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GOVERNOR



February 18, 1998

The Honorable Donna E. Shalala
Department of Health and Human Services
200 Independence Avenue S.W.
Washington D.C. 20201

Dear Secretary Shalala:

Oregon is embarking on an ambitious effort to reduce unintended pregnancies and improve the well-being of children and families. Increasing access to family planning services is an essential part of this effort. As Governor, I am very pleased to forward a Medicaid 1115(a) waiver proposal, the Oregon Family Planning Expansion Project, for the review and approval of your Department.

The Oregon Family Planning Expansion Project is heavily influenced by recommendations of the Institute of Medicine in its report, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. The project draws heavily on the framework for providing public family planning services which your Department has institutionalized in the federal Title X Family Planning Program. We believe the project is an innovative blending of policies and practices of both the Title X Family Planning Program and the Title XIX Medicaid Program.

We are proposing to extend Medicaid coverage for family planning services only, to all Oregon women and men with family incomes at or below 185 percent of the federal poverty level. Client eligibility will be determined annually at family planning clinics. The clinic provider network will be based on the existing federal Family Planning Title X delivery system. Covered services will include medical exams, lab tests, counseling services, patient education, contraceptive method of choice for women, and vasectomy services for low-income men (abortions are not a covered service). The project will include a statewide education campaign and local community outreach and education to let people know about the availability of services.

We estimate that the Oregon Family Planning Expansion Project will save the federal Medicaid program and the State of Oregon an estimated \$20 million over the five-year duration of the project. However, the Oregon Family Planning Expansion Project is more than a cost-saving measure. It will result in improved health among low-income women, including teens. It will result in fewer abortions. Perhaps most importantly, it will reduce the individual, family and societal burdens of unintended pregnancy and give low income Oregonians - women, men, and teens - the freedom and support to plan their families and their lives.

**OREGON
FAMILY PLANNING
EXPANSION PROJECT**

**A STRATEGY TO REDUCE UNINTENDED PREGNANCY AND
IMPROVE THE WELL-BEING OF WOMEN, CHILDREN AND FAMILIES**

February 1998

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INTRODUCTION

The Institute of Medicine's startling report, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* calls for a new social norm:

All pregnancies should be intended—that is, they should be consciously and clearly desired at the time of conception.

Family planning services are a critical strategy for reducing unintended and/or inadequately spaced pregnancies. "Contraception is the keystone in the prevention of unintended pregnancy." (AJP, 1995, p. 479).

To curb a growing crisis in access to public family planning services and as part of Oregon's Action Agenda for Teen Pregnancy Prevention, the Oregon Health Division and the Office of Medical Assistance Programs jointly propose to implement the Oregon Family Planning Expansion Project for low income Oregonians and teens. The demonstration project will be implemented in 1998. Over the five-year period, we hope to learn enough about reducing unintended pregnancy among low income women and teens to institutionalize the project.

In order to implement the Expansion Project, the State of Oregon is requesting an 1115(a) waiver to extend Medicaid coverage for family planning services to all Oregon women and men with family incomes below 185 percent of the federal poverty level. Also included are teens below 185 percent of poverty, based on their own income. Oregon projects that providing family planning services to Oregonians under 185 percent of poverty will cost the state and federal governments less than the cost of prenatal care, delivery and infant health care.

The Expansion Project is part of an overall strategy to increase access to family planning services and reduce unintended pregnancies in Oregon. The project has been designed in accordance with the Oregon philosophy of preventive health care for low-income Oregonians which is the basis of the Oregon Health Plan, our other Medicaid demonstration project. Providing contraceptive services is an inexpensive, prevention strategy which avoids unnecessary individual, family and societal burdens.

The Expansion Project design is heavily influenced by recommendations of the Institute of Medicine and by the framework for providing public family planning services which the federal Department of Health and Human Services has institutionalized in the Title X family planning program.

The design is built upon strong community partnerships and collaboration at all levels of government. Not only does the Expansion Project require a concerted collaborative effort and integration of systems between two Oregon state agencies and local family planning agencies, but also between the Office of Population Affairs and the Health Care Financing Administration. To best meet the goal of reducing unintended pregnancies and improving the well-being of women, children and families, the Oregon Family Planning Expansion Project requires flexibility and foresight by all.

BACKGROUND

Problem Definition

The magnitude of unintended and inadequately spaced pregnancies has been revealed by the Institute of Medicine's report, *The Best Intentions*. According to the report, 57 percent of all pregnancies in the United States are unintended - either mistimed or unwanted altogether. In 1987, just over half of the unintended pregnancies ended in abortion and just under half in live births. Of the *births* that occurred, about 39 percent were from unintended pregnancies. The proportion of births that were unintended at conception is increasing. By 1990, 44 percent of births were the result of unintended pregnancy. (IOM, 1995, p. 2).

Applying the national rates to Oregon's 55,900 total pregnancies in 1996, there were an estimated 31,900 unintended pregnancies of which 12,300 ended in abortion. Of the 43,600 births (as opposed to pregnancies), roughly 19,600 were unintended.

Women

Low income women are at a higher risk of unintended pregnancy than the national average. "Low income and minority women have greater difficulties than other women in avoiding unplanned pregnancy: 74 percent of pregnancies to women with a family income of less than 150 percent of federal poverty level are unplanned, compared with 52 percent of those among higher income women." (Forrest, J.D., et al., 1996, p. 246).

In Oregon, there are approximately 95,900 women between the ages of 20 and 44 whose income is less than 185 percent of the poverty level and who are at risk of unintended pregnancy. Another estimated 40,300 women are between 185 and 250 percent of poverty and at risk of unintended pregnancy. (AGI, 1990). These women often cannot afford to purchase family planning and reproductive health services in the private sector and are therefore in need of subsidized family planning services.

Low income women of color are at the highest risk of unintended pregnancy. In the United States, 79 percent of pregnancies among black women are unintended, compared with 63 percent among Hispanic women and 54 percent among white women. "The greater prevalence of unplanned pregnancy among low income women and among black or Hispanic women reflects their lower levels of contraceptive use and higher likelihood of contraceptive failure." (Forrest, J.D., et al., 1996, p. 246).

Teens

Teens have a particularly high rate of unintended pregnancy: nationally, more than 80 percent of teen pregnancies are unintended. There are approximately 37,700 Oregon teens, ages 13 to 19, at risk of unintended pregnancy. (expanded YRBS data, 1995). In 1996, there were approximately 8,500 pregnancies to Oregon women under the age of 19, which resulted in roughly 5,800 births and 2,700 abortions.

The Oregon Benchmark for the year 2000 is to reduce the pregnancy rate for 10 to 17 year olds to 15 per 1,000 females. Currently, there are 3,300 pregnancies each year, at a rate of 19 per 1000 females. The birth rate is 12 per 1,000 females and the abortion rate is 7 per 1,000.

Although a large percentage of teen pregnancies are unintended, it is important to note that in absolute numbers teen pregnancies are a small part of the universe of unintended pregnancy. In 1996, teens accounted for about 13 percent of Oregon births and 22 percent of abortions. The Institute of Medicine affirms, "Unintended pregnancy is not just a problem of teenagers or unmarried women or poor women or minorities: it affects all segments of society." (IOM, 1995, p. 1).

Men

Generally in our society, the burden of contraceptive responsibility is on the woman. Male responsibility significantly declined when the pill and IUD became widely available in the 1960s. Few pregnancy prevention programs that target men have been initiated. Historically, such programs have not been politically popular: therefore, have not received adequate funding. Very little research has been done concerning the impact of male sterilization on the prevention of unintended pregnancy nor on the development of male contraceptive devices.

Nick Danforth, men's program advisor for the Association for Voluntary Surgical Contraception in New York, encourages, "There is a self-fulfilling prophesy that men won't respond, so we don't involve them. We have found that if good programs are available, many men will come to them."

According to research by James Trussel, et al., a vasectomy is one of the most effective and economical contraceptive methods. (Trussel, J., et al., 1995, p. 494). Nationally, half a million men receive vasectomies each year to prevent pregnancy. However, a majority of vasectomy recipients are "well educated, have incomes above 300 percent of poverty level and are white." (Washington State Department of Health, 1997, p. 1). Low income, at risk men without viable access to vasectomies, are dependent on their partners to provide the most effective contraceptive option. These men have little choice and do not have direct control over their reproductive lives and future economic burdens.

Causes

According to a study by Suzanne Delbanco, et al., comparisons of public knowledge and perceptions about unplanned pregnancy and contraception were made between the United States, Canada and the Netherlands. The unintended pregnancy rate in the Netherlands at 6 percent is the lowest among most Western nations. Canada reports a rate of 39 percent. The U.S. rate at 57 percent is among the highest. The study attributed many factors to the disparity in unintendedness rates, including: government support of public education, information, access and coverage of contraceptive services; cultural norms and religious values reflected in laws, medical, educational and media policies; and different attitudes and beliefs about sexual activity. (Delbanco, S., et al., 1997, p. 70). Numerous, complex forces influence contraceptive use and unintended pregnancy. Others include: varying sexual behavior, racism, violence and sexual saturation of the media.

Consequences

We know that children who are planned and wanted are more likely to be healthy children. As illustrated in the Institute of Medicine's report, *The Best Intentions*, the consequences of unintended pregnancy are not borne by the babies or their families alone. In Oregon, as in the rest of the country, we all pay the price in terms of lower educational achievement; increased health care and welfare costs; and a less highly trained and productive work force.

The Best Intentions describes the range of consequences of unintended pregnancy:

With an unwanted pregnancy especially, the mother is more likely to seek prenatal care after the first trimester or not to obtain care. She is more likely to expose the fetus to harmful substances such as tobacco or alcohol. The child of an unwanted conception is at greater risk of weighing less than 2,500 grams at birth (e.g., being low birth weight), of dying in its first year of life, of being abused, and of not receiving sufficient resources for healthy development. The mother may be at greater risk of physical abuse herself, and her relationship with her partner is at greater risk of dissolution. Both mother and father may suffer economic hardship and fail to achieve their educational and career goals. (IOM, 1995, p. 81).

In addition to the personal and social costs endured by individuals, families and society, there are high monetary costs associated with unintended pregnancy. The cost to U.S. taxpayers of teen childbearing, along with other disadvantages faced by adolescent mothers, is \$13 to \$19 billion per year. (Robin Hood Foundation, 1996, p. 19). Public expenditures, policies and institutional practices are heavily impacted by the rising rate of unintended pregnancy.

Welfare dependency is a common outcome of unintended pregnancy. Many women and families find that a pregnancy is the economic burden that pushes the family over the brink into poverty and onto the welfare rolls. For teenagers especially, a pregnancy's disruption of schooling can have long-term effects on the mother's ability to earn a living. Each year 175,000 women under the age of 17 give birth in the U.S. As a result, more than 80 percent of these young mothers end up in poverty and reliant on welfare. (Robin Hood Foundation, 1996, p. 1).

Each year in Oregon there are approximately 43,000 births. Of those births, the Oregon Health Plan pays for roughly 15,000 each year, costing taxpayers nearly \$80 million. Based on IOM figures, an estimated 9,000 of the OHP births are unintended each year.

Contraceptive Access is *Crucial*

Family planning services are a critical and cost-effective strategy for reducing unintended pregnancies. "Contraception is the keystone in the prevention of unintended pregnancy . . . Ensuring voluntary choice from the broadest possible array of method options is a cost-saving contraceptive care strategy." (American Journal of Public Health, 1995, p. 479).

Institute of Medicine's Recommendations

The Committee on Unintended Pregnancy, responsible for the Institute of Medicine's (IOM) report, *The Best Intentions*, recommends a new social norm. The new social norm is simply that all pregnancies should be intended. The committee urges a multifaceted, public-private, national campaign that focuses on access to contraceptives and education. The recommended campaign would enable the United States to reach its goal to reduce unintended pregnancies to 30 percent by the year 2000. The five goals of the campaign are to: (1) improve knowledge, (2) *increase access to contraceptives*, (3) address the role of feelings, attitudes and motivation in contraceptive use, (4) develop and evaluate local programs and (5) stimulate research.

The report identifies three strategies to overcome *financial barriers* to accessing contraceptive services:

- 1- increase the proportion of health insurance policies that cover contraceptive services and supplies, including both male and female sterilization, with no copayments or other cost sharing requirements, as for other selected preventive health services;
- 2- extend Medicaid coverage for all postpartum women for two years following childbirth for contraceptive services, including sterilization; and
- 3- continue to provide public funding- federal, state and local- for comprehensive contraceptive services, especially for those low income women and adolescents who face major financial barriers in securing such care. (IOM, 1995, p. 13).

The report also identifies three steps which should be taken to broaden the range of health professional and institutions that promote and provide methods of birth control:

- 1- medical educators should revise, where necessary, the training curricula of a wide variety of health professional to increase their competence in reproductive health and contraceptive counseling for both males and females and, when appropriate, in actually providing contraceptive methods.

- 2- administrators should increase the coordination (sometimes even co-location) between basic family planning services and many other health and social programs that often serve individuals at high risk of unintended pregnancy, such as STD clinics, homeless centers, drug treatment centers, WIC offices, and well-child and immunization clinics.
- 3- those who provide social work, employment training, educational counseling, and other social services should be taught about the importance of talking with their clients regarding the benefits of pregnancy planning and how to do so. (IOM, 1995, p. 14).

Health Insurance Coverage of Contraception

The Alan Guttmacher Institute estimates that more than three in every four women in the United States who use a contraceptive method each year (excluding sterilization) obtain it from a private source. No Oregon-specific data are available. While the services may be obtained from a private source, they are not necessarily reimbursable by private insurance. Almost half, 49 percent, of all typical large group plans do not routinely cover any contraceptive method. Only 15 percent cover all five reversible methods: IUD insertion, diaphragm fitting, Norplant insertion, Depo Provera injection and oral contraception. "Oral contraceptives, the most commonly used reversible method in the United States, are routinely covered by 33 percent of large group plans." (AGI, 1993, p. 12).

Many in need of family planning services are minors and spouses, who may be in particular need of confidential care, but who are very likely to be indirectly insured as dependents on someone else's insurance policy. Among those with employment-related health insurance, 42 percent of women ages 18 to 44 have indirect coverage. (AGI, 1993, p. 2).

Numerous un- and underinsured women and men must expend personal resources for services or go without. Oral contraceptives purchased from a pharmacy cost an average of \$25.00 per month (\$300.00 a year).

There is hope for the future. On May 14, 1997, ground breaking bipartisan legislation was introduced in the U.S. Senate. Senate Bill 766, "The Equity in Prescription Insurance and Contraceptive Coverage Act" (EPICC), would require insurance plans which offer prescription drug coverage to also cover prescription contraceptive drugs and devices. The measure would also require health plans which offer coverage for outpatient medical services to offer coverage for outpatient contraceptive services. Senate Bill 766 would help to remedy a fundamental inequity in health care coverage,

A similar bill which would have required all private insurance companies to cover an array of contraceptive services and supplies was considered by the 1997 Oregon Legislature. The bill was passed in the Senate, but not considered in the House.

Current Access to Publicly Funded Services

Publicly funded services--the Oregon Health Plan and the Title X Family Planning Program-- help provide financial access to contraception for un- and underinsured low income Oregonians. Further, the Title X Family Planning Program provides both funding and a service delivery system designed specifically to meet the needs of sexually active teens and of low-income, high risk populations.

Oregon Health Plan

The Oregon Health Plan or OHP is Oregon's innovative Medicaid demonstration project for low income Oregonians. Refer to Exhibit A for detailed information about the Oregon Health Plan. OHP covers all eligible residents with incomes up to 100 percent of the federal poverty level *regardless* of whether they qualified for cash grant welfare assistance.

Effective March 1, 1998, pregnant women with family incomes between 100 and 170 percent of the poverty level are also covered and this coverage continues through 60 days postpartum. Previously, coverage had been up to only 133% of poverty level. *Also* covered are children to age 12. Oregon's CHIP program, currently being designed, will cover children up to age 19 whose families are under 170 percent of the poverty level.

The Oregon Health Plan covers family planning services including all contraceptive methods. The Prioritized List of Health Services, the cornerstone of the Oregon Health Plan concept, ranks preventive services higher than other services. All contraceptive methods are ranked in the top 20 percent of the list.

Title X Family Planning Program

The major source of family planning services for low income Oregon women with neither public nor private insurance coverage for contraception and for sexually active teens is the Title X family planning program. This federal program not only reduces financial barriers to family planning services but provides services tailored to the needs of populations at high risk of unintended pregnancy including teens. Refer to Exhibit B for detailed information about the federal Title X program.

In Oregon, there are two Title X grantees, the Oregon Health Division (OHD) and Planned Parenthood of the Columbia Willamette (PPCW). The Oregon Health Division has 37 local delegate agencies including all 34 local health departments. Family planning funds disbursed to OHD delegate agencies include: Title X, Title V (federal maternal and child health block grant) and state general funds. The funding is distributed according to a formula with multiple factors reflecting both need and performance.

Together, the two Title X grantees form a network of more than 90 clinic sites, serving all 36 Oregon counties. Services are provided on a sliding fee scale to clients below 250% of poverty level. No fee is charged for those below 100 percent of poverty level. No one is turned away because of inability to pay.

In 1996, Title X clinics served nearly 60,000 clients including 10,000 Oregon Health Plan clients. Ninety seven per cent of the clients were below 250% of poverty level. Thirty two percent of the clients were teens. Only 16 percent of clients were covered by Medicaid for family planning services, yet roughly 76 percent of these clients would be eligible if they gave birth.

Public Funding is Cost Effective

In fiscal year 1987, the public sector expended \$412 million for contraceptive services. If the subsidized services had not been available, "the federal and state governments would have spent an additional \$1.2 billion through their Medicaid programs for expenses associated with unplanned births and abortions." For each public dollar spent on contraceptive services, an average of \$3.00 was saved in Medicaid costs for pregnancy related health care and newborn medical care. (Forrest, J.D., 1996, p. 188).

When considering other public expenses like welfare and nutritional services, the average government savings is \$4.40 for every \$1.00 spent on family planning services. (Forrest, J.D., 1990, p. 6).

Need for Expansion

As noted above, those women below 100% of poverty level can receive family planning services under the Oregon Health Plan. While pregnant women from 100% to 170% of poverty level are eligible for coverage through 60 days postpartum, most were not eligible for coverage before they became pregnant.

Title X-subsidized services are designed to meet the needs of these low income women and of sexually active teens. Unfortunately, the ability to both expand access and to maintain adequate services for existing clients is severely limited *due to the scarcity of resources*. The allotment of Title X funds has been stagnant for almost two decades. In real dollars, funding for the program declined by more than 70 percent between 1980 and 1992, at the same time, health care costs soared, the number of eligible patients increased and the cost of contraceptive supplies rose dramatically, (AGI, 1995, p. 2).

Increasingly, state and local funds have been necessary to sustain Oregon's Title X clinic system. Recently, tax limitations approved by voters have reduced the availability of these other funds as well. Clearly, Oregon's ability to provide publicly subsidized family planning services is eroding.

Oregon's Plan to Reduce Unintended Pregnancies

Oregon is embarking on a major effort to reduce unintended pregnancies, including teen pregnancy, and to increase access to family planning services.

Oregon Action Agenda for Teen Pregnancy Prevention

At the request of Governor John Kitzhaber, Oregon's Action Agenda for Teen Pregnancy Prevention was developed by a broad-based coalition. The agenda solidifies teen pregnancy prevention efforts by local and state partners into a cohesive, integrated course of action for 1997 and beyond. Together local and statewide efforts concentrate on six strategies to confront the primary issues surrounding teen pregnancy: (1) supporting positive community values and norms, (2) skills for life instruction, (3) responsible sex education, (4) STARS: postponing sexual involvement, (5) *contraceptive access* and (6) legal issues and protections. See Exhibit C for a copy of the Action Agenda.

Legislative Support

The 1997 Oregon legislature allocated additional state general funds for unintended pregnancy prevention. Some of the funds were specifically dedicated to improving access to contraceptives.

Embodied in both the Governor's Action Agenda and the legislatively-approved budget is the strategy of pursuing a federal waiver to expand Medicaid eligibility for family planning services, the subject of this document.

PROJECT GOAL AND OBJECTIVES

The goal and objectives of the Family Planning Expansion Project are aligned with related national and state family planning and maternal child health objectives including the National Healthy People 2010 objectives and the Oregon Benchmarks. Refer to Exhibits D and E for related objectives from these documents.

Goal

Reduce unintended pregnancies and improve the well-being of children and families.

Objectives

- 1- Reduce the rate of unintended pregnancies among Oregon women in general and among women who are eligible for Medicaid paid deliveries.
- 2- Reduce the proportion of births spaced less than two years apart in the general population and among women who are eligible for Medicaid paid deliveries.
- 3- Reduce the teen pregnancy rate for 10 to 17 year olds.
- 4- Reduce second births among teens.
- 5- Increase the number of Oregon women and teens receiving services from publicly funded family planning clinics.
- 6- Increase the number of men receiving services from publicly funded family planning clinics.
- 7- Increase the use of more effective contraceptive methods by clients receiving services from publicly funded family planning clinics.

These goals and objectives are operationalized in the project's design and in the evaluation.

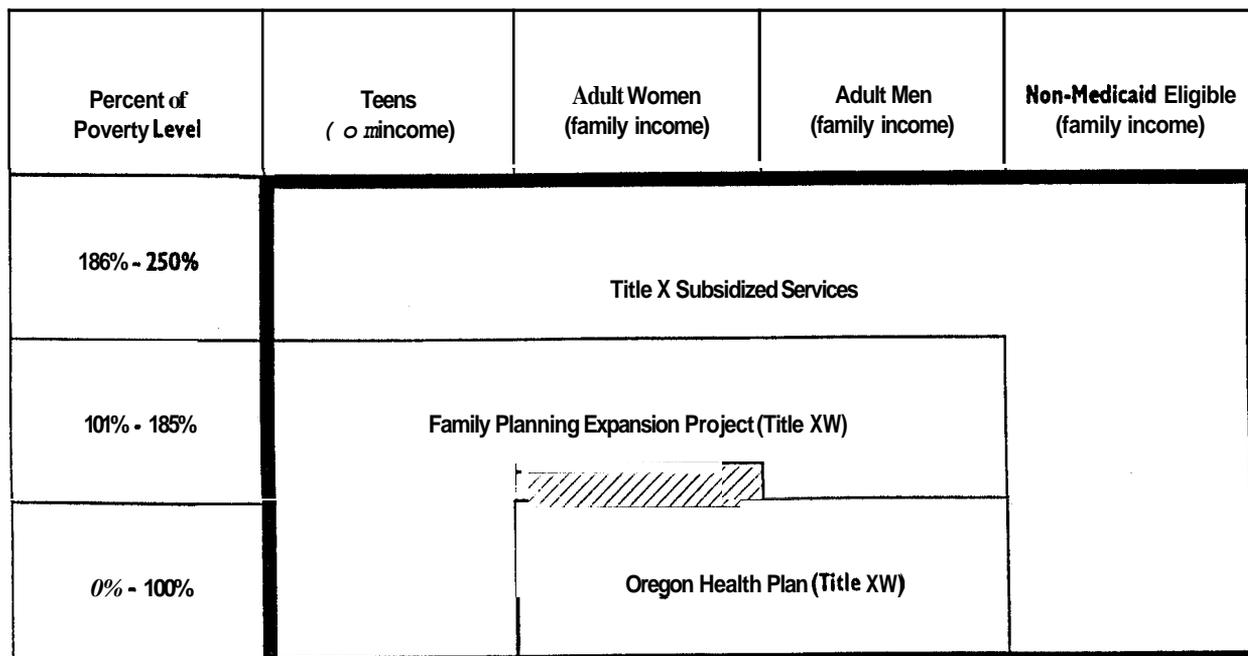
PROJECT DESIGN

The Oregon Family Planning Expansion Project or FPEP is part of an overall strategy to increase access to family planning services and reduce unintended pregnancies in Oregon. The Expansion Project design is heavily influenced by the recommendations of the Institute of Medicine and by the framework for providing public family planning services which the federal Department of Health and Human Services has institutionalized in the Title X family planning program. The project design replicates this existing effective family planning service delivery model and blends Title XIX and Title X approaches to providing publicly funded family planning services.

The project design was developed by representatives of local health departments, Planned Parenthoods, and the Office of Medical Assistance Programs (OMAP) and Oregon Health Division within the Oregon Department of Human Resources. Representatives have taken all aspects of the project design back to the organizations they represent in order to gain additional input and ideas. Broader input has also been gained by distribution of a previous draft of this proposal to multiple community partners for comment. Federally recognized Indian tribes in Oregon have been given an opportunity for input,

It is important to note that this project is not a stand-alone system. It builds on and will be fully integrated into Oregon's existing systems for financing and delivering public family planning services. The chart below shows how the Oregon Health Plan, the Family Planning Expansion Project, and Title X-subsidized services together provide financial access to family planning for various population groups in Oregon. This chart is an important reference in understanding the elements of the project design described below.

Oregon's Publicly Funded Family Planning Services



Between 101 - 133% includes OHP postpartum women for 60 days. Eligibility will increase to 170% effective March 1, 1998

Provider Network

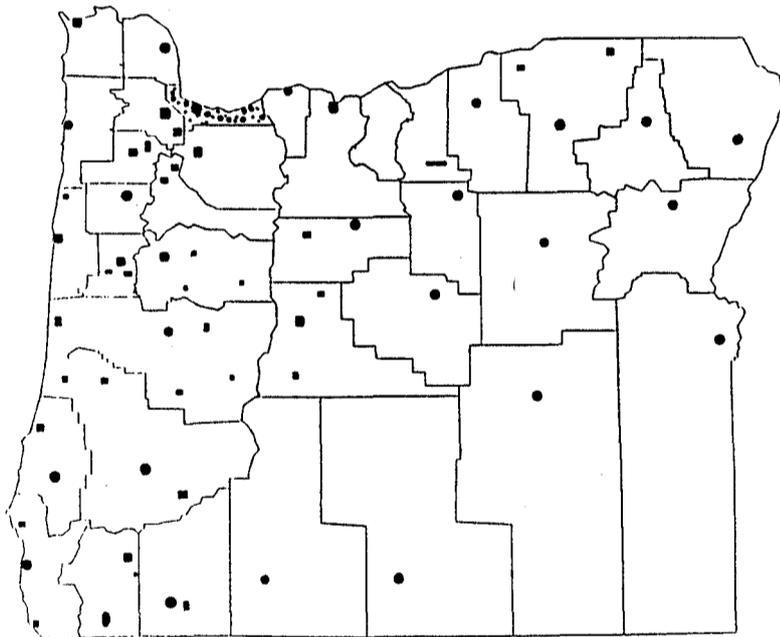
The provider network for the Family Planning Expansion Project is envisioned as a network of clinics which are easily identified by the eligible population as sources of free, user-friendly, confidential family planning services.

Public (Title X) Clinic System

The provider network for the Family Planning Expansion Project will be based on Oregon's existing public family planning clinic system, i.e., those agencies which currently receive federal Title X and state funds *specifically* for providing family planning services. This approach was chosen for several reasons:

Expertise: Title X agencies specialize in family planning services for low income, high risk Oregonians and for sexually active teens. They serve hard-to-reach populations, including those not likely to seek and sustain services (e.g., homeless, non-English speaking, and people with risk taking behaviors such as using drugs). They also have expertise in addressing the special needs of teens and persons with disabilities. In addition to providing clinical services, Title X agencies provide extensive patient education and counseling, referrals and linkages to other health services and community resources, and community education and outreach. Most Title X agencies have been providing public family planning services for more than 25 years. They have dedicated, experienced staff with extensive training in family planning service delivery.

Accessibility: As shown on the map below, Oregon's 38 public family planning agencies have more than 90 clinic sites serving all of Oregon's 36 counties. Eighty one percent of the people in Oregon's population centers (i.e., towns with a high school) have a clinic located in their town. Several clinics are based in high schools. Refer to Exhibit F for a directory of Title X clinic sites by county,



Please note that the large counties with few sites shown are arid, sparsely populated areas.

Since nearly all Oregon Title X agencies are local health departments and all local health departments are Title X delegate agencies, family planning services are generally co-located with other health department services serving low income and high risk individuals such as STD, immunization, and WIC clinics. They are locations well-known to community residents, especially those with no other sources of health care. Note that this co-location follows the recommendation of the Institute of Medicine.

In addition to being co-located with other health services, all Title X agencies are licensed to dispense contraceptives. Clients are thus able to receive both family planning services and supplies in one visit.

Standards/Quality Assurance: Title X clinics follow rigorous administrative and clinical standards. The Title X regulations and official program guidelines outline in great detail protocols for the provision of family planning services in line with nationally recognized medical standards. Refer to Exhibit G for a copy of the regulations and guidelines. These standards assure consistent, high quality, appropriate services for all family planning clients.

In-depth quality assurance reviews are conducted on a 3-year cycle at all Title X agencies to assure compliance with these standards. The review includes clinic observation, review of all policies and procedures, and chart audits. The reviewer follows up on issues identified during the review. Frequently, Title X supported training and technical assistance are a result of the review findings. Review for compliance with Medicaid policies and procedures will be integrated into this existing review process.

Administrative Efficiencies: Title X clinics participate in existing administrative systems. Building on these existing systems will avoid duplication and reduce administrative costs at both the state and local level.

Most significant of these administrative systems is the client data system. Title X clinics participate in a uniform client data collection system, the DHHS Region X Family Planning Reporting System, also known as the Ahlers system. This system tracks client demographics, services received, method of contraception and several other important data elements. The system has a 20-year track record of providing consistent, reliable data. Clinic staff are already trained in the system. This system will be the client information system and claims submission system for the Family Planning Expansion Project providers.

As noted above, Title X agencies are licensed to dispense contraceptives. This will eliminate the need to process and pay pharmacy claims, reducing the cost of the program.

Other Providers

In addition to Title X agencies, other providers may be interested in participating because they best serve certain population groups. This issue will play out differently in each county/community. In areas where the Title X agency has adequate capacity to serve all the Family Planning Expansion Project clients, no additional providers may be interested. In other areas, there may be non-Title X providers who are very interested in becoming Expansion Project providers. These might include

migrant and community health centers, rural health clinics, women’s health clinics, and other providers serving special populations. These agencies could become direct Expansion Project providers or elect to subcontract with the local Title X agency. Oregon has a culture of local control and community collaboration which will help assure the best system for each community.

As Title X providers have already, non-Title X Family Planning Expansion Project providers will need to meet specific requirements, criteria, and conditions. Major requirements will include meeting Title X standards, using the Ahlers data system, and demonstrating ability to meet an unmet community need such as improving geographic access or providing services to a special population group.

All federally recognized Indian tribes in Oregon have been invited to participate in the project, All Indian Health Service and tribal clinics which are interested in providing Expansion Project services will become part of the provider network.

Eligible Population

The eligible population for the Family Planning Expansion Project includes:

- Women and men with a family income between 100 and 185 percent of the federal poverty level and
- Teens based on their own income up to 185 percent of the federal poverty level.

Client Projections/Demographics

The Family Planning Expansion Project will serve approximately 66,500 clients annually at capacity, essentially filling the “unmet need” for financial access to family planning services for Oregonians under 185% of poverty level. It is anticipated that this level will be reached by the end of year two of the project. The following table shows the projected age, gender, and racial ethnic breakdown of the projected clients.

Demographics

Age			Gender			Racial / Ethnic Group		
Adults	24,900	63%	Women	65,900	99%	White	59,500	89%
Teens	24,600	37%	Men	600	1%	Hispanic	2,700	4%
						African American	1,700	3%
						Asian/Pac. Isl.	1,500	2%
						Native American	700	1%
						Other	400	1%
Total	66,500	100%	Total	66,500	100%	Total	66,500	100%

Increase in Public Clinic System Capacity

The Expansion Project will fund services for only a portion of Oregon's public family planning clinic system clients. By providing full coverage of family planning services for lower income Oregonians, the Family Planning Expansion Project frees up Title X resources to serve more clients between 185% and 250% of poverty level and others not eligible for Medicaid on a sliding fee scale basis. The following chart shows how the various public funding sources will collectively enable Oregon to expand its public family planning clinic system capacity from 60,000 to nearly 100,000 clients annually.

	Oregon Health Plan	FP Expan. Project	Title X - Subsidized	Total
Existing Clients	10,000	36,000*	13,500	59,500
New Clients	0	30,500	7,000	37,500
Total	10,000	66,500	20,500	97,000

Eligibility Determination

Eligibility for the Family Planning Expansion Project will be available on-site through all participating providers at the time of service.

Eligibility Process

The proposed process is administratively simple and low-cost. Clients will complete a simple self-declaration form. The form will include information about income and financial resources and family size and will be used to assess citizenship status. It will be incorporated into existing intake forms. Eligibility will be immediately determined. This model is based on the current process used to assess the sliding fee scale in Title X clinics. Non-citizens and over-income clients will be served using other funds.

Teens will be eligible based on their own income in order to assure confidentiality and reduce barriers to service. Many teens do not know what their family income is nor do they have access to the income to pay for family planning services. This is based on the current process used to assess sliding fee scale charges for teens in Title X clinics.

Eligibility Duration

Eligibility will be redetermined after one year. The redetermination date will generally coincide with the client's annual exam visit, but this is not essential.

Eligibility will be site specific. If a client moves to another county and goes to a different provider then she or he must reapply with the new provider. This circumvents the need for an identification card.

Covered Services

The Family Planning Expansion Project will cover comprehensive family planning services for teen and adult women. Vasectomies will be covered for men desiring them.

Services for Teen and Adult Women

Comprehensive family planning services will be covered for teen and adult women. These services include history and physical exam, necessary laboratory tests, patient education and counseling, referral and follow-up services, assurance of client confidentiality, dispensing of contraception, and approved methods of contraception. Pregnancy tests visits will also be covered. In some cases, home visits will be required to deliver these services or a bilingual provider or interpreter will be needed. These services will also be covered.

Tubal ligations will also be covered for women who do not wish further pregnancies and complete the Federal sterilization consent process including extensive counseling. The project will not cover abortion.

These are the same family planning services which are covered under the Oregon Health Plan, and providers will bill the same way they do for fee-for-service family planning under the Oregon Health Plan.

Services for Men

A unique aspect of the Expansion Project is the provision of vasectomy services for low income men.

Neighboring Washington State recently allocated state general funds for a Vasectomy Project. The allocated funds were intended to sustain a program for 24 months, however due to unanticipated demand for publicly funded vasectomies, the funds were expended in nine months. Between October 1995 and June 1997 more than 900 men received subsidized vasectomies,

While no Oregon data are available, the Washington State Vasectomy Project clearly indicates an unmet need for vasectomies for low income men. Vasectomies will be covered for men who complete the Federal sterilization consent process including extensive counseling.

Other services for men (e.g., counseling, referrals, condoms, etc.) will be available.

Reimbursement

The Family Planning Expansion Project reimbursement will be on a fee-for service basis using bundled codes to reduce administrative costs.

Claims Submission

Claims will be submitted through the Ahlers data system. The existing Ahlers system will be modified to provide billing for the Family Planning Expansion Project clients (and OHP clients on an optional basis) while continuing to collect and report visit information to the DHHS Region X Family Planning Reporting System.

Claims Payment

Ahlers will generate a monthly report which the Oregon Health Division will use to generate monthly payments to each Expansion Project provider.

Social Marketing Campaign

A key component of Oregon's effort to increase access to family planning services and reduce unintended pregnancies is a social marketing campaign. This campaign will include strategies specifically targeting potential Family Planning Expansion Project clients.

General Concepts

Social marketing combines education, marketing, mass communications and applied behavioral sciences to promote behavior changes that are in the public's best interest. Research and evaluation are the cornerstone of social marketing and customer needs are at the heart. This means that our customers (e.g., representatives from our target populations(s)) will be involved in all aspects of the campaign. This is what sets social marketing apart from other outreach and marketing approaches. This is what makes the social marketing approach so effective and long-lasting.

The campaign will reflect the recommendations of the Institute of Medicine and thus will educate the public about the high rate of unintended pregnancies and will improve knowledge about pregnancy planning and contraception. The campaign will specifically educate potential Expansion Project clients about the availability of public family planning services. In keeping with the Governor's Teen Pregnancy Prevention Action Agenda, the campaign will include specific messages for teens (both male and female).

Implementation Plan

Planning and research for the campaign have begun. During the research phase factors will be identified which motivate and deter low-income women, men and teens from using effective methods of contraception. Effective messages, information channels, and spokespersons for promoting contraceptive use among low-income women, men and teens in Oregon will be identified. Finally, effective strategies will be identified for encouraging private providers, health and social service agencies, and community organizations to promote unintended pregnancy prevention and use of family planning services by their clients.

Specific messages, communication channels and strategies will be determined by talking with members of the target audiences. For example, a survey among women enrolled in the Oregon Health Plan might reveal that the most effective way to notify them of continued eligibility for public

family planning services would be a personal telephone call instead of a letter. Or we might survey WIC clients at their six-week postpartum visit to find out what it would take to help them successfully access family planning services. This might turn out to be a verbal referral by the WIC nutritionist, a brochure given during the visit, a WIC voucher insert with a family planning message, or it might be the opportunity to schedule a family planning appointment at the same time as a WIC appointment. Focus groups with low-income men and women might reveal that radio is better than television for placing information about contraceptive use and family planning services. So while we cannot commit to a specific message or strategy at this time, we expect to use a variety of media and a variety of messages to reach our goal.

We will local representatives of our potential target audiences from WIC clinics, teen parent programs, school-based health clinics, Adult and Family Services (AFS, our state's TANF agency) offices, employers of potentially eligible clients (e.g., convenience stores, fast food restaurant chains, hotels, etc.), community organizations, local coalitions, etc. Special effort will be made to include teen and adult men.

Based on the findings of the research, target audiences including potential Expansion Project clients will be further identified. A marketing strategy including campaign messages and materials will be developed and pretested for each. It is estimated that the social marketing campaign will begin in July of 1999. This should coincide with the early implementation phase of Expansion Project.

Project Administration

The Family Planning Expansion Project will be jointly managed by the Oregon Health Division and the Office of Medical Assistance Programs (OMAP), both agencies within Oregon's Department of Human Resources (DHR). The mission of Oregon's Department of Human Resources to assist people to become independent, healthy and safe. Refer to Exhibit H for a DHR organization chart.

The Oregon Title XIX Medicaid Program is administered by the Office of Medical Assistance Programs (OMAP). OMAP is an agency within the Director's Office of the Department of Human Resources. OMAP's mission is to plan and implement medical programs assuring access to adequate health care for eligible clients. The agency oversees and manages the Oregon Health Plan, a five-year demonstration project to expand preventive health care services to low income Oregonians. Staff support for the Expansion Project will come from OMAP's Program and Policy Section. The primary OMAP responsibilities relating to the project are oversight of Title XIX policies and procedures and provision of OMAP data for evaluation and budget neutrality.

OMAP's partner agency, the Oregon Health Division (OHD), is Oregon's public health agency, OHD's mission is to protect, preserve and promote the health of all people in Oregon, OHD manages multiple large public health grants including a Title X Family Planning grant. Staff support for the Expansion Project will be provided by the Women's and Reproductive Health Section of the Division's Center for Child and Family Health which also administers the Title X grant. Primary

responsibilities of OHD relating to the project include: day-to-day management: the provider reimbursement system, the social marketing campaign, project evaluation, and budget neutrality.

PROJECT EVALUATION

The Family Planning Expansion Project evaluation will focus on measurements related to the Expansion Project objectives, specified in this section of the proposal. Attainment of the objectives will be examined through a series of quasi-experimental comparisons to determine if outcomes differ from what would be expected without the Project. These comparisons will include pre-post trend analyses to determine if post-implementation outcomes deviate from historical trends in Oregon,

In addition, to control for current secular trends, we will: 1) compare Oregon data relevant to this Project to the data collected in other states that have not implemented a family planning Expansion Project; and 2) whenever possible, compare data from Oregon counties which have programs whose goals are related to the goals of the Family Planning Expansion Project (e.g., programs targeting teen pregnancy) to counties which do not have those programs. The purpose of these comparisons is to determine if our findings can be reasonably attributed to the Family Planning Expansion Project, or to the effects of the other programs, or both.

The evaluation will be conducted under the guidance of Michael Stark, Ph.D., Director of OHD's Program Design and Evaluation Services Section. Consultants to the evaluators will include: David Fleming, M.D., the Oregon State Epidemiologist and past president of the National Association of State and Territorial Epidemiologists; Kenneth Rosenberg, M.D., OHD's Maternal and Child Health Epidemiologist; Joan Kapowich, Manager of OMAP's Program Evaluation Unit; and David Fine, Ph.D., Region X Title X Data Consultant.

Data for the evaluation will come from multiple data sets including: Oregon's Medicaid Program (OMAP) data, Oregon State's Title X Family Planning Program (Ahlers) Data, birth and abortion records from the Oregon Health Division Vital Statistics Section, and survey information. Data from other states will be obtained for comparisons to their Family Planning Program data, Vital Statistics, and three surveys: the Pregnancy Risk Assessment Monitoring System (PRAMS), the Behavioral Risk Factor Surveillance System (BRFSS), and the Youth Risk Behavior Survey (YRBS). In order to compare our data to other states, we will identify states who have similar demographics, who have Ahlers, PRAMS, and YRBS data, and who are implementing the BRFSS Family Planning module,

The remaining information to be collected are time lines and descriptions of this Project's activities as well as other programs' activities that could impact some of the results. Those programs include Oregon's Poverty Level Medical Program for pregnant women and their children (coverage is increasing from 133 to 170 percent of the federal poverty level in 1998) and a number of Oregon initiatives occurring under the auspices of the Governor's Teen Pregnancy Action Agenda, e.g. STARS (Students Today Aren't Ready for Sex, our postponing sexual involvement program.) We will also monitor the progress of proposed national and Oregon legislation to mandate private insurance coverage of contraception and examine the effects of any new legislation in this area.

The impact of national welfare reform is another variable to consider. Welfare reform is less of a new issue for Oregon than it is for many other states. The Oregon Health Plan, which began in 1994,

separates medical care from welfare. In Oregon, Medicaid has covered and will continue to cover those whose income is less than 100% of poverty. Oregon has also pioneered a welfare-to-work program called JOBS. Oregon's uniqueness makes comparisons of our data to other states problematic. We will, however, obtain information on the progress of welfare reform in comparison states, and this information will be considered as we interpret the results of the evaluation.

Links Between Goals & Objectives, Project Design, and Evaluation

The following pages list the Project objectives, and link these objectives with the major hypotheses and outcome measures for the evaluation of the Project. The primary goal of the Expansion Project is to reduce unintended pregnancy. Objectives 1-4 and their accompanying hypotheses address this goal in specific populations with multiple measures. In order to meet objectives 1-4, the Project is designed to include the following components: public education and outreach, provider training, improved financial support, and high quality services. The education, outreach and improved financial support are designed to bring more clients into the system (Objectives 5 and 6). The financial support and provider training should result in these clients receiving high quality services (Objectives 6 and 7).

Objective 1

Reduce the rate of unintended pregnancies among Oregon women in general and among women who are eligible for Medicaid paid deliveries.

Hypothesis 1

There will be a reduction in the rate of unintended pregnancies among Oregon women in general and among women who are eligible for Medicaid paid deliveries following the implementation of the Expansion Project.

Measures

We will implement two statewide surveys to assess the rate of unintended pregnancies among Oregon women. First, we will survey a representative random sample of postpartum women in Oregon. Names and birth outcomes of postpartum women will come from birth records from the Oregon Health Division's Vital Statistics Section. These women will be asked questions about the intendedness of their pregnancies. (The questions will be parallel to those in the CDC PRAMS, the Pregnancy Risk Assessment Monitoring System.)

Of course a postpartum survey misses pregnant women who obtained an abortion or miscarried. So a second survey will be conducted of a representative sample of women ages 15-44. It will consist of the questions in the Family Planning Issues module of the CDC BRFSS (Behavioral Risk Factor Surveillance System). These questions relate to unintended pregnancy and the use of contraception and family planning services.

Both the Postpartum survey and the new BRFSS questions will begin in 1998. We will compare the baseline and post-baseline results to determine changes in the rates of unintended pregnancies and changes in the rates of unintended pregnancies for women eligible for Medicaid paid deliveries.

Eligibility will be estimated by income and family size data that are part of the two surveys. Data from PRAMS surveys and BRFSS surveys from other states will be used to compare with Oregon's results as a way to control for secular trends.

Objective 2

Reduce the proportion of births spaced less than two years apart in the general population and among women who are eligible for Medicaid paid deliveries.,

Hypothesis 2

The proportion of inadequately spaced births (less than two years) in general and among women eligible for Medicaid paid deliveries will decline following the implementation of the Expansion Project.

Measures

We will use birth records from the Oregon Health Division's Vital Statistics Section. Trend analyses will be used to compare the spacing of all deliveries and Medicaid deliveries during the Expansion Project to spacing in previous years. Vital statistics data from other states will be used to compare to Oregon to control for secular trends.

Objective 3

Reduce the teen pregnancy rate for 10 to 17 year-olds.

Hypothesis 3a

More sexually active teens will report using a birth control method following implementation of the Expansion Project.

Measures

We will use Oregon Youth Risk Behavior Survey (YRBS) data to assess the use of birth control methods. We will compare the percent of sexually active teens reporting birth control use at baseline to subsequent years after the Expansion Project has been implemented. Data from YRBS surveys from other states will be used to compare to Oregon to control for secular trends.

Hypothesis 3b

There will be a reduction in the pregnancy rate for 10 to 17 year-olds following the implementation of the Expansion Project.

Measures

We will use birth and abortion records from the Oregon Health Division's Vital Statistics Section. Oregon is fortunate to have a long history of required abortion reporting. We will compare the teen pregnancy rate at baseline to subsequent years after the Expansion Project has been implemented. Teen birth data but not abortion data from other states can easily be obtained for comparison purposes.

Since the Family Planning Expansion Project is only one of multiple strategies Oregon will be using to

reduce teenage pregnancy, it is important to ascertain the impact of this Project alone on the teen pregnancy rate. Clear information about one of these strategies, the STARS program, will allow comparisons between counties who have STARS programs vs. those which do not. The comparisons will allow a determination of the Family Planning Expansion Project's impact independent of the STARS program.

Objective 4

Reduce second births among teens.

Hypothesis 4

There will be a reduction in the proportion of births to teens 10 to 17 years old which are their second births.

Measures

We will use birth records from the Oregon Health Division's Vital Statistics Section. We will compare the proportion of second or more births for teens 10 to 17 at baseline to the proportion in subsequent years. Vital statistics data from other states will be used to compare to Oregon to control for secular trends.

Objective 5

Increase the number of Oregon women and teens receiving services from publicly funded family planning clinics.

Hypothesis 5a

There will be an increase in the annual number of women and teens obtaining family planning services at Title X clinics following the implementation of the Expansion Project.

Measures

The current Title X data collection system, called Ahlers, includes a question about payment source. We will use the Ahlers data to determine the numbers and ages of women using Medicaid and Title X family planning services at our clinics. Trend analyses will be used to compare the number of women served before and during the Expansion Project. Title X Family Planning Program data will be available from other states for comparison purposes.

Hypothesis 5b

Among women who do not use any birth control, fewer will report not being able to pay for birth control as the reason for non-use.

Measures

Questions added to the BRFSS include current use of family planning services and reasons for not using birth control for non-users. We will compare the rates of responses to these questions at baseline and at post-baseline annual waves to determine changes in the prevalence of those reporting not being able to pay as the reason for not using birth control. Data from BRFSS surveys from other

states using this module will be used to control for secular trends.

Objective 6

Increase the number of men receiving services from publicly funded family planning clinics.

Hypothesis 6a

There will be an increase in the annual number of men obtaining family planning services at Title X clinics following the implementation of the Expansion Project.

Measures

We will use the Ahlers data to determine the number men using Medicaid and Title X family planning services at our clinics. Trend analyses will be used to compare the number of men served before and during the Expansion Project. Title X Family Planning Program data will be available from other states for comparison purposes.

Hypothesis 6b

Among men who do not use any birth control, fewer will report not being able to pay for birth control as the reason for non-use.

Measures

Oregon's BRFSS will include a representative sample of men 15-44 asked questions that are parallel to the questions asked for women in the family planning module. Questions include current use of family planning services and reasons for not using birth control for non-users. We will compare the rates of responses to these questions at baseline and at post-baseline in annual waves to determine changes in the prevalence of those reporting not being able to pay as the reason for not using birth control.

Hypothesis 6c

Men will report an increase in contraceptive use and a decrease in unintended pregnancies for their partners over the course of the Expansion Project.

Measures

Oregon will include questions on the BRFSS for men that are parallel to the questions asked for women in the family planning module. Questions will include contraceptive use and intendedness of pregnancies. We will compare the rates of responses to these questions at baseline and post-baseline. We will also compare men's perceptions of intendedness to women's.

Hypothesis 6d

The number of men obtaining Medicaid-funded vasectomies will increase following the implementation of the Expansion Project.

Measures

OMAP data will be used to assess the numbers of Medicaid-funded vasectomies performed before and during the Expansion Project. Trend analyses will also be used to determine if there is an increase in the number of Medicaid-funded vasectomies during the life of the Project.

Objective 7

Increase the use of more effective contraceptive methods by clients receiving services from publicly funded family planning clinics.

Hypothesis 7

Women and teens will receive more effective (e.g., Depo-Provera, Norplant, sterilization) means of contraception after implementation of the Expansion Project. (Also see Hypothesis 6d for men.)

Measures

Ahlers data will be used to determine the method of contraception used. Trend analyses will be used to compare the types of contraception women and teens use before and after the implementation of the Expansion Project. Title X Family Planning Program data from other states will be compared to Oregon to control for secular trends.

BUDGET NEUTRALITY

The provision of family planning services directly results in substantial savings - in both human and financial terms. According to the Alan Guttmacher Institute, if all publicly funded family planning services were no longer available, the women who rely on them would have 1.2 million additional unintended pregnancies each year. (Forrest, J.D., et al., 1996, p. 188).

Since a large percentage of women receiving publicly funded family planning services are Medicaid recipients *or would become eligible if they became pregnant*, "every public dollar spent on contraception saves \$3.00 that would otherwise have to be spent for pregnancy-related and newborn medical care *alone*." (Forrest, J.D., et al., 1996, p. 188). This conservative savings estimate does not account for welfare benefits and other publicly funded social services consumed by low income women and their children. When considering other public expenses like welfare and nutritional services, the average government savings is \$4.40 for every \$1.00 spent on family planning services. (Forrest, J.D., et al., 1990, p. 6).

The benefits of Oregon's Family Planning Expansion Project were originally envisioned in terms of the above cost-benefit statistics. Since then, we have developed a detailed budget neutrality model specifically to fit Oregon's project. According to our current estimates, the Expansion Project will be budget neutral by the end of the second year. By the end of the Project, there will be a substantial savings to both the State of Oregon and the federal Medicaid Program.

Key Assumptions

Savings

When a woman at 185 percent of poverty becomes pregnant, one person is added to her family size. This pushes the family below 170 percent of poverty, the level of Medicaid coverage for prenatal care in Oregon, effective March 1, 1998. Thus, all births averted by the project would result in savings to the Medicaid program. *Savings per averted birth is estimated at \$3,560 for prenatal care, delivery, and routine medical care for the mother.* This is a conservative estimate. *Annual savings for a young child's health care are estimated at \$5,100.* These estimates are based on current Medicaid reimbursement levels in Oregon. A 61/39 match is assumed for all of these savings.

Births Averted

Several sources estimate that the approximate ratio of births averted to family planning clients served is 1 to 10, or 10%. (Oregon Ahlers data, 1996; Trussel et al., 1995; and Forrest et al., 1990). We have adjusted our estimate downward from this to reflect the fact that some of the Expansion clients may have been receiving services elsewhere prior to the Expansion. It is estimated that *six percent or 3,990 of our clients will avert an unintended birth each year.* Our estimate is a reasonable goal in light of the number of unintended births in Oregon's target population.

Number of Clients

An estimated 66,500 clients can be served annually with available Medicaid expansion funding. This number represents a reasonable portion of the target population- Oregonians with incomes between 100 and 185 percent of poverty. Many clients in the target population are currently served by the Title X Program. New clients are expected to increase rapidly in the first 18 months. As a result, full capacity could be reached by the end of the second year of the project,

Cost Per Client

The cost of family planning services, including contraceptives, are *estimated at an average of \$200 per client per year* based on Medicaid reimbursement levels for family planning clients in Oregon. A 90/10 match is assumed on these expenditures.

Budget Neutrality Worksheets

Oregon's budget neutrality model is laid out in worksheet form, with one worksheet showing **ALL COSTS**, and a second worksheet showing **FEDERAL COSTS**. The following narrative describes the worksheets:

ALL COSTS Worksheet

The main row headings of the ALL COSTS worksheet are *WITHOUT WAIVER*, *WITH WAIVER*, and *DIFFERENCE*. There is a column for each year of the project (Years 1-5). In recognition of the fact that gestation is nine months long, births are not projected to be averted nor savings accrued until at least nine months after the project begins. To simplify the presentation of this issue, we conservatively used a one-year lag period. Therefore savings for Year 1 are shown in Year 2, savings for Year 2 are shown in Year 3, etc. This also means the savings for Year 5 are not included in the model.

WITHOUT WAIVER

Per Capita estimates for Basic Family Planning Services, Deliveries, and Infant Health Care are estimated as follows: Basic Family Planning Service, including an annual visit, contraceptives and other services as necessary, \$200; Delivery costs, including routine medical care, prenatal care and delivery, \$3,560. Infant Health Care for one year, \$5,100.

The number of deliveries and therefore infants that are covered by Medicaid (as indicated on the birth certificate) each year is about 15,000. It should be noted that these numbers do not show an entirely accurate picture of Oregon without the waiver, because as of 1998, Oregon's Medicaid eligibility for pregnant women and their children is changing from 133% to 170% of the federal poverty level. Since these costs should be the same under *WITHOUT WAIVER* and *WITH WAIVER*, they do not impact the *DIFFERENCE* line.

WITH WAIVER

For more details on the administrative budget for the Expanded FP Service, please see the Project Budget section of the proposal. Per capita costs are estimated at \$200. The maximum number of Persons that can be served annually with available Medicaid Expansion funding is 66,500. The number of Persons in Year 1 is less than in Year 2 because of the need to allow time for start-up.

Births are not expected to be averted until at least nine months after the project begins. To simplify the presentation of this issue, we conservatively used a one-year lag period. A reduction in Deliveries and thus Infant Health Care is therefore shown beginning in Year 2. The size of the reduction is six percent times the number of clients served in the Expansion (see Births Averted under Key Assumptions). This means that when the project is fully operational, we estimate that 3,990 unintended births will be averted each year.

DIFFERENCE

This line is simply the subtraction of the *WITH WAIVER* line from the *WITHOUT WAIVER* line.

FEDERAL COSTS Worksheet

The FEDERAL COSTS worksheet is organized in precisely the same as the ALL COSTS worksheet. The only difference in this worksheet is that Per Capita costs are all based on the federal match rates (shown in the lefthand column) applied to ALL COSTS.

TOTAL SAVINGS

As shown on the Worksheets, we project that the Expansion Project will be budget neutral by the end of the second year. By the end of the Project, there will be a substantial savings to both the State of Oregon and the federal Medicaid Program.

Although not shown in the worksheets, additional savings are expected to accrue to the Medicaid program:

- Because family planning services in one year avert births nine months later, savings are expected to continue in the year after the Project.
- Child health care costs would have been incurred beyond the first year of life (up to 12 years of age for children under 170 percent poverty in Oregon).
- Unintended births are more likely to be low birth weight and have higher medical costs, including long term costs due to disabilities.
- With Title X dollars freed up, additional women outside the target population can be served, thus averting additional births. Some of the women would have qualified for Medicaid emergency assistance for delivery and Medicaid coverage for their children up to age 12.

- Routine health care costs for women who would have ended up on the Oregon Health Plan roles had they an unintended birth.

Additional non-Medicaid federal savings are expected to accrue but have not been estimated, including WIC, TANF, food stamps, etc. Savings in terms of decreased social costs are incalculable.

ALL COSTS

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
WITHOUT WAIVER						
Deliveries						
Per Capita	\$3,560	\$3,560	\$3,560	\$3,560	\$3,560	
Persons	15,000	15,000	15,000	15,000	15,000	
Total	\$53,400,000	\$53,400,000	\$53,400,000	\$53,400,000	\$53,400,000	\$267,000,000
Infant Health Care						
Per Capita	\$5,100	\$5,100	\$5,100	\$5,100	\$5,100	
Persons	15,000	15,000	15,000	15,000	15,000	
Total	\$76,500,000	\$76,500,000	\$76,500,000	\$76,500,000	\$76,500,000	\$382,500,000
TOTAL Without Waiver	\$129,900,000	\$129,900,000	\$129,900,000	\$129,900,000	\$129,900,000	\$649,500,000
WITH WAIVER						
Expanded FP Service						
Administration	\$391,000	\$27,300	\$527,300	\$27,300	\$527,300	\$1,500,200
Systems Changes	\$239,000	\$102,700	\$102,700	\$102,700	\$102,700	\$649,800
Subtotal	\$630,000	\$230,000	\$630,000	\$230,000	\$630,000	\$3,150,000
Per Capita	\$200	\$200	\$200	\$200	\$200	
Persons	52,800	66,500	66,500	66,500	66,500	
Subtotal	\$10,560,000	\$13,300,000	\$13,300,000	\$13,300,000	\$13,300,000	\$60,000,000
Deliveries						
Total	\$11,190,000	\$13,930,000	\$13,930,000	\$13,930,000	\$13,930,000	\$66,910,000
Infant Health Care						
Per Capita	\$3,560	\$3,560	\$3,560	\$3,560	\$3,560	
Persons without Waiver	15,000	15,000	15,000	15,000	15,000	
Averted Births	0	(3,168)	(3,990)	(3,990)	(3,990)	
Total	\$53,400,000	\$42,121,920	\$39,195,600	\$39,195,600	\$39,195,600	\$213,408,720
TOTAL With Waiver	\$141,090,000	\$116,395,120	\$109,276,600	\$109,276,600	\$109,276,600	\$585,314,920
DIFFERENCE	(\$11,190,000)	\$13,504,880	\$20,623,400	\$20,623,400	\$20,623,400	\$64,185,080

FEDERAL COSTS

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Infant Health Care						
Per Capita (61%)	\$3,111	\$3,111	\$3,111	\$3,111	\$3,111	
Persons	15,000	15,000	15,000	15,000	15,000	
Total	\$46,665,000	\$46,665,000	\$46,665,000	\$46,665,000	\$46,665,000	\$233,325,000
TOTAL Without Waiver						
	\$79,239,000	\$79,239,000	\$79,239,000	\$79,239,000	\$79,239,000	\$396,195,000
WITH WAIVER						
Expanded FP Service						
Administration (50%)	\$195,500	\$263,650	\$2,3650	\$263,650	\$263,650	\$1,250,100
Systems Changes (75%)	\$179,250	\$77,025	\$77,025	\$77,025	\$77,025	\$487,350
Subtotal	\$374,750	\$340,675	\$3,40,675	\$340,675	\$340,675	\$1,737,450
Per Capita (90%)	\$180	\$180	\$180	\$180	\$180	
Persons	52,800	66,500	66,500	66,500	66,500	
Subtotal	\$9,504,000	\$11,970,000	\$11,970,000	\$11,970,000	\$11,970,000	\$57,384,000
Total	\$9,878,750	\$12,310,675	\$12,310,675	\$12,310,675	\$12,310,675	\$59,121,450
Deliveries						
Per Capita (61%)	\$2,172	\$2,172	\$2,172	\$2,172	\$2,172	
Persons without Waiver	15,000	15,000	15,000	15,000	15,000	
Averted Births	0	(3,168)	(3,990)	(3,990)	(3,990)	
Total	\$32,574,000	\$25,694,371	\$23,909,316	\$23,909,316	\$23,909,316	\$129,996,319
Infant Health Care						
Per Capita (61%)	\$3,111	\$3,111	\$3,111	\$3,111	\$3,111	
Persons without Waiver	15,000	15,000	15,000	15,000	15,000	
Averted Births	0	(3,168)	(3,990)	(3,990)	(3,990)	
Total	\$46,665,000	\$39,574,000	\$32,574,000	\$32,574,000	\$32,574,000	\$186,230,682
TOTAL With Waiver						
	\$89,117,750	\$74,814,398	\$70,472,101	\$70,472,101	\$70,472,101	\$375,348,451
DIFFERENCE						
	(\$9,878,750)	\$4,424,602	\$8,766,899	\$8,766,899	\$8,766,899	\$20,846,549

Percentages in the left-hand column are the federal match rates applied to ALL COSTS to calculate FEDERAL COSTS.

PROJECT BUDGET

PROJECT BUDGET

BUDGET CATEGORY						Total
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YR 1-5
A. PERSONNEL Increase estimated at 5% per year	\$133,247	\$139,909	\$146,905	\$154,250	\$161,963	\$730,274
B. FRINGE BENEFITS Benefits are estimated at 38% of salary.	\$50,000	\$53,106	\$55,824	\$58,015	\$60,546	\$279,784
C. TRAVEL	\$43,993	\$44,000	\$11,445	\$10,310	\$15,666	\$73,514
D. EQUIPMENT	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$25,000
E. SUPPLIES	\$8,400	\$8,400	\$8,400	\$8,400	\$8,400	\$42,000
F. RENT / PHONE	\$9,720	\$19,725	\$19,726	\$19,725	\$19,726	\$98,628
G. SYSTEMS	\$239,000	\$102,700	\$102,700	\$102,700	\$102,700	\$649,800
H. EVALUATION	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000	\$200,000
I. SOCIAL MARKETING CAMPAIGN	\$120,000	\$245,000	\$240,000	\$235,000	\$215,000	\$1,045,000
J. SUB-TOTAL ADDITIONAL BUDGET	<u>\$630,000</u>	<u>\$630,000</u>	<u>\$630,000</u>	<u>\$630,000</u>	<u>\$630,000</u>	<u>\$3,150,000</u>
K. DIRECT SERVICES	\$10,560,000	\$13,300,000	\$13,300,000	\$13,300,000	\$13,300,000	\$66,760,000
L. TOTAL	\$11,190,000	\$13,920,000	\$13,930,000	\$13,930,000	\$13,930,000	\$66,910,000

PROJECT BUDGET DETAIL

A. PERSONNEL

	Annual Salary	FTE	Title X	Waiver
OHD:				
Project Coordinator Program Tech 2	\$37,176	1	\$0	\$37,176
FP Health Ed. Consultant PHE 2	\$24,523	0.6	\$0	\$24,523
FP Nurse Consultant PHN 2	\$45,024	0	\$45,024	\$0
Research Analyst RA 3	\$37,176	0.5	\$18,588	\$18,588
FP Health Ed. Consultant PHE 2	\$32,698	0	\$32,698	\$0
Project Admin. Specialist AS 2	\$30,732	0.5	\$15,366	\$15,366
Project Secretary OS 2	\$22,248	0	\$22,248	\$0
Program Manager Principle Mgr. C	\$45,960	0.67	\$30,334	\$15,626
Section Manager Exec. Mgr. E	\$50,652	0.25	\$12,663	\$12,663
OMAP:				
Policy Analyst Program Tech 2	\$37,848	0.05	\$0	\$1,892
Budget Analyst Program Tech 2	\$37,848	0.05	\$0	\$1,892
Fiscal Analyst RA 2	\$28,464	0.05	\$0	\$1,423
Systems Analyst Sys. Analyst 1	\$32,784	0.05	\$0	\$1,639
Program Manager Principle Mgr. D	\$49,176	0.05	\$0	\$2,459
TOTAL			\$176,921	\$133,247

B. FRINGE BENEFITS

Benefits are estimated at 38% of salary. Benefits include FICA, Retirement, Worker's Compensation Insurance, Health and Dental Insurance.

C. TRAVEL

Travel and materials expenses for training and technical assistance:
average cost per year \$14,000.

Out-of-state travel for one person - one trip per year: \$1,500 per year.

D. EQUIPMENT

Computer and equipment replacement: \$5,000 per year.

E. SUPPLIES

General office supplies, Xeroxing, postage = \$200 per mo. x 3.5 FTE

F. RENT / PHONE

\$5636 per year x 3.5 FTE

G. SYSTEMS

Set-up:	Systems Development Contractor	\$20,000
	OIS	\$20,000
	Computers	
	40 @2,500	\$1 00,000
	User Support Analyst	
	Includes OPE &trave	\$49,000
On-going:	Claims Processing	\$53,200
	(66,500 clients x 2 claims per year x .40 per claim)	
	Local Computer Suppor	\$24,500
	Additional equipment	\$25,000

H. EVALUATION

Post-partum Surveys	\$30,000
Evaluation Consultant Contract	\$10,000

I. SOCIAL MARKETING CAMPAIGN

Design, development of materials, media purchase, contractors

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Washington State Department of Health, *Washington State's Vasectomy Project- A Progress Report*, 1997, pages 1-21

Exhibits

- A. The Oregon Health Plan
- B. Description of Title X
- C. Teen Pregnancy Prevention - Oregon Action Agenda
- D. Healthy People 2010
- E. Oregon Benchmarks
- F. Directory of Family Planning Clinics
- G. Title X Guidelines
- H. DHR Organization Chart