018.

Hearing Officer: Jana Fussell

Testimony Received: No oral testimony was received at the hearing.

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RH Program Coverage of
Pregnancy Termination Services
Hearing Officer Report
Page 1 of 3

Other Comments: Three individuals submitted written comments to the Authority within the period allotted for public comment. These comments are briefly summarized as follows:

Grayson Dempsey, Executive Director, NARAL Pro-Choice Oregon, Oregon Foundation for Reproductive Rights

Ms. Dempsey expressed appreciation for the timely response by the Reproductive Health Program, as part of the Authority, in developing the proposed rules. She made recommendations to the agency in several areas: (1) the need to be “aware of the potential increased risk for people without documentation status in providing personal information to a government agency”; (2) the necessity of providing information that is translated into an individual’s preferred language; and (3) the need to provide an information sheet that explicitly explains what services are excluded for patients who are seeking abortion care.

Ms. Dempsey’s written comments are attached to this report as “Exhibit 1”.

Agency response: The Reproductive Health (RH) Program appreciates the written testimony submitted by NARAL Pro-Choice Oregon/Oregon Foundation for Reproductive Health in response to proposed OARs 333-004. The RH Program will take under consideration the three recommendations proposed by the organization.

Samantha Gladu, Board Vice President, Northwest Abortion Access Fund and Patricia Atwater, Travel Support Manager, Northwest Abortion Access Fund

Ms. Gladu and Ms. Atwater submitted joint comments on behalf of the Northwest Abortion Access Fund. Their comments pose a number of questions. The Authority has responded to these questions. The joint comments and the agency response to the questions raised are attached to this report as “Exhibit 2”.

Ms. Gladu and Ms. Atwater also made a number of observations regarding the proposed rules. In relation to proposed OAR 333-004-1020, they expressed concern about the use of “residency” as an eligibility concept because it “may imply a certain immigration status for some” as opposed to the description of a person who lives in Oregon. In regard to proposed OAR 333-004-1040, they suggested that the term “abortion” be used instead of “pregnancy termination”. They would also like further clarification of what services are available under proposed OAR 333-004-1040. Ms. Gladu and Ms. Atwater also strongly recommended “OHA develop a protocol for clinics outside of Oregon to provide care to Oregonians under HB 3391.”

Agency response: In response to the written testimony submitted by the Northwest Abortion Access Fund to proposed OARs 333-004, the RH Program clarified the

OAR 333-004
RH Program Coverage of
Pregnancy Termination Services
Hearing Officer Report
Page 2 of 3

services covered under 333-004-1040. The Northwest Abortion Access Fund, as noted above, made several other recommendations and raised a number of questions. The RH Program's response to these can be found in a separate letter drafted and sent to Ms. Gladu and Ms. Atwater.

OAR 333-004
RH Program Coverage of
Pregnancy Termination Services
Hearing Officer Report
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NARAL Pro-Choice Oregon

December 6, 2017
Proposed Rulemaking Public Comment
RE: Reproductive Health Program Coverage
of Pregnancy Termination Services

Thank for opportunity to submit testimony and be involved in the rulemaking process.

NARAL Pro-Choice Oregon (NPCO) is dedicated to developing and sustaining a constituency that uses the political process to guarantee every woman and person who can become pregnant the right to make personal decisions regarding the full range of reproductive choices, including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion.

The Oregon Foundation for Reproductive Health (OFRH) is dedicated to improving access to comprehensive reproductive health care, such as preventing unintended pregnancy and planning healthy families. We are committed to advancing reproductive rights and advocating for reproductive health equity in all Oregon communities.

We know access to reproductive health care is critical for the health and economic security of all Oregonians. That's why everyone in Oregon, regardless of income, citizenship status, gender identity or type of insurance, needs access to the full range of reproductive health services, and why NPCO played a critical role in the creation of and work to pass HB 3391 into law.

We appreciate the timely response by the the Reproductive Health Program, as part of the Oregon Health Authority(OHA), with the proposed rules for the coverage of pregnancy termination services, per HB 3391. This will enable coverage of abortion for women who would otherwise be eligible for medical assistance if not for their immigration status to be effective January 1, 2018.

As advocates, we have additional comments for the agency below:

Be aware of the potential increased risk for people without documentation status in providing personal information to a government agency. Provide adequate protection of privacy for individuals enrolling for coverage, via data storage, questions required to enroll, and providing accurate information regarding how OHA interfaces with federal agencies.

Ensure that information on coverage and services are provided to individuals is translated into their preferred language, including written and verbal communications.

Include an information sheet that explicitly explains what the excluded services are particular for patients who are seeking abortion care (*Services not listed in OAR 333-004-1040 are not covered by RH for any eligible client, including complications that require inpatient services*). Work with health centers to learn what are the most frequent occurrence and experiences of their patients to develop what is the most helpful information to include, with examples.

We look forward to continuing to work with OHA to implement HB 3391 and are thankful for the commitment that has been demonstrated so far in ensuring the program works well for health care providers and patients.

Sincerely,

Grayson Dempsey

Grayson Dempsey
Executive Director
NARAL Pro-Choice Oregon
Oregon Foundation for Reproductive Health

December 7, 2017

Brittany Hall, Rules Coordinator
800 NE Oregon St. Suite 930
Portland, OR 97232



Dear Brittany,

Thank you for coordinating the rules process for the Reproductive Health Equity Act. At the Northwest Abortion Access Fund, we help people in Oregon, Washington, Idaho and Alaska to pay for their abortion, get to and from the clinic, and make sure that people traveling for care have a safe place to stay. Every day in our work, we consider the barriers to abortion care. We appreciate the chance to comment and ask questions about the proposed rules.

333-004-1020

- Using "residency" as an eligibility concept internally makes sense, but any marketing or outreach should stress that the only requirement is for a person to live in Oregon, as the term "residency" may imply a certain immigration status for some.
- How was 250% FPL set? Do we know that this will capture the majority of people who are currently not eligible for Medicaid or other insurance programs that pay for abortion?
- How is pregnancy reported/determined? Will proof of pregnancy be required, or will this be self-reported?

333-004-1030

- How will enrollment work in practice? Can a community agency or abortion fund enroll a client? Could a client who forgets to sign the form on the day of their procedure return on a later date to sign?
- Paper forms, online enrollment, or both?
- Will there be an eligibility and/or claims database?
- Why is retroactive enrollment (like OHP) barred?

333-004-1040

- Suggest using the term abortion. Pregnancy termination is a euphemism.
- Up to what gestation is abortion covered? What will happen if a person's EGA is too high for them to be seen in Oregon due to location of providers?
- Does "outpatient settings" include telemedicine?

333-004-1050

- Please clarify what services are listed in OAR 333-004-1040. These rules are not available online.
- Are reaspirations (in the case of failed MAB or TAB) covered?
- Are complications related to contraceptive devices (perforation, infection, etc.) or medications (blood clots, etc.) covered?
- Will ultrasound only appointments be covered/offered?

Northwest Abortion Access Fund | PO Box 10894 | Eugene, OR 97440 | 1-866-692-2310 | nwaafund.org

333-004-1070

- As of 2014, 78% of Oregon counties had no abortion providers and 30% of Oregon women lived in those counties. We often hear from eastern Oregonians that they are closer in proximity to abortion services in Washington or Idaho. We strongly recommend that OHA develop a protocol for clinics outside of Oregon to provide care to Oregonians under HB 3391.

Other

- What will be the effect of these changes, if any, on the package price associated with abortion care? For example, if a patient turns out to be ineligible for the program, how much will they be expected to pay? Will the reimbursement rates (low or high) affect how providers price abortion care?

Thank you for your consideration of these items.

Sincerely,

Samantha Gladu
Board Vice President
Northwest Abortion Access Fund
she/her/hers | samantha@nwaafund.org

Patricia Atwater
Travel Support Manager
Northwest Abortion Access Fund
she/her/hers | patricia@nwaafund.org



PUBLIC HEALTH DIVISION
Oregon Reproductive Health Program
Kate Brown, Governor

Oregon
Health
Authority

800 NE Oregon Street, Suite 370
Portland, OR 97232
Voice: 971-673-0355
Fax: 971-673-0371
www.healthoregon.org/rh

December 13, 2017

Dear Samantha Gladu and Patricia Atwater,

Thank you for submitting written comment in response to the proposed Oregon Administrative Rules (OARs) for the coverage of pregnancy termination services by the Oregon Reproductive Health (RH) Program (333-004-1000 through 333-004-1160). We would like to offer our response to your comments. Also, please note that the referenced OARs are intended to take effect January 1, 2018 through April 1, 2018, at which point, larger, more comprehensive rules regarding the coverage of both abortion services and reproductive health services will be made effective. These more comprehensive rules will be made available for public comment in February, 2018.

333-004-1020

- Using “residency” as an eligibility concept internally makes sense, but any marketing or outreach should stress that the only requirement is for a person to live in Oregon, as the term “residency” may imply a certain immigration status for some.
 - Your suggestion is well-taken. Public facing materials, and those intended for clients and community members in particular, will include culturally acceptable and specific descriptions of eligibility requirements.
- How was 250% FPL set? Do we know that this will capture the majority of people who are currently not eligible for Medicaid or other insurance programs that pay for abortion?
 - 250% FPL aligns with eligibility criteria for the state’s family planning Medicaid waiver, Oregon ContraceptiveCare, and the sliding fee scale requirements associated with Title X.
- How is pregnancy reported/determined? Will proof of pregnancy be required, or will this be self-reported?
 - There will be no requirement upon enrollment that a client indicates pregnancy status whatsoever; it will not be a criterion for enrollment into the program regardless of what services the client is seeking.

333-004-1030

- How will enrollment work in practice? Can a community agency or abortion fund enroll a client? Could a client who forgets to sign the form on the day of their procedure return on a later date to sign?
 - The RH Program will maintain its practice of onsite, same-day enrollment. Enrollment may only occur at the clinic site itself. Retroactive eligibility is prohibited.
- Paper forms, online enrollment, or both?
 - For the near future, enrollment will be facilitated via paper-based enrollment forms. The RH Program does intend to explore the possibility of creating an online enrollment form, though such capacity does not exist now.
- Will there be an eligibility and/or claims database?

- Yes to both questions.
- Why is retroactive enrollment (like OHP) barred?
 - For the purposes of program integrity and auditing procedures, retroactive enrollment is barred. Additionally, because eligibility can be determined at the clinic site, on the day of the client visit, there should be no need for retroactive eligibility.

333-004-1040

- Suggest using the term abortion. Pregnancy termination is a euphemism.
 - We appreciate this suggestion for many reasons, including the term's scientific accuracy and its use in the statutory language of HB 3391 itself. The RH Program will use the term abortion for all materials related to implementation of the broader, more comprehensive set of OARs to be made effective April 1, 2018. The term 'pregnancy termination' will be used only in the proposed rules for January 1, 2018 through April 1, 2018 and Medical Services Agreement that expires April 1, 2018.
- Up to what gestation is abortion covered? What will happen if a person's EGA is too high for them to be seen in Oregon due to location of providers?
 - RH Program coverage of abortion includes any procedures performed by a contracted provider in an outpatient setting. Gestational age limits are set by the clinical guidelines practiced by the contracted providers. The Health Systems Division of the Oregon Health Authority is responsible for coverage of any abortion procedures performed in an inpatient setting and will, similarly, correspond to the clinical practice guidelines adhered to by those facilities. The RH Program will contract with any providers of abortion services within 75 miles of the Oregon state border. The RH Program will not contract with any providers outside of this boundary.
- Does "outpatient settings" include telemedicine?
 - While the RH Program does not currently reimburse for any services provided via telemedicine, the program will work with providers interested in providing telemedicine services to ensure appropriate reimbursement.

333-004-1050

- Please clarify what services are listed in OAR 333-004-1040. These rules are not available online.
 - The RH Program has revised the text of 333-004-1040 to read: 'Medication abortion (MAB) and therapeutic abortion (TAB) procedures, ultrasound services, sedation and anesthesia services, re-aspirations, and certain other services associated with pregnancy termination.' Expanded language regarding coverage of abortion services will be included in the larger, more comprehensive set of rules to be made effective April 1, 2018. Additionally, the claims form to be used by contracted abortion providers details the specific services covered by the RH Program.
- Are re-aspirations (in the case of failed MAB or TAB) covered?
 - Yes.
- Are complications related to contraceptive devices (perforation, infection, etc.) or medications (blood clots, etc.) covered?
 - No, medical complications related to contraceptive devices or medications are not covered by the RH Program. Though a post-abortion visit is.
- Will ultrasound only appointments be covered/offered?
 - Yes.

333-004-1070

- As of 2014, 78% of Oregon counties had no abortion providers and 30% of Oregon women lived in those counties. We often hear from eastern Oregonians that they are closer in proximity to abortion

services in Washington or Idaho. We strongly recommend that OHA develop a protocol for clinics outside of Oregon to provide care to Oregonians under HB 3391.

- This point is well-taken, and as described above, the RH Program will contract with any certified provider within 75 miles of the state's border to ensure access for Oregon residents.

Other

- What will be the effect of these changes, if any, on the package price associated with abortion care? For example, if a patient turns out to be ineligible for the program, how much will they be expected to pay? Will the reimbursement rates (low or high) affect how providers price abortion care?
 - The RH Program's reimbursement rates for covered services provided to eligible clients do not in any way impact the costs and/or charges of abortion care provided to ineligible clients.

We appreciate the opportunity to consider and respond to your comments and questions. If you have any additional comments or questions, please feel free to reach out to the RH Program at rh.program@state.or.us.

Sincerely,

Oregon Reproductive Health Program

Appendix D: Certification Requirements for Reproductive Health Services



Oregon Reproductive Health Program Certification Requirements for Reproductive Health Services Version 1

Introduction

The Oregon Reproductive Health (RH) Program oversees a statewide network of certified health care providers to ensure access to a suite of reproductive health services (preventive reproductive health care, preconception, and contraception). These services are provided to all individuals regardless of race, color, national origin, immigration status, sex, sexual orientation, gender identity, age, or disability.

This document outlines the minimum requirements service providers must meet in order to be certified by the Oregon Health Authority (OHA) RH Program and receive funding per OAR 333-004-2000 through 333-004-2190.

The Certification Requirements provide the foundation for high-quality services based on national standards of care and align with best practices and recommendations for comprehensive client-centered, culturally-responsive preventive care. The Certification Requirements are based on the following:

- Program Requirements for Title X Funded Family Planning Projects
- Nationally Recognized Standards (e.g., US Preventive Services Task Force, US Medical Eligibility Criteria)
- Providing Quality Family Planning Services (QFP) – Recommendations from the Centers for Disease Control and Prevention (CDC), and the Office of Population Affairs (OPA)
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

Background

Oregon has received Title X funds for family planning services since 1970. The purpose of these federal funds is to assist individuals in determining the number and spacing of their children through the provision of affordable, voluntary family planning services. The program is designed to provide contraceptive supplies and information to all who want and need them, regardless of citizenship status, with priority given to persons from low-income families.

In 1999, Oregon applied for and received a Medicaid 1115 waiver for family planning which allowed for an expansion of Medicaid coverage to include more people, and was built on the same quality principles as Title X. This program eventually became Oregon ContraceptiveCare or CCare. As a Medicaid program, clients must be either a U.S. citizen or hold eligible immigration status to receive services under CCare.

In 2017, the Oregon Legislature passed the Reproductive Health Equity Act (HB 3391) in response to community partners advocating for the necessity for all women to receive the full array of reproductive health services without cost sharing. The evolution and convergence of these three foundational funding sources constitutes the Oregon Reproductive Health Program.

Section A: Certification Process for Reproductive Health Services

A.1 Application, Certification, and Renewal Process for Reproductive Health Services

- a. An agency must submit an Application for Certification for Reproductive Health Services and all supporting documents to the RH Program. (Application and instructions are available on the RH Program's website healthoregon.org/rhcertification).
- b. The RH Program will determine if the application is complete and notify the agency of its determination within seven calendar days of receipt of the application.
 1. If the RH Program determines that the application is not complete, the RH Program will notify the agency and the agency will have 30 calendar days to complete their application.
 - A. If the agency does not complete their application within 30 calendar days, their application will be denied.
 - B. The agency may then re-apply or appeal the decision per OAR 333-004-2170.
- c. Once an application is determined to be complete, the RH Program will review the applicable documents and determine if the agency meets the certification requirements.
- d. If the RH Program determines that the certification requirements for reproductive health services are met, the RH Program will inform the agency in writing that the application has been approved and that the agency is certified. This notification will occur no more than 30 calendar days after the RH Program has determined the application to be complete.
- e. Once an application for certification has been approved the RH Program will provide a Medical Services Agreement (MSA) for Reproductive Health Services to be signed by both the Oregon Health Authority and the certified agency.
- f. Certification requirements attested to in the initial application will be verified in an on-site review by the RH Program within one year of approval. (See Section A.2)
- g. If an agency does not meet all requirements in its application for certification for reproductive health services, the RH Program may deny certification.
 1. The RH Program will respond to the agency with a letter of denial providing a clear description of reasons for denial, based on the certification requirements.
 2. An agency may request that the program reconsider the denial of RH Program certification. A request for reconsideration must be submitted in writing to the RH Program within 90 calendar days of the date of the denial letter and must include a detailed explanation of why the applicant believes the Program's decision is an error along with any supporting documentation.
 3. The RH Program shall inform the agency in writing, within 30 calendar days of receipt of the request, whether it has changed its decision.
 4. The agency may appeal this decision per OAR 333-004-2170.
- h. A certified agency must renew its certification annually by completing the RH Program's annual recertification form.

A.2 Verification of Certification Requirements for Reproductive Health Services

- a. The RH Program will conduct an on-site verification review to determine compliance with certification requirements of each approved new agency within one year of application approval.
- b. After the initial on-site verification review, the RH Program will conduct regular on-site compliance reviews for all agencies every three years, based on a schedule developed by the RH Program.
- c. RH Program staff will work with the agency to schedule the on-site verification review at a mutually agreed upon time. The agency will be notified, in writing, a minimum of 30 calendar days before its scheduled on-site verification review.
- d. The onsite review includes, but is not limited to:
 1. Review of enrollment forms, consent forms, and all other forms used in providing reproductive health services;
 2. Review of documents, policies, procedures and protocols;
 3. Chart audit;
 4. On-site clinical observation; and
 5. On-site observation of patient environment and physical environment.
- e. An exit report will be provided at the completion of the review.
 1. Preliminary findings will be presented to the Reproductive Health Coordinator (RHC), designated under Section B.6., the administrator, and other staff interested in attending.
 2. If no certification deficiencies are identified during the review, the RH Program shall indicate as such in the exit report.
 3. If certification deficiencies are identified, the agency will be provided an opportunity to dispute any findings identified during the review at this time.
 4. A timeframe will be determined in which all compliance findings must be addressed.
 5. The RH Program may conduct an on-site follow-up visit to ensure compliance findings have been resolved.
- f. A copy of all the review materials and a final written exit report will be provided to the RHC within 14 calendar days after the exit review.
- g. The RH Program will perform regular billing, enrollment, medical chart audits, and other quality assurance reviews.
- h. The RH Program may conduct a review of the agency without notice of any or all certification requirements for compliance and perform a verification on-site review if the RH Program is made aware of issues of compliance or complaints from any source.
- i. At any time, the agency may request an administrative review of compliance, which includes an on-site visit. The review will be considered a “no-penalty” review with the exception of gross violation or negligence that may result in agency decertification.
- j. The agency must notify the RH Program within seven calendar days of any change that brings the agency out of compliance with the certification requirements.

A.3 Process for Ensuring Compliance

- a. If certification deficiencies are found during any RH Program or agency-initiated review, the agency must:
 1. Submit a plan for corrective action and date for meeting compliance within a 30, 60 or 90 calendar day period, depending on the finding and compliance feasibility; and
 2. Come into compliance by the specified date or the RH Program will issue a letter of non-compliance with notification of suspension or decertification.
- b. Compliance verification may be determined through submission of documentation or through an additional on-site review.
- c. An agency with its certification status suspended may have its suspension lifted once the RH Program determines that compliance with certification requirements for reproductive health services has been achieved satisfactorily.
- d. If compliance findings are not met within the designated 30, 60 or 90 calendar day timeframe, the agency may ask for an extension, providing justification.
- e. If the agency fails to address all compliance findings within 180 calendar days of the date of the initial non-compliance notification, the RH Program may seek to suspend or terminate the agency's certification.
- f. An agency that has been decertified may reapply with an amended application and additional documentation at any time.

Section B: Administrative Requirements for Reproductive Health Services

B.1 Administrative Policies

- a. Agencies must follow written administrative policies approved by the RH Program. A complete set of sample policies is available on the RH Program's website (healthoregon.org/rh).
- b. An agency must adopt or adapt current RH Program administrative policies.
- c. Agencies must update administrative policies within six months of notification of any revisions to the sample policies by the RH Program.
- d. Administrative policies must be approved and signed by agency's authorizing official (AO).
- e. For agencies that do not currently have administrative policies approved by the RH Program, signed policies must be submitted for approval by the RH Program prior to certification.
- f. Agencies must review its administrative policies annually.

B.2 Informed Consent

- a. The informed consent process, provided verbally and supplemented with written materials by the agency, must be presented in a language and style the client understands.
- b. An agency must inform clients that:
 1. Services are provided on a voluntary basis.

2. They cannot be coerced to accept services or to use any particular method of birth control.
3. Receipt of reproductive health services is not a prerequisite to receipt of other services provided by the agency.
- c. Staff must be informed by the agency that they may be subject to prosecution if they coerce clients to receive services per 42 CFR 59.5(a)(2) footnote 1.
- d. An agency must have clients sign an informed consent form annually.

B.3 Confidentiality

- a. Agencies must follow the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, HIPAA Security Rule, and Health Information Technology for Economic and Clinical Health (HITECH) Act.
- b. Services must be provided in a manner that respects the client's privacy and dignity.
- c. Clients must be assured of the confidentiality of services and their medical and legal records.
- d. Services must remain confidential during billing and collecting payments, when requested by clients.

B.4 Linguistic and Cultural Responsiveness

- a. Agencies must have a comprehensive strategy to provide culturally and linguistically appropriate services.
- b. All services, support, and other assistance must be provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, languages, and behaviors of the client receiving services, and in a manner that has the greatest likelihood of ensuring maximum program participation.
- c. The agency must make interpretation services available to all clients needing or requesting such assistance at no cost to the client. Qualified or certified interpretation services are strongly recommended when available.
 1. The agency must notify clients in need of interpretation services of the availability of such services in accordance with the Civil Rights Act of 1964 and sections 1557, 1331 and 1001 of the Affordable Care Act (ACA).
 2. All persons providing interpretation services must adhere to confidentiality guidelines.
 3. Family and friends shall not be used to provide interpretation services, unless requested by the client.
 4. Individuals under age 18 shall never be used as interpreters for clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance.
 5. When possible, the agency shall employ bilingual staff, personnel, or volunteers skilled or certified in the provision of medical and clinical interpretation that meets the needs of clients with limited English proficiency or who otherwise need this level of assistance during all clinic encounters.

- d. The agency shall make easily understandable print materials available to clients and post signage in the languages of groups represented or commonly encountered in the service area.
- e. Culturally and linguistically appropriate health educational materials must be available for clients needing them.
 - 1. All print, electronic, and audiovisual materials shall be appropriate in terms of the client's language and literacy level. A client's need for alternate formats must be accommodated.
- f. A patient bill of rights shall be posted in a public area of the clinic. See the RH Program's website for a sample patient bill of rights (healthoregon.org/rh).

B.5 Federal Requirements Regarding Abortion Services.

- a. An agency may not use federal funds for abortion services.
- b. Abortion may not be provided as a method of birth control.
- c. For agencies that provide abortion services, the agency must have clear policies that require the separation of federal funds (Title X and CCare) from other funds used for abortion services.

B.6 Designation of Reproductive Health Coordinator (RHC)

- a. The agency must designate an individual as the RHC to be the key point of contact in accordance with OAR 333-004-2070(4)(f). The RHC is responsible for:
 - 1. Having an understanding of all aspects of the RH Program and how it is operationalized within all clinic sites, including client enrollment, clinical services, and billing and data submission;
 - 2. Ensuring program compliance at all clinic sites;
 - 3. Responding to requests for information from the RH Program in a timely manner; and
 - 4. Attending the annual Reproductive Health Coordinators' Meeting, and other required trainings and meetings provided by the RH Program.

B.7 Required Training

- a. Orientation to the RH Program is provided to all new agencies by state Program staff within three months of becoming a certified provider of reproductive health services.
- b. The designated RHC at each agency is responsible for coordinating subsequent staff orientation and training.
- c. At minimum, the agency/RHC is responsible for providing annual training to staff on the following:
 - 1. Encouraging family involvement,
 - 2. Relationship safety – counseling on resisting sexual coercion,
 - 3. HIPAA compliance,
 - 4. Mandatory reporting,
 - 5. Cultural responsiveness,
 - 6. Blood borne pathogen prevention, and

7. Emergency management – medical emergencies.

B.8 Review of Informational and Educational Material

- a. All educational material provided to clients who receive reproductive health services must be reviewed by an Information and Education (I&E) committee to determine that material is:
 1. Factually correct;
 2. Suitable for the population or community receiving the information;
 3. Culturally and linguistically appropriate; and
 4. Provided at clients' level of understanding.
- b. There must be documentation of the materials review, including the review outcome.
- c. An agency may maintain and use its own I&E committee, or use the RH Program's statewide I&E committee.

B.9 Community Participation, Education, and Project Promotion

- a. Collaborate with Local Public Health Authorities (LPHAs), community partners, and other RH service providers to:
 1. Identify ways community members will be involved in developing, assessing and/or evaluating the reproductive health services.
 2. Periodically assess the needs of the community with regards to awareness of and need for access to reproductive health services.
 3. Develop and implement a community education and service promotion plan to:
 - A. Enhance the community's understanding of the RH Program; and
 - B. Make known the availability of services.

B.10 Compliance with Federal, State, and Local Laws and Regulations

- a. Agencies must maintain the appropriate level of Clinical Laboratory Improvement Amendments (CLIA) certification.
- b. Agencies must meet the following pharmacy requirements:
 1. Apply for and maintain Community Health Center License from Oregon Board of Pharmacy if agency utilizes RNs for dispensing.
 2. Register and maintain 340B and Apexus Prime Vendor certification.
Reimbursement for supplies at acquisition cost will be based on 340B drug program pricing.
- c. Agencies must comply with all relevant National Voter Registration Act (NVRA) rules. (OAR 165-005-0060 through 165-005-0070).

B.11 Access to Care

- a. All services must be provided in a manner that protects the dignity of the client.
- b. All services must be provided to clients without regard to race, color, national origin, immigration status, sex, sexual orientation, gender identity, age, or disability in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964,

section 1557 of the ACA, the Americans with Disabilities Act (ADA) of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A.

- c. The agency's clinic facility(s) must be compliant with ADA requirements.
- d. Clients must be offered information about where to access free or low-cost primary care services.
- e. Clients in need of full-benefit health insurance coverage, private or public, must be given information about how to obtain health insurance enrollment assistance.

B.12 Quality Assurance / Quality Improvement Process

- a. Agencies must have a documented process to address quality assurance and quality improvement efforts within their clinic(s), per the RH Program's administrative policy.

Section C: Clinical Requirements for Reproductive Health Services

C.1 Collaborative Agreements and Partnerships

- a. The agency must maintain current collaborative agreements or partnerships with relevant agencies to facilitate client access to clinics, such as: Women, Infant, and Children (WIC), Oregon Health Plan (OHP) enrollment assisters, and transportation providers.
- b. The agency must maintain current collaborative agreements or partnerships with relevant providers of other health care services, including:
 - 1. Emergency care,
 - 2. HIV/AIDS care,
 - 3. Treatment agencies,
 - 4. Infertility specialists,
 - 5. Primary care, and
 - 6. Diagnostic services.

C.2 Clinical Protocols

- a. Agencies must follow written clinical protocols for services that are in accordance with QFP, US Medical Eligibility Criteria for Contraceptive Use (US MEC), US Selected Practice Recommendations for Contraceptive Use (US SPR), US Preventive Services Task Force (USPSTF) and other national standards of care. Agencies must cite and follow national standards.
- b. An agency must adopt or adapt current RH Program clinical protocols located on the RH Program's website (healthoregon.org/rh).
- c. Agencies must update clinical protocols within 6 months of notification of any revisions by the RH Program.
- d. Clinical protocols must be approved and signed by agency's Medical Director or Health Officer responsible for the clinic site(s).
- e. For agencies that do not currently have clinical protocols approved by the RH Program, signed protocols must be submitted for approval by the RH Program with the application for certification.

- f. Agency must review its clinical protocols annually.

C.3 Clinical and Preventive Services

- a. Clinical services must operate under the direction of a physician, preferably with experience in reproductive health.
- b. The agency must provide comprehensive medical, informational, educational, social and referral services related to reproductive health services for clients seeking such services.
- c. Appointments for established clients must be available within a reasonable time period, generally less than two weeks. New clients who cannot be seen within this time period must be given the option to be referred to other qualified provider agencies in the area.
- d. Core services must be offered to clients, as appropriate. Core services are defined as:
 - 1. A broad range of contraceptives as defined by the RH Program;
 - 2. Pregnancy testing and options counseling;
 - 3. Counseling and education to assist with achieving or preventing pregnancy;
 - 4. Basic infertility;
 - 5. STI screening and treatment;
 - 6. Preconception health; and
 - 7. Breast and cervical cancer screening.
- e. Clients in need of additional medical or psychosocial services beyond the scope of the agency must be provided information about available local resources.

C.4 Pharmacy / Contraceptive Drugs, Devices, and Supplies

- a. The agency must have a broad range of acceptable and effective approved contraceptive methods and services, including emergency contraception, available to the client on-site during the clinic visit.
- b. Clients must be able to get their first choice of contraceptive method unless there are specific contraindications.
 - 1. Approval from the RH Program must be obtained when unable to provide a long-acting reversible contraceptive (LARC) method(s), and a referral system for the method must be in place.
 - 2. Agencies must have a referral system in place for the provision of vasectomy and female sterilization services.
- c. Birth control methods must be dispensed on-site following Oregon Board of Pharmacy rules (OAR 855-043-0700 through 855-043-0750).
 - 1. RNs may dispense three and no more than six months of a birth control method under a standing order.
 - 2. A client's ongoing use of a birth control method must be under a current written prescription.
- d. The agency must follow written policies and procedures for drug management, including security, acquisition, storage, dispensing and drug delivery, disposal, and record keeping.

- e. The agency must establish procedures to ensure training and continued competencies in the dispensing of drugs by RNs.

C.5 Laboratory

- a. Testing must be available on-site following CLIA rules and regulations.
- b. The agency must have the ability to collect specimens and samples. Samples may be sent off-site to a CLIA-certified laboratory.
- c. Written policies and procedures for laboratory testing following CLIA regulations must be maintained. Staff proficiency testing must be included in the policies.
- d. Written policies and procedures for Infection Control following CDC recommendations must be maintained.

C.6 Medical Emergencies

- a. The agency must maintain a current plan for medical emergencies.

C.7 Education and Counseling Services

- a. Education and counseling services must be provided using a client-centered approach that helps the client clarify their needs and wants, promotes personal choice and risk reduction, and takes into account diverse cultural and socioeconomic factors of the client and psychosocial aspects of reproductive health.
- b. Clients should be offered client-centered counseling and education on the following:
 - 1. Contraceptives
 - 2. STI risk reduction
 - A. Assessment
 - B. Prevention methods
 - 3. Encouraging parental/family involvement in seeking reproductive health services
 - 4. Resisting sexual coercion
 - A. Relationship safety
 - B. Intimate partner violence
 - C. Human trafficking
 - 5. Preconception
 - A. Pregnancy intention
 - 6. Abstinence
 - 7. Infertility
- c. Pregnant women must be offered information and counseling regarding each of the following options in a neutral, factual and non-directive manner:
 - 1. Prenatal care and delivery
 - 2. Infant care, foster care, or adoption
 - 3. Abortion
- d. A written brochure with pregnancy options information and referrals to agencies that provide services in a factual and non-directive manner must be offered and provided upon request.
- e. Agency staff must make referrals for clients for additional counseling, as needed.

Section D: Fiscal and Billing Requirements for Reproductive Health Services

D.1 Compliance with Federal, State, and Local Requirements

- a. The agency must comply with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled “Audits of States, Local Governments and Non-profit Organizations”.
- b. The agency must follow the written fiscal policy in accordance with RH Program-approved administrative policies. A sample fiscal policy is located on the RH Program’s website (healthoregon.org/rh).
- c. For agencies that don’t currently have fiscal policies approved by the RH Program, signed policies must be submitted for approval by the RH Program with their application for certification.
- d. Provider agencies are required to submit quarterly revenue and expenditure reports using forms provided by the OHA.

D.2 Billing Requirements

- a. The agency must be able to submit claims to the RH Program claims processing vendor (currently Ahlers and Associates).
- b. The agency has a legal obligation to seek third party reimbursement, if applicable. The agency:
 1. Must be enrolled with and be able to bill the (OHP);
 2. Must be credentialed with and able to bill private insurance companies; and
 3. Must provide assurance of confidentiality, when indicated.
- c. Agencies may not request a deposit from the client in advance of services covered by RH Program.

D.3 Payment

- a. Reimbursement from the RH Program for services provided to eligible clients under OAR 333-004-2020 must be accepted as payment in full with no charge to the client.
- b. Clients can be billed for services that are outside of the RH Program scope of services as defined in OAR 333-004-2040.
- c. The agency must notify clients prior to the visit that they may be billed for services not covered by the RH Program.
- d. No one shall be denied reproductive health services if unable to pay.
- e. An agency may accept voluntary donations.

Section E: Data Collection and Reporting Requirements for Reproductive Health Services

E.1 Collection of Client Enrollment and Encounter Data

- a. The agency must assure that all required client enrollment data is collected using the RH Program Enrollment Form and has the capability to enter such data into the web-based RH Program Eligibility Database.
- b. The agency must assure that all required visit/encounter data variables as indicated on the RH Program Clinic Visit Record (CVR) are being collected and the agency must have the capability to submit data and billing information to the RH Program data collection vendor (currently Ahlers and Associates).
- c. The agency must assure that all RH Program required data are collected and submitted for all clients receiving reproductive health services regardless of source of pay.

E.2 Annual Request for Information

- a. Agencies must submit annual updates on agency, clinic, and staff contact information to the RH Program.

E.3 Additional Reporting

- a. Agencies must submit additional data required by federal funders, as needed.

Appendix E: RH Program Enrollment Form



Clinic label

Reproductive Health Program Enrollment Form

The Reproductive Health (RH) Program pays for birth control and medical services related to reproductive health. **We do not discriminate. You can get services no matter your citizenship, immigration, documentation status, or gender identity.** Please fill out this form to help us decide if you qualify for these free services. This information is kept as private as possible.

If you have any questions when filling out this form, please ask clinic staff for help.

1	Legal last name(s):	Legal first name:	MI:
2	Oregon address:	City:	ZIP:
3	Date of birth:	Age:	Optional: What is your current gender identity? Sex assigned at birth: ☐ Female ☐ Male

4	If you are age 45 or older, are you post-menopausal? (<i>No periods for the last 12 months</i>) ☐ Yes ☐ No ☐ Not Applicable
5	Have you been sterilized for more than 6 months? (<i>This includes female sterilization, hysterectomy, or vasectomy.</i>) ☐ Yes ☐ No
If you answered yes to either question 4 or 5, please stop and talk to a clinic staff person.	

Questions 6 and 7 are only to help us determine how to pay for your services. No matter how you answer these two questions, you can still get free services.	
6	Please see the Citizen and Immigration Status chart for help with this question. Do you have: ☐ U.S. citizenship or U.S. national status ☐ Eligible immigration status ☐ Another immigration status
7	A Social Security Number (SSN) is required if you have one. Do you have a SSN? ☐ Yes. Please write it here: _____ ☐ Yes, but I don't know it ☐ No

Reproductive Health Program Enrollment Form

8	Do you currently have the Oregon Health Plan (OHP)? ☐ Yes ☐ Yes, but just for emergencies or pregnancy (CAWEM or CAWEM Plus) ☐ No ☐ I don't know
9	Do you have any other health insurance? ☐ Yes ☐ No
10	If you have insurance, are you worried your partner, spouse, or parent will find out about the services you get today? ☐ Yes ☐ No ☐ I don't have insurance

11	<u>Household size based on tax filings (fill in only one of the spaces below):</u> If you file taxes and claim yourself: Write the total number of people you claim on your taxes. Include yourself, your spouse, your children, and any other tax dependents in your count. _____ OR If someone else claims you on their taxes: Write the total number of people that person lists on their taxes. Include yourself in the count. _____ OR If you don't file taxes and no one claims you on their taxes: Write 1. _____
----	---

12	<u>Your income BEFORE taxes (only include your income):</u> <u>This month</u> <i>Income from jobs.</i> Please list how much money you think you will get from work this month before any taxes or other money is taken out. If you are self-employed, list your NET income. _____ AND <i>Other income.</i> Please list any money you think you will get from sources other than a job this month. Be sure to include unemployment, tips, and alimony. Do not include child support, veteran's payments, or Supplemental Security Income (SSI). _____ Total _____
----	---

13	Do you want to register to vote today? ☐ Yes ☐ No ☐ Not Applicable
----	--

Reproductive Health Program Enrollment Form

Use of your Social Security number (SSN)

Federal laws (cited below) state that anyone applying for medical benefits must state their SSN, if they have one. When you write your SSN on the RH Program Enrollment Form, it means that you give permission for Department of Human Services (DHS) or Oregon Health Authority (OHA) to use it to:

- Help us decide if you qualify for benefits. We will use your SSN to make sure the income and assets you gave on the enrollment form are correct. We will match that information with other state and federal records. This includes the Internal Revenue Service, Department of Revenue and Medicaid. It also includes child support, Social Security and unemployment benefits.
- Help us improve the programs by doing quality reviews.
- Make sure that you receive the right medical benefits.

Federal laws – 42 USC 1320b-7(a), 42 CFR 435.910, 42CFR 435.920.

I understand I have the right to a copy of OHA's Notice of Privacy Practices.

I must give information to the OHA's Public Health Division to prove my identity and citizenship or immigrant status. This is so they can decide how to pay for my services. I understand and agree to this.

I understand that if I get services not covered by the RH Program I may have to pay for them.

The information I gave is correct and complete to the best of my knowledge. I declare this under penalty of perjury.

Client signature:

Date:

Reproductive Health Program Demographics Form

Your answers will help us understand the diversity of people who receive services. It also helps to make sure that everyone gets good care. We keep your answers private. Ask clinic staff if you have questions.

1	Does anyone in your household speak a language other than English? ☐ Yes ☐ No (<i>skip to question 3</i>)
2	In what language do you want us to: Speak to you: _____ Write to you: _____ (<i>If left blank, English will be listed</i>)
3	Do you need a sign language interpreter for us to communicate with you? ☐ Yes. Which type (American Sign Language (ASL), Pidgin Signed English (PSE), tactile interpreting, etc.): _____ ☐ No ☐ Don't know ☐ Decline or don't want to answer
4	Do you need an interpreter for us to communicate with you? ☐ Yes ☐ No ☐ Don't know ☐ Decline or don't want to answer
5	How well do you speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all ☐ Don't know or unknown ☐ Decline or don't want to answer
6	Do you need written materials in a different format (<i>Braille, large print, audio recordings, etc.</i>)? ☐ Yes. Which format: _____ ☐ No ☐ Don't know or unknown ☐ Decline or don't want to answer

Reproductive Health Program Demographics Form

7	How do you identify your race or ethnicity, tribal affiliation, country of origin, or ancestry? ☐ Decline or don't want to answer													
8	Which of the following describes your racial or ethnic identity? Check ALL that apply. <table border="0"> <tr> <td style="vertical-align: top;"> American Indian or Alaska Native ☐ American Indian ☐ Alaska Native ☐ Canadian Inuit, Metis, or First Nations ☐ Indigenous Mexican, Central American, or South American </td> <td style="vertical-align: top;"> Asian ☐ Asian Indian ☐ Chinese ☐ Filipino/a ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ South Asian ☐ Vietnamese ☐ Other Asian </td> <td style="vertical-align: top;"> Black or African American ☐ African American ☐ African (Black) ☐ Caribbean (Black) ☐ Other Black </td> </tr> <tr> <td></td> <td style="vertical-align: top;"> Hispanic or Latino/a ☐ Hispanic or Latino Mexican ☐ Hispanic or Latino Central American ☐ Hispanic or Latino South American ☐ Other Hispanic or Latino </td> <td style="vertical-align: top;"> Native Hawaiian or Pacific Islander ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Micronesian ☐ Tongan ☐ Other Pacific Islander </td> <td style="vertical-align: top;"> White ☐ Eastern European (examples: Bosnia and Herzegovina, Serbia, Ukraine) ☐ Slavic (examples: Albania, Armenia, Latvia, Romania) ☐ Western European ☐ Other White </td> </tr> <tr> <td></td> <td style="vertical-align: top;"> Middle Eastern or Northern African ☐ Middle Eastern ☐ Northern African </td> <td></td> <td style="vertical-align: top;"> Other categories ☐ Other, please list: _____ ☐ Unknown ☐ Decline or don't want to answer </td> </tr> </table>			American Indian or Alaska Native ☐ American Indian ☐ Alaska Native ☐ Canadian Inuit, Metis, or First Nations ☐ Indigenous Mexican, Central American, or South American	Asian ☐ Asian Indian ☐ Chinese ☐ Filipino/a ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ South Asian ☐ Vietnamese ☐ Other Asian	Black or African American ☐ African American ☐ African (Black) ☐ Caribbean (Black) ☐ Other Black		Hispanic or Latino/a ☐ Hispanic or Latino Mexican ☐ Hispanic or Latino Central American ☐ Hispanic or Latino South American ☐ Other Hispanic or Latino	Native Hawaiian or Pacific Islander ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Micronesian ☐ Tongan ☐ Other Pacific Islander	White ☐ Eastern European (examples: Bosnia and Herzegovina, Serbia, Ukraine) ☐ Slavic (examples: Albania, Armenia, Latvia, Romania) ☐ Western European ☐ Other White		Middle Eastern or Northern African ☐ Middle Eastern ☐ Northern African		Other categories ☐ Other, please list: _____ ☐ Unknown ☐ Decline or don't want to answer
American Indian or Alaska Native ☐ American Indian ☐ Alaska Native ☐ Canadian Inuit, Metis, or First Nations ☐ Indigenous Mexican, Central American, or South American	Asian ☐ Asian Indian ☐ Chinese ☐ Filipino/a ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ South Asian ☐ Vietnamese ☐ Other Asian	Black or African American ☐ African American ☐ African (Black) ☐ Caribbean (Black) ☐ Other Black												
	Hispanic or Latino/a ☐ Hispanic or Latino Mexican ☐ Hispanic or Latino Central American ☐ Hispanic or Latino South American ☐ Other Hispanic or Latino	Native Hawaiian or Pacific Islander ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Micronesian ☐ Tongan ☐ Other Pacific Islander	White ☐ Eastern European (examples: Bosnia and Herzegovina, Serbia, Ukraine) ☐ Slavic (examples: Albania, Armenia, Latvia, Romania) ☐ Western European ☐ Other White											
	Middle Eastern or Northern African ☐ Middle Eastern ☐ Northern African		Other categories ☐ Other, please list: _____ ☐ Unknown ☐ Decline or don't want to answer											
9	If you checked more than one category above, is there ONE you think of as your primary racial or ethnic identity? ☐ Yes. Please CIRCLE the ONE you think of as your primary racial or ethnic identity. ☐ No. I have more than one primary racial or ethnic identity. ☐ I only checked one category above. ☐ Decline or don't want to answer													

Reproductive Health Program Demographics Form

Your answers below will help us understand the diversity of people with disabilities and limitations.

10	Are you deaf, or do you have serious difficulty hearing? ☐ Yes. At what age did this condition begin? ____ ☐ No ☐ Don't know ☐ Decline or don't want to answer
11	Are you blind or do you have serious difficulty seeing, even when wearing glasses? ☐ Yes. At what age did this condition begin? ____ ☐ No ☐ Don't know ☐ Decline or don't want to answer
12	Do you have serious difficulty walking or climbing stairs? ☐ Yes. At what age did this condition begin? ____ ☐ No ☐ Don't know ☐ Decline or don't want to answer
13	Do you have difficulty dressing or bathing? ☐ Yes. At what age did this condition begin? ____ ☐ No ☐ Don't know ☐ Decline or don't want to answer
14	Because of a physical, mental, or emotional condition, do you have serious difficulty: A) Concentrating, remembering, or making decisions? ☐ Yes. At what age did this condition begin? ____ ☐ No ☐ Don't know ☐ Decline or don't want to answer B) Doing errands alone such as visiting a doctor's office or shopping? ☐ Yes. At what age did this condition begin? ____ ☐ No ☐ Don't know ☐ Decline or don't want to answer If yes, do you have serious difficulty making medical decisions? ☐ Yes ----- ☐ No ☐ Don't know ☐ Decline/don't want to answer If you have serious difficulty making medical decisions, please talk to your health care provider. ←
15	Does a physical, mental, or emotional condition limit your activities in any way? ☐ Yes. At what age did this condition begin? ____ ☐ No ☐ Don't know ☐ Decline or don't want to answer

Reproductive Health Program

For Clinic Staff Only		
Agency #:	Clinic #:	Date:
Staff name:		Client's RH program #:
Client's income is _____% of the Federal Poverty Level (FPL).		
Offered OHA Notice of Privacy Practices.		☐ Yes
Explained services covered by the RH Program. Also discussed payment options for services not covered by the RH Program.		☐ Yes
Gave information on where to access primary care services.		☐ Yes ☐ Not needed
Gave health insurance enrollment information.		☐ Yes ☐ Not needed
Only complete if client claimed U.S. citizenship, U.S. national status, or eligible immigration status		
Provided a voter registration card. Offered assistance completing and submitting the form.		☐ Yes ☐ Not needed
Citizenship or Immigration Status, and Identity Verification <i>If the client claimed another immigration status no documentation is required.</i>		
<u>U.S. citizenship or U.S. national status</u> ☐ Client provided proof of U.S. citizenship or U.S. national status. A photocopy or scan of the original is placed in the client's chart or birth certificate number is entered into the RH Program Eligibility Database. OR ☐ Electronic verification by the state is requested. OR ☐ Client's citizenship is already verified in the RH Program Eligibility Database.		
<u>Eligible immigration status</u> ☐ Client provided proof of eligible immigration status. A photocopy or scan of the original will be sent to the state for electronic verification. OR ☐ Electronic verification by the state is requested. The client provided the following information, as applicable and it is entered into the Eligibility Database: Immigration document type _____ Alien or USCIS number or I-94 number _____ Expiration date _____ Card number or Passport number _____ Country of issuance or SEVIS ID: _____ OR ☐ Client's immigration status is already verified in the RH Program Eligibility Database.		
<u>Identity</u> ☐ Client provided proof of identity. A photocopy or scan of the original is placed in the client's chart.		



Oregon Reproductive Health Program Certification Requirements for Abortion Services Version 1

Introduction

The Oregon Reproductive Health (RH) Program oversees a network of certified health care providers to ensure access to abortion services.

This document outlines the minimum requirements for abortion services that providers must meet in order to be certified by the Oregon Health Authority (OHA) RH Program and receive funding per OAR 333-004-2000 through 333-004-2190.

The Certification Requirements provide the foundation for high-quality services based on national standards of care and align with best practices and recommendations for client-centered, culturally-responsive care. The Certification Requirements are based on the following:

- Nationally Recognized Standards (e.g., US Preventive Services Task Force, National Abortion Federation)
- Providing Quality Family Planning Services (QFP) – Recommendations from the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA)
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

Background

The Reproductive Health Equity Act (HB 3391), passed by the Oregon legislature in 2017, expands coverage for a broad suite of reproductive health services for low-income individuals who can become pregnant and who would otherwise be eligible for medical assistance if not for their immigration status. The Reproductive Health Program provides coverage for these services, including abortion.

Section A: Certification Process for Abortion Services

A.1 Application and Certification Process for Abortion Services

- a. An agency must submit an Application for Certification for Abortion Services and all supporting documents to the RH Program. (Application and instructions are available on the RH Program's website healthoregon.org/rhcertification).
- b. The RH Program will determine if the application is complete and notify the agency of its determination within seven calendar days of receipt of the application.

1. If the RH Program determines that the application is not complete, the RH Program will notify the agency and the agency will have 30 calendar days to complete their application.
 - A. If the agency does not complete their application within 30 calendar days, their application will be denied.
 - B. The agency may then re-apply or appeal the decision per OAR 333-004-2170.
- c. Once an application is determined to be complete, the RH Program will review the applicable documents and determine if the agency meets the certification requirements.
- d. If the RH Program determines that the certification requirements for abortion services are met, the RH Program will inform the agency in writing that the application has been approved and that the agency is certified. This notification will occur no more than 30 calendar days after the RH Program has determined the application to be complete.
- e. Once an agency is certified the RH Program will provide a Medical Services Agreement (MSA) for Abortion Services to be signed by both the Oregon Health Authority and the certified agency.
- f. Certification requirements attested to in the initial application will be verified in an on-site review by the RH Program within one year of approval. (See Section A.2)
- g. If an agency does not meet all requirements in its application for certification for abortion services, the RH Program may deny certification.
 1. The RH Program will respond to the agency with a letter of denial providing a clear description of reasons for denial, based on the certification requirements.
 2. An agency may request that the RH Program reconsider the denial of RH Program certification. A request for reconsideration must be submitted in writing to the RH Program within 90 calendar days of the date of the denial letter and must include a detailed explanation of why the agency believes the RH Program's decision is an error along with any supporting documentation.
 3. The RH Program shall inform the agency in writing, within 30 calendar days of receipt of the request, whether it has changed its decision.
 4. The agency may appeal this decision per OAR 333-004-2170.

A.2 Verification of Certification Requirements for Abortion Services

- a. The RH Program will conduct an on-site verification review to determine compliance with certification requirements for abortion services of each approved agency within one year of application approval.
- b. After the initial on-site verification review, the RH Program will conduct regular on-site compliance reviews for all agencies every year based on a schedule developed by the RH Program.
- c. RH Program staff will work with the agency to schedule the on-site compliance review at a mutually agreed upon time. The agency will be notified, in writing, a minimum of 30 calendar days before its scheduled on-site verification review.

- d. An onsite agency review includes, but is not limited to:
 - 1. Review of enrollment forms, consents and all forms used in providing abortion services;
 - 2. Review of documents, policies, procedures, and/or protocols;
 - 3. Chart audit;
 - 4. On-site observation of patient counseling and education services; and,
 - 5. On-site observation of patient environment and physical environment.
- e. An exit report will be provided at the completion of the review.
 - 1. Preliminary findings will be presented to the Reproductive Health Coordinator (RHC), designated under Section B.5., the administrator and other staff interested in attending.
 - 2. If no certification deficiencies are identified during the review, the RH Program shall indicate as such in the exit report.
 - 3. If certification deficiencies are identified, the agency will be provided an opportunity to dispute any findings identified during the review at this time.
 - 4. A timeframe will be determined in which all compliance findings must be addressed.
 - 5. The RH Program may conduct an on-site follow-up visit to ensure compliance findings have been resolved.
- f. A copy of all the review materials and a final written exit report will be provided to the RHC within two weeks after the exit review.
- g. The RH Program will perform regular billing, enrollment, medical chart audits, and other quality assurance reviews.
- h. The RH Program may conduct a review of the agency without notice of any or all certification requirements for compliance and perform a verification on-site review if the RH Program is made aware of issues of compliance or complaints from any source.
- i. At any time, the agency may request an administrative review of compliance, which includes an on-site visit. The review will be considered a “no-penalty” review with the exception of gross violation or negligence that may result in agency decertification.
- j. The agency must notify the RH Program within seven calendar days of any change that brings the agency out of compliance with the certification requirements.

A.3 Process for Ensuring Compliance

- a. If certification deficiencies are found during any RH Program or agency-initiated review, the agency must:
 - 1. Submit a plan for corrective action and date for meeting compliance within a 30, 60 or 90 calendar day period, depending on the finding and compliance feasibility; and
 - 2. Come into compliance by the specified date or the RH Program will issue a letter of non-compliance with notification of suspension or decertification.

- b. Compliance verification may be determined through submission of documentation or through an additional on-site review.
- c. An agency with its certification status suspended may have its suspension lifted once the RH Program determines that compliance with certification requirements for abortion services has been achieved satisfactorily.
- d. If compliance findings are not met within the designated 30, 60 or 90 calendar day timeframe, the agency may ask for an extension, providing justification.
- e. If the agency fails to address all compliance findings within 180 calendar days of the date of the initial non-compliance notification the RH Program may seek to suspend or terminate the agency's certification.
- f. An agency that has been decertified may reapply with an amended application and additional documentation at any time.

Section B: Administrative Requirements for Abortion Services

B.1 Informed Consent

- a. The informed consent process, provided verbally and supplemented with written materials by the agency, must be presented in a language and style the client understands.
- b. An agency must inform clients that:
 - 1. Services are provided on a voluntary basis.
 - 2. They cannot be coerced to accept services or to use any particular method of birth control.

B.2 Confidentiality

- a. Agencies must follow the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, HIPAA Security Rule, and Health Information Technology for Economic and Clinical Health (HITECH) Act.
- b. Services must be provided in a manner that respects the client's privacy and dignity.
- c. Clients must be assured of the confidentiality of services and their medical and legal records.
- d. Services must remain confidential during billing and collecting payments, when requested by clients.

B.3 Linguistic and Cultural Responsiveness

- a. Agencies must have a comprehensive strategy to provide culturally and linguistically appropriate services.
- b. All services, support, and other assistance must be provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, languages, and behaviors of the client receiving services, and in a manner that has the greatest likelihood of ensuring maximum program participation.

- c. The agency must make interpretation services available to all clients needing or requesting such assistance at no cost to the client. Qualified or certified interpretation services are strongly recommended when available.
 - 1. The agency must notify clients in need of interpretation services of the availability of such services in accordance with the Civil Rights Act of 1964 and sections 1557, 1331 and 1001 of the Affordable Care Act (ACA).
 - 2. All persons providing interpretation services must adhere to confidentiality guidelines.
 - 3. Family and friends shall not be used to provide interpretation services, unless requested by the client.
 - 4. Individuals under age 18 shall never be used as interpreters for clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance.
 - 5. When possible, the agency shall employ bilingual staff, personnel, or volunteers skilled or certified in the provision of medical and clinical interpretation that meets the needs of clients with limited English proficiency or who otherwise need this level of assistance during all clinic encounters.
- d. The agency shall make easily understandable print materials available to clients and post signage in the languages of groups represented or commonly encountered in the service area.
- e. Culturally and linguistically appropriate health educational materials must be available for clients needing them.
 - 1. All print, electronic, and audiovisual materials shall be appropriate in terms of the client's language and literacy level. A client's need for alternate formats must be accommodated.
- f. A copy of a patient bill of rights shall be posted in a public area of the clinic. See the RH Program's website for a sample patient bill of rights (healthoregon.org/rh).

B.4 Federal Requirements Regarding Abortion Services.

- a. An agency may not use federal funds for abortion services.
- b. Agencies that receive federal funds and provide abortion services must have clear policies regarding the separation of federal funds from other funds.

B.5 Designation of Reproductive Health Coordinator (RHC)

- a. The agency will designate an individual as the RHC to be the key point of contact in accordance with OAR 333-004-2070(4)(f). The RHC is responsible for:
 - 1. Having an understanding of relevant aspects of the RH Program and how it is operationalized within all clinic sites, including client enrollment, clinical services, billing and data submission;
 - 2. Ensuring program compliance at all clinic sites;
 - 3. Responding to requests for information from the RH Program in a timely manner; and

4. Attending the annual Reproductive Health Coordinators' Meeting, and other required trainings and meetings provided by the RH Program.

B.6 Required Training

- a. Orientation to relevant aspects of the RH Program is provided to all new agencies by RH Program staff within three months of becoming a certified agency of abortion services.
- b. The designated RHC at each agency is responsible for coordinating subsequent staff orientation and training.

B.7 Client Informational and Educational Materials

- a. All educational material provided to clients who receive abortion services must be:
 1. Factually correct;
 2. Suitable for the population or community receiving the information;
 3. Culturally and linguistically appropriate; and
 4. Provided at the client's level of understanding.

B.8 Compliance with Federal, State, and Local Laws and Regulations

- a. Agencies must maintain appropriate level of Clinical Laboratory Improvement Amendments (CLIA) certification.
- b. Agencies must maintain appropriate licensure/certification based on facility type, as needed.
- c. Agencies must apply for and maintain appropriate licensure from the Oregon Board of Pharmacy, as applicable.

B.9 Access to Care

- a. All services must be provided in a manner which protects the dignity of the client.
- b. All services must be provided to clients without regard to race, color, national origin, immigration status, sex, sexual orientation, gender identity, age, or disability in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964, section 1557 of the ACA, the Americans with Disabilities Act (ADA) of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A.
- c. The agency's clinic facility(s) must be compliant with ADA requirements.
- d. Clients must be offered information about where to access free- or low- cost primary care services.

Section C: Clinical Requirements for Abortion Services

C.1 Clinical Services

- a. Clinical services must operate under the direction of a physician.

- b. The agency must follow practices related to abortion services based on evidence-based, national standards of care (e.g. The American College of Obstetricians and Gynecologists, the National Abortion Federation, Society of Family Planning, etc.).
- c. Clients must be informed of where and how to obtain 24-hour emergency care services.
- d. Appointments for clients must be available within a reasonable time period, based upon their needs and preferably within a week of initial contact. Clients for whom the clinic cannot meet their desired timeframe must be given the option to be referred to another contracted RH Program agency, preferably within close proximity.
- e. Core services must be offered to clients, as appropriate. Core services are defined as:
 - 1. Abortion services, including medication abortion (MAB) and therapeutic abortion (TAB) procedures occurring in an outpatient setting.
 - A. If the agency is unable to provide both of the above services, the agency must have a referral system in place. Clients must be notified, prior to their appointment, of the agency's inability to offer both services and be referred to another contracted RH Program agency, preferably within close proximity.
 - 2. Contraceptive drugs, devices, and supplies provided immediately following abortion services.
- f. Clients in need of additional medical or psychosocial services beyond the scope of the agency must be provided information about available local resources, including domestic violence and substance abuse related services.

C.2 Education and Counseling Services

- a. The general advantages and disadvantages of medication and therapeutic abortion should be explained early in the counseling process.
- b. Education and counseling services must be provided using a client-centered approach that helps the client clarify their needs and wants, promotes personal choice and risk reduction, and takes into account diverse cultural and socioeconomic factors of the client and psychosocial aspects of reproductive health and abortion services.
- c. Prior to a medication or therapeutic abortion, clients should also be offered client-centered counseling and education on the following:
 - 1. Contraceptives
 - 2. STI risk reduction
 - A. Assessment
 - B. Prevention methods
 - 3. Resisting sexual coercion
 - A. Relationship safety
 - B. Intimate partner violence
 - C. Human trafficking

- d. Agency staff must make referrals for additional counseling, as needed.

C.3 Pharmacy / Contraceptive Drugs, Devices, and Supplies

- a. The agency must offer a broad range of acceptable and effective approved family planning methods and services, including emergency contraception, available at the clinic site.
 - 1. If the agency is unable to dispense or administer contraception onsite, the agency must have a referral system in place for the provision of contraceptive methods. Referrals should preferably be made to another agency within close proximity.
 - A. Clients must be notified, prior to a medication or therapeutic abortion, of the agency's ability to dispense or administer contraception onsite.
- b. An agency dispensing birth control methods on-site must follow Oregon Board of Pharmacy rules (OAR 855-043-0700 through 855-043-0750).
- c. The agency must follow written policies and procedures for drug management, including security, acquisition, storage, dispensing and drug delivery, disposal and record keeping.
- d. The agency must establish procedures to ensure training and continued competencies in the dispensing of drugs by RNs, if applicable.

C.4 Laboratory

- a. Testing must be available on-site following CLIA rules and regulations.
- b. The agency must have the ability to collect specimens and samples. Samples may be sent off-site to a CLIA-certified laboratory.
- c. An agency must have and maintain written policies and procedures for laboratory testing following CLIA regulations. Staff proficiency testing must be included in the policies.
- d. An agency must have and maintain written policies and procedures for Infection Control following CDC recommendations.

C.5 Medical Emergencies

- a. The agency must have and maintain a current plan for medical emergencies.

Section D: Fiscal and Billing Requirements for Abortion Services

D.1 Billing Requirements (refer to OAR 333-004-2080 for additional information)

- a. The agency must be able to submit claims to the RH Program claims processing vendor (currently Ahlers and Associates).
- b. The agency has a legal obligation to seek third party reimbursement if applicable. The agency:
 - 1. Must be enrolled with and be able to bill the Oregon Health Plan (OHP);

2. Must be credentialed with and able to bill private insurance companies, per client's preference; and
 3. Must provide assurance of confidentiality, when indicated.
- c. Agencies may not request a deposit from the client in advance of services covered by the RH Program.

D.2 Payment

- a. Reimbursement from the RH Program for services defined in OAR 333-004-2040(3)(b) must be accepted as payment in full with no charge to the client.
- b. Clients can be billed for services that are outside of the scope of services defined in OAR 333-004-2040(3)(b).
- c. The agency must notify clients prior to the visit that they may be billed for services not included under OAR 333-004-2040(3)(b).
- d. The agency may accept voluntary donations.

Section E: Data Collection and Reporting Requirements for Abortion Services

E.1 Collection of Client Enrollment and Encounter Data

- a. The agency must assure that all required client enrollment data is collected using the RH Program Enrollment Form and must have the capability to enter such data into the web-based RH Program Eligibility Database.
- b. The agency must assure that all required visit/encounter data variables are being collected using the RH Program Client Visit Record (CVR) and must have the capability to submit data and billing information to the RH Program data collection vendor (currently Ahlers and Associates).

Provider matters

Updates about claim processing, policy and resources for Oregon Medicaid providers

March 22, 20

In this issue ...

- [Important reminders](#)
- [Training and technical assistance](#)
- [Claims](#)
- [Rules and program changes](#)
- [Need help?](#)

Additional services available through the Reproductive Health Equity Act (RHEA) effective April 1, 2018

Starting April 1, 2018, women enrolled in CAWEM Plus (CWXP) will be able to access the following care for 60 days postpartum:

- Comprehensive medical services, and
- Immediate postpartum reproductive health care, including immediate postpartum IUDs, implants and female sterilization.

In addition, individuals enrolled in CAWEM (CWM) will be able to access the following services starting April 1:

- Female sterilization, and
- Hospital-based abortion services.

Providers should bill OHA fee-for-service for these services. For sterilizations, please continue to obtain sterilization consent at least 30 days prior to the procedure (as outlined in [Oregon Administrative Rule 410-130-0580 - Hysterectomies and Sterilization](#)).

In addition, RHEA covers the following reproductive health services for any individual who would otherwise be eligible for medical assistance if not for their immigration status:

- Contraception and contraceptive-related services, including counseling;
- Well-woman visits;
- Screenings for breast and cervical cancer;
- Screenings for pregnancy and sexually transmitted infections (STIs);
- Counseling on STIs, relationship safety, and tobacco use;
- Mammography and screening for genetic cancer risk factors; and
- Outpatient abortion services (effective January 1, 2018).

Where can individuals receive care?

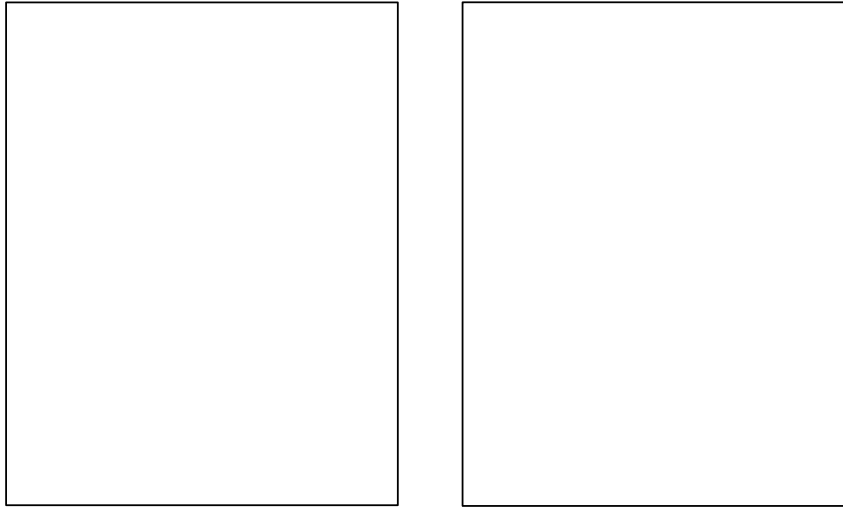
Individuals can access these services at any clinic within the Reproductive Health Program network. This network includes many local county health departments, Planned Parenthood clinics, federally qualified health centers (FQHCs), and other community-based health centers. Individuals may complete a Reproductive Health Program Enrollment Form onsite and receive services and supplies the same day. For a complete list of Reproductive Health Program clinics, please visit: www.healthoregon.org/rhclinics.

Appendix H: Reproductive Health Program print materials

Reproductive Health (RH) Program/RHEA Print Materials

RHEA Provider Referral Fact Sheet: an OHA-branded digital fact sheet intended for primary care and perinatal referring providers, available in English and Spanish. If printed, the fact sheet is 8.5 x 11 inches. The contact information on the back refers to the RH Program. The fact sheet is available:

- On the state forms server in English: <https://apps.state.or.us/Forms/Served/le9161a.pdf>
- On the state forms server in Spanish: <https://apps.state.or.us/Forms/Served/ls9161a.pdf>



RH Program Client Brochure: a brochure meant for clients describing available services at RH Program clinics. The brochure is English on one side and Spanish on the other. Legal size 8.5 x 14 in. The brochure is available:

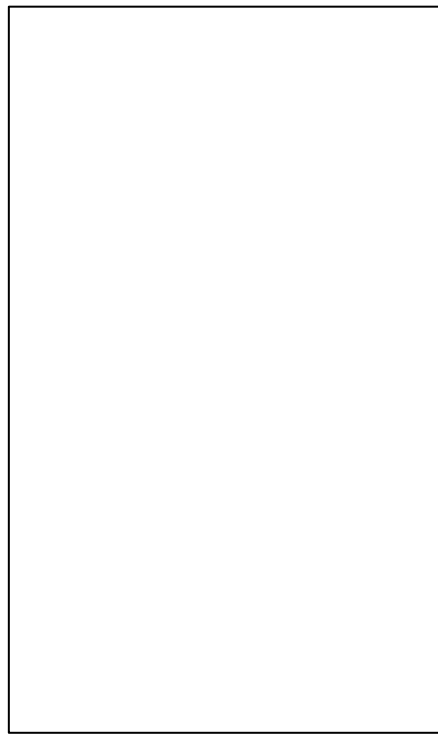
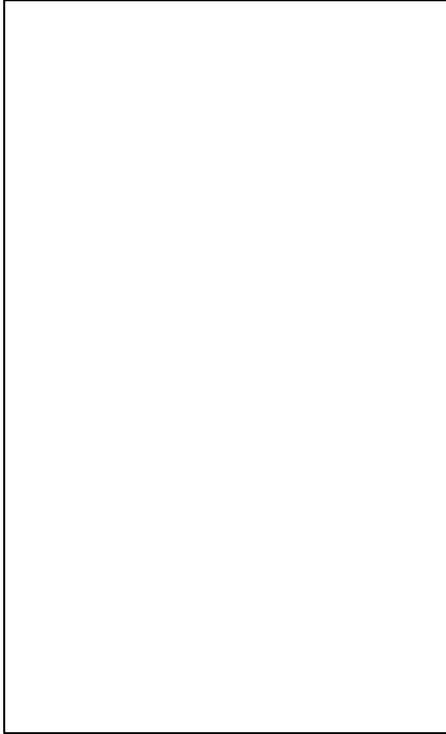
- On the state forms server: <https://apps.state.or.us/Forms/Served/le9133.pdf>



RHEA Community-Based Organization Referral Poster: “Pathways to Care: Helping Your Clients Access Free Reproductive Health Care” is intended for social service organizations that don’t directly provide clinical services. It is currently available in English, with a Spanish version forthcoming, legal size 8.5 x 14 in.

The poster is available:

- On the state forms server: <https://apps.state.or.us/Forms/Served/le9135.pdf>



Appendix I: House Bill 3391 evaluation matrix

Evaluation Matrix – HB 3391				
Core Concepts <i>What are the major areas this program addresses?</i>	Key Indicators <i>What can we observe or measure to generate evidence?</i>	Methods & Sources <i>How and from whom or where will we collect this information?</i>	Time Frame/Notes	Include in report to legislature?
Access to services	1. Number of clients enrolled 2. Utilization of different services 3. 1st trimester entry into prenatal care/CAWEM+ (gauges general access to healthcare system) 4. Earlier access to abortion (gestational age)	1. CAWEM+ and RH Program enrollments 2. Claims data. For MMIS, includes hospital-based abortion, female sterilization, and post-partum care 3. CAWEM+ data 4. RH Program claims data, compare to ITOP data	1. Ongoing 2. Timely filing deadlines	Yes
Quality of services	1. Client satisfaction 2. Effective contraceptive use 3. Pregnancy intention screening 4. Recommended screenings/services	1. Biennial RH Program client survey; Dehlendorf's patient reported outcome tool 2. Claims data – RHP and MMIS for post-partum period 3. Claims data – RHP 4. Claims data – RHP (CT screen, Pap testing, relationship safety counseling); MMIS (postpartum period: screening for tobacco use; domestic & interpersonal violence; breastfeeding support, counseling and supplies)	1. Biennial 2. Timely filing deadlines	
Health outcomes	1. Preterm births 2. Interpregnancy interval <18 months 3. Infant health outcomes – infant mortality...	1. Vital stats 2. Vital stats 3. Vital stats	Ongoing	Yes but not for 2018; birth outcome data is on longer timeframe
Equity	1. Demographic analysis – enrollment, utilization 2. Need for language services	1. Enrollment and claims data/RH Program and CAWEM+; Client satisfaction survey 2. RH Program enrollment data;	1. Ongoing	
Cost-effectiveness to the state	1. Costs of claims 2. Number of CAWEM/CAWEM+ deliveries	1. Claims data – RHP + MMIS 2. MMIS		Yes

Sustainability/cost-effectiveness to clinics	1. Revenue from 3391 2. Revenue from other sources 3. Client numbers 4. Cost analysis 5. Clinic hours, staffing 6. Clinics opening/closing	RHP		Probably not
End-user engagement (clients, providers and community partners)	1. Identification of barriers to RH Program accessing end-user engagement 2. Number of engagement opportunities (workgroups, partner forums)	1. RH Program assessment (internal and external) 2. RH Program will keep a list of opportunities		
Partnerships	1. Number of partnerships with RH Program 2. Number of partnerships with clinics 3. Nature of partnerships – MOU, formal agreements, informal 4. Partner satisfaction	1. RH Program assessment 2. RHC meeting evaluation and Partner Forum 3. RHC meeting evaluation, Partner Forum, clinic surveys? 4. Partner survey?		
Outreach to the community	1. Identification of barriers to outreach 2. Identification of strengths in the community 3. Nature of outreach efforts 4. Scope of efforts (geographic, media)	1. RH Program assessment (internal and external) 2. RH Program assessment 3. RH Program will keep a list of opportunities		



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For questions or comments about this report, or to request this publication in another format or language, please contact the Oregon Health Authority, Reproductive Health Program at 971-673-0355 or rh.program@dhsosha.state.or.us. We accept all relay calls or you can dial 711.