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CHAPTER 333
OREGON HEALTH AUTHORITY
PUBLIC HEALTH DIVISION

FILING CAPTION: Amend Reproductive Health Program Rules to reflect changes in funding and updates to Certification Requirements

EFFECTIVE DATE: 10/27/2022

AGENCY APPROVED DATE: 10/14/2022

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RULES:
333-004-3010, 333-004-3030, 333-004-3040, 333-004-3050, 333-004-3070, 333-004-3080, 333-004-3090, 333-004-3110, 333-004-3140, 333-004-3150, 333-004-3200, 333-004-3230, 333-004-3240

AMEND: 333-004-3010

REPEAL: Temporary 333-004-3010 from PH 50-2022

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3010 Clarify RH Program sources of funding; update version numbers for Certification Requirements for RHCare Clinics, Certification Requirements for CCare Clinics, Certification Requirements for AbortionCare clinics; and, add definition for Title X.

CHANGES TO RULE:

333-004-3010
Definitions
(1) "AbortionCare Clinic" means a clinic operated by an agency certified with the RH Program to receive reimbursement for abortion services provided to enrollees who meet RHEA eligibility criteria.¶
(2) "Abortion services" means any services provided in an outpatient setting to end a pregnancy so that it does not result in a live birth. Services include medication and therapeutic abortion procedures. Contraceptive drugs, devices, and supplies related to follow-up care are also included.¶
(3) "Acquisition cost" means the amount or unit cost of the drugs, devices, or supplies the agency actually pays to the pharmaceutical manufacturer, supplier or distributor after applying any discounts, promotions or other reductions. Shipping and handling may be included in the acquisition cost only if supported by an invoice.¶
(4) "Agency" means an entity certified by the RH Program to operate RHCare clinics, CCare clinics, and/or AbortionCare clinics.¶
(5) "Agency number" or "Project number" means the administrative number assigned by the RH Program to an agency.¶
(6) "Applicant agency" means an entity who is applying to be certified by the RH Program to operate RHCare clinics, CCare clinics, and/or AbortionCare clinics.¶
(7) "Authority" means the Oregon Health Authority.¶

(8) "Authorizing Official" means an individual with legal authority to act on behalf of the agency.¶
(9) "CCare" means Oregon ContraceptiveCare which is a 1115 family planning Medicaid demonstration waiver that expands Medicaid coverage for contraceptive services. CCare provides family planning services to Oregonians not enrolled in the Oregon Health Plan (OHP), with incomes at or below 250 percent of the Federal Poverty Level (FPL). CCare services are limited to those related to preventing unintended pregnancy.¶
(10) "CCare Clinic" means a clinic operated by an agency certified with the RH Program to receive reimbursement for CCare services provided to enrollees who meet CCare eligibility criteria.¶
(11) "Center" means the Center for Prevention and Health Promotion, within the Public Health Division of the Authority.¶
(12) "Certification Requirements for CCare Clinics" means Oregon Reproductive Health Program Certification Requirements for CCare Clinics, Version ~~1~~2.¶
(13) "Certification Requirements for AbortionCare Clinics" means Oregon Reproductive Health Program Certification Requirements for AbortionCare Clinics, Version ~~2~~3.¶
(14) "Certification Requirements for RHCare Clinics" means Oregon Reproductive Health Program Certification Requirements for RHCare Clinics, Version ~~2~~3.¶
(15) "Certification" means the agency has attested to meeting the certification requirements, submitted all required documents, been approved by the RH Program, and has an executed MSA with the RH Program.¶
(16) "CLIA" means the Clinical Laboratory Improvement Amendments of 1988, which establishes quality standards for all laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results, and allows for certification of clinical laboratories operating in accordance with these federal amendments.¶
(17) "Client" means any person who has reproductive capacity and is seeking reproductive health, family planning, or abortion services at a RHCare, CCare, or AbortionCare clinic.¶
(18) "Client-centered" means care that is respectful of, responsive to, and allows individual client preferences, needs, and values to guide all clinical decisions.¶
(19) "Clinic" means a site within an agency that meets certification requirements and is listed on the agency's MSA.¶
(20) "Clinic number" or "Site number" means the administrative number assigned by the RH Program to each clinic within an agency.¶
(21) "Clinic Visit Record" or "CVR" means the form or set of information that is completed for each client visit and serves as the billing mechanism for the RH Access Fund.¶
(22) "CMS" means the Centers for Medicare and Medicaid Services, located within the federal Department of Health and Human Services.¶
(23) "Drugs, devices, or supplies" means FDA-approved product(s) provided to a client pursuant to reproductive health services.¶
(24) "Enrollee" means a client who has completed an RH Access Fund Enrollment Form and been enrolled in the RH Access Fund.¶
(25) "Family planning services" means clinical, counseling, or education services related to achieving or preventing pregnancy.¶
(26) "FPL" means the federal poverty level guidelines established each year by the U.S. Department of Health and Human Services.¶
(27) "GC/CT" means gonorrhea and Chlamydia.¶
(28) "Health Systems Division" means the Division within the Oregon Health Authority that administers the Oregon Health Plan.¶
(29) "Medical Services Agreement" or "MSA" means an agreement that sets forth the relationship between the Center and the enrolling agency regarding payment by the Center for reproductive health services, drugs, devices or, supplies.¶
(30) "Minor" means anyone under the age of 18, per ORS 419B.550.¶
(31) "Nationally-recognized standard of care" means a diagnostic, screening, or treatment process recognized by a national organization, including but not limited to the American Cancer Society (ACS), American College of Obstetrics and Gynecologists (ACOG), U.S. Preventative Services Task Force (USPSTF), or the U.S. Medical Eligibility Criteria (USMEC).¶
(32) "NVRA" means the National Voter Registration Act.¶
(33) "Provider" means a licensed health care professional operating within the appropriate scope of practice according to their license, who works for an agency.¶
(34) "Reasonable opportunity period" or "ROP" means a 90-day period during which individuals who declare U.S. citizenship or Eligible Immigration Status may receive services under CCare while documentation of such status is gathered and verified, under section 1903(x) of the Social Security Act.¶
(35) "RHCare clinic" means a clinic operated by an agency certified with the RH Program to provide reproductive health services to all clients and to receive reimbursement for covered reproductive health services provided to

all enrollees.¶
(36) "Reproductive capacity" means able to become pregnant or cause a pregnancy.¶
(37) "Reproductive Health Access Fund" or "RH Access Fund" means a source of coverage for reproductive health services as defined in OAR 333-004-3070 (RH Access Fund Covered Services by Funding Source) provided to enrollees who complete the RH Access Fund Enrollment Form and are deemed eligible.¶
(38) "Reproductive Health Program" or "RH Program" means the program within the Center for Prevention and Health Promotion of the Oregon Health Authority that certifies RHCare, CCare, and Abortion clinics and administers the RH Access Fund which includes CCare, ~~RH GF~~Title X, and RHEA funds.¶
(39) "Reproductive health services" or "RH services" means preventive services, including family planning, and related drugs, devices, and supplies, to support the healthy reproductive processes, functions and system.¶
(40) "RHEA" means Reproductive Health Equity Act (ORS 414.432) funding, which provides access to reproductive health and abortion services to Oregonians who are able to get pregnant and who would be eligible for medical assistance if not for 8 U.S.C. 1611 or 1612.¶
(41) "RH GF" means Oregon Reproductive Health Program General Funds which provide preventive reproductive health and related services for individuals with reproductive capacity.¶
(42) "RH Program Coordinator" or "RHC" means an agency staff person assigned to ensure compliance at all clinic sites within each agency and to be the primary liaison between state RH Program staff and the agency.¶
(43) "RH Access Fund Eligibility Database" means the centralized, web-based data system operated by the RH Program to house information about enrollees.¶
(44) "RH Access Fund Enrollment Form" means the form whereby individuals apply for RH Access Fund coverage.¶
(45) "Sanction" means an action against agencies taken by the Authority in cases of fraud, misuse, abuse, or non-compliance of RH Program requirements.¶
(46) "School-Based Health Center" means a health center certified by the School-Based Health Center State Program, as defined in OAR 333-028-0210 (School-Based Health Center Program: Definitions).¶
(47) "Special confidentiality" means that an agency is permitted to bill the RH Program in lieu of billing a private insurer because a client fears that they will suffer harm if the policy holder of the private insurance finds out about the services they are receiving.¶
(48) "Telehealth" means the provision of healthcare remotely by means of telecommunications technology.¶
(49) "Title X" means Title X of the Public Health Service Act, Section 1001 (42 U.S.C. § 300), which is a federal grant administered by the Department of Health and Human Services, Office of Population Affairs intended to ensure access to equitable, affordable, client-centered, quality family planning services for clients, especially low-income clients.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec 10

AMEND: 333-004-3030

REPEAL: Temporary 333-004-3030 from PH 50-2022

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3030 Update Certification Requirements for RHCare Clinics to come into alignment with Title X. Update Certification Requirements for RHCare Clinics, Certification Requirements for CCare Clinics, and Certification Requirements for AbortionCare to enhance requirements related to culturally-responsive care, streamline requirements related to laboratories and pharmacy, specify when agencies must notify the RH Program due to staff changes, correct grammatical errors, etc. Specify when agencies will be bound to operate under the updated RHCare, CCare, and/or AbortionCare Certification Requirements.

CHANGES TO RULE:

333-004-3030
Agency Certification Requirements
(1) Agencies newly certified or recertified with the RH Program to operate RHCare clinics on or after October 27, 2022 shall:¶
(a) Adhere to the following sections of the Certification Requirements for RHCare Clinics Version ~~2~~3, incorporated by reference.¶
(A) Section A: Facility, Operations, and Staffing;~~.~~¶
(B) Section B: Equitable Access;¶
(C) Section C: Clients' Rights and Safety;~~.~~¶
(D) Section D: Service ~~Provisions~~;¶
(E) Section E: Data Collection and Reporting; and¶
(F) Section F: Reproductive Health Access Fund.¶
(b) Be eligible for reimbursement from the RH Program for reproductive health services, as described in OAR 333-004-3070(2), (3), and (4)(a) (RH Access Fund Covered Services by Funding Source), provided to enrollees who meet CCare, ~~RH GF~~Title X, or RHEA eligibility criteria.~~.~~¶
(c) Serve all clients of reproductive capacity seeking reproductive health services.¶
(~~2) Agencies~~ d) Deliver services in compliance with the requirements of the Federal Title X Program as detailed in statutes and regulations, including but not limited to 42 USC 300 et seq., 42 CFR Part 50 subsection 301 et seq., and 42 CFR Part 59 et seq., the Title X Program Requirements, and Office of Population Affairs Program Policy Notices (PPN).¶
(2) Agencies newly certified or recertified with the RH Program to operate CCare clinics on or after October 27, 2022 shall:¶
(a) Adhere to the following sections of the Certification Requirements for CCare Clinics Version ~~1~~2, incorporated by reference.¶
(A) Section A: Facility, Operations, and Staffing;~~.~~¶
(B) Section B: Equitable Access;¶
(C) Section C: ~~Client~~Enrollee's' Rights and Safety;~~.~~¶
(D) Section D: Service ~~Provisions~~;¶
(E) Section E: Data Collection and Reporting; and¶
(F) Section F: Reproductive Health Access Fund.¶
(b) Be eligible for reimbursement from the RH Program for CCare-covered services, as described in OAR 333-004-3070(3) (RH Access Fund Covered Services by Funding Source), provided to enrollees who meet CCare eligibility criteria.¶
(3) Agencies newly certified or recertified with the RH Program to operate AbortionCare clinics on or after October 27, 2022 shall:¶
(a) Adhere to the following sections of the Certification Requirements for AbortionCare Clinics Version ~~2~~3, incorporated by reference.¶
(A) Section A: ~~Administrative Requirements; ¶~~
~~(B) Section B: Clinical Requirements;¶~~
~~(C) Section C: Fiscal and Billing Requiremen~~Facility, Operations, and Staffing;¶
(B) Section B: Equitable Access;¶
(C) Section C: Enrollees' Rights~~,~~ and Safety; ¶
(D) Section D: ~~Data Collection and Billing Requirements~~Services;¶
(E) Section E: Data Collection and Reporting; and¶

(F) Section F: Reproductive Health Access Fund.¶
(b) Be eligible for reimbursement from the RH Program for abortion services, as described in OAR 333-004-3070(4)(b) (RH Access Fund Covered Services by Funding Source), provided to enrollees who meet RHEA eligibility criteria.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec 10

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

RHCare Certification Requirements, Version 3.0

Please note: For the purposes of these requirements, client means any person who has reproductive capacity and is seeking reproductive health services at a RHCare clinic.

Section A. Facility, Operations, and Staffing

A.1 Clinic Space

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

A.2 Infection Control

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

A.3 Laboratory

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

A.4 Pharmacy and Dispensing Medications and Contraceptive Methods

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

A.5 Emergencies

a. Clinics must maintain a written plan for medical emergencies, including:
    1. Anaphylaxis/Shock;
    2. Vaso-vagal reaction/Syncope;
    3. Cardiac Arrest/Respiratory Difficulty (if the clinic has an automated external defibrillator (AED) include protocol on how to use); and
    4. Hemorrhage.
b. Clinics must maintain a written after-hours emergency policy management plan.
c. Clinics must meet applicable fire, building, and licensing codes and standards and maintain Exit Routes, Emergency Action Plans, and Fire Prevention Plans in accordance with OSHA.

A.6 Reproductive Health Coordinator

a. The agency must designate a staff person as a Reproductive Health Coordinator (RHC) to be the key point of contact in accordance with OAR 333-004-3040. The RHC is responsible for all the items listed in the RH Coordinator Competencies, including, but not limited to:
    1. Ensuring program compliance at all clinic sites;
    2. Being the agency's subject matter expert on all aspects of the RHCare certification requirements and how they are operationalized within clinic sites;
    3. Acting as the primary contact with the Oregon RH Program; and
    4. Managing the implementation and operationalization of RHCare certification requirements in all participating clinics.
b. If the agency's designated RHC does not comply with these responsibilities, the RH Program may require the agency to designate a different agency staff person.
c. When an RHC is designated, the designated RHC and a higher-ranking staff member (e.g. agency administrator, the RHC's supervisor) who understands the RHC's workload and job duties must sign the RH Coordinator Competencies.
d. The agency must notify the RH Program within 10 business days of when the designated RHC leaves the agency, takes a leave of absence longer than one month, or if a different staff member is being assigned the role of RHC.
    1. In the case of a leave of absence longer than one month, an interim RHC must be assigned.

A.7 Staff Training Requirements

a. Upon RHCare clinic certification or new hire, clinic staff must receive training on the following topics:
    1. RHCare certification requirements, policies, and processes (as applicable to staff roles);
    2. Title X orientation (all staff working in reproductive health);
    3. Client-centered, nondirective pregnancy options counseling (staff who provide pregnancy options counseling); and
    4. Reproductive Justice in the clinical setting (all staff working in reproductive health).
b. Annually, clinic staff must receive training on the following topics:
    1. Healthy relationships and adult engagement, including how to document the provider/client discussion (direct service providers);
    2. Identifying and reporting suspected abuse (i.e., mandatory reporting), including human trafficking (all staff designated as mandatory reporters); and

3. Equity, including topics related to racism, health equity, cultural-responsiveness[1], and/or trauma-informed[2] care in providing sexual and reproductive health clinical services (all staff working in reproductive health).

c. On an ongoing basis, clinic staff who interact with clients must be offered training opportunities on topics related to reproductive health, as appropriate to their staff roles.

A.8 Quality Assurance and Quality Improvement

a. Agencies must follow a documented process to address quality assurance and quality improvement efforts related to reproductive health care services within their clinic(s).
b. Agencies must ensure that end-user engagement, feedback, and data is used to inform and improve the provision of client-driven, trauma-informed, culturally-responsive services. This must include:
    1. Using a client advisory panel or other structured means for clients to provide input.
    2. Using client demographic data to inform and improve the provision of trauma-informed, culturally-responsive services.

A.9 Compliance with Financial Oversight

a. The agency must comply with the applicable financial oversight, audit requirements, and responsibilities set forth in the Oregon Revised Statutes, use of general funds under ORS 293.590 – 293.660, and ORS 297
b. The agency must adhere to proper fiscal oversight and stewardship of all public funds. This includes but is not limited to, proper accounting and documentation of all funds received, financial reporting completed as requested, and review of all documentation and submissions to ensure proper recordkeeping of all funds.

Section B. Equitable Access

B.1 Access to Care

a. Reproductive health services must be provided to any individual of reproductive capacity who is seeking them.
b. Clinics must offer the same scope and quality of services regardless of:

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

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

1. Race, skin color, national origin, religion, immigration status, sex, sex characteristics, sexual orientation, gender identity, age, number of pregnancies, marital status, or disability, in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964, section 1557 of the ACA, the Americans with Disabilities Act (ADA) of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A.
2. Ability to pay or insurance coverage.
3. Location of residence.

c. All reproductive health services must be provided without a referral requirement.
d. Clients who cannot be provided services within two weeks must be offered information about other reproductive health providers in the area, including whether or not they are RHCare providers.

B.2 Cultural Responsiveness

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

B.3 Linguistic Responsiveness

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

2. All print, electronic, and audiovisual materials must use plain language[3] and be easy to understand. A client's need for alternate formats must be accommodated.

B.4 Information & Education Committee (I & E Committee)

a. Health education materials[4] must be reviewed by an Information and Education (I & E) committee. Agencies can develop and maintain their own I & E committee, or they can have materials reviewed and approved by the state I & E committee. In addition to the I & E committee your agency may also choose to have additional groups review materials that are issue or identity specific and require expertise the I & E Committee may not hold.
    1. If an agency chooses to maintain their own I & E Advisory Committee, the agency must assure that it broadly represents the population and community for whom the materials are intended.
    2. The I & E committee must maintain a minimum of five members.
    3. In reviewing materials, the I & E committee must:
        i. Consider the educational, cultural, and diverse backgrounds of individuals to whom the materials are addressed;
        ii. Consider the standards of the population or community to be served with respect to such materials;
        iii. Review the content of the material to assure that the information is factually correct, medically accurate, culturally and linguistically appropriate, inclusive, and trauma informed;
        iv. Determine whether the material is suitable for the population or community to which is to be made available; and
        v. Establish a written record of its determinations.

B.5 Fiscal Requirements

a. Clients may not be denied any reproductive health services or be subjected to any variation in the quality of services based on their inability to pay or insurance coverage.
b. Prior to the visit and in a confidential manner, clients receiving services for which they do not have coverage (e.g., OHP, RH Access Fund) must be informed that they may be expected to pay.
c. Clinics must use a sliding fee schedule up to 250% of the Federal Poverty Level for reproductive health services provided to clients without coverage, unless federal regulations say otherwise.
    1. Clients whose self-reported income is at or below 100% of the Federal Poverty Level must not be charged.

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

[4] Health education materials are any brochures, posters, videos, or other materials, printed or electronic, that your agency uses to help inform or educate clients about reproductive health.

2. The sliding fee schedule must be based on an analysis of the costs of all services offered in the clinic.
3. When assessing a client's fees based on the sliding fee schedule, clinics must use the client's household size and only the client's own income.
4. Income is self-reported, and proof of income may not be required.
5. The agency's fee schedule must be available upon request.
6. Clinics may not charge a flat fee (e.g. minimum fee, nominal fee, no-show fee, etc.).
7. If a client has private insurance, their Federal Poverty Level must be assessed before copays or additional fees are charged. The client should not pay more in copays or additional fees than what they would otherwise pay when the sliding fee scale is applied.

d. Clients with insurance must be informed of any potential for disclosure of their confidential health information to the policyholder(s) of their insurance.
e. Priority may not be given to clients with sources of insurance coverage or with incomes above 250% of the Federal Poverty Level.
f. Clinics must make reasonable efforts to collect charges without jeopardizing client confidentiality. Clients may not be sent to collection agencies.
g. A clinic may accept voluntary donations.

Section C. Clients' Rights and Safety

C.1 Confidentiality

a. Safeguards must be in place to ensure confidentiality, and to protect clients' privacy and dignity throughout the clinic space, during clinic interactions, and in record keeping.
b. Information obtained by staff may not be disclosed without written consent, except as required by law or as may be necessary to provide services to the individual.
c. All aspects of service provision must be compliant with the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and Health Information Technology for Economic and Clinical Health (HITECH) Act.
d. For services provided via telehealth, staff must comply with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (Authority/OHA) Confidentiality and Privacy Rules and security protections for the client in connection with telemedicine technology, communication, and related records.
e. A copy of a patients' bill of rights must be posted in a public area of the clinic in the languages most commonly used by clients.

f. Minors (under 18 years)[5] & Confidentiality
    1. Clinic staff are prohibited from requiring written consent from parents or guardians for the provision of reproductive health services to minors.
    2. Clinic staff may not notify a parent or guardian before or after a minor has requested and/or received reproductive health services.
    3. Services must, however, comply with legislative mandates to encourage family participation in the decision of minors to seek reproductive health services, and as such, staff will encourage, but not require, the inclusion of parents/guardians/responsible adults in their decision to access reproductive health services.

C.2 Noncoercion

a. All services must be voluntary
    1. Clients may not be coerced to accept services or to use a particular method of birth control.
        i. Clinic staff must be informed that they may be subject to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure.
    2. Receipt of reproductive health services may not be a prerequisite for eligibility for, or receipt of services, assistance, or participation in any other program.

C.3 Informed Consent

a. Upon establishing care, clients must sign an informed consent form for reproductive health services.
    1. Informed consent for reproductive health services may be incorporated into the clinic's general consent for services.
b. The informed consent process, provided verbally and supplemented with written materials by the clinic, must be presented in plain language.
c. Telehealth
    1. Clinics must obtain informed consent from the client for the use of telehealth as an acceptable mode of delivering reproductive health services. The consent must be documented in the client's health record or in each telehealth visit note.

C.4 Mandatory Reporting

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

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

Section D. Services

D.1 Service Delivery

a. Services must be provided using a trauma-informed, inclusive[6], culturally-responsive, and client-driven[7] approach that helps the client clarify their needs and wants, promotes personal choice and risk reduction, and takes into account the cultural and socioeconomic factors of the client and psychosocial aspects of reproductive health.

D.2 Clinical Practice Standards

a. Clinics must adopt and follow the RHCare Clinical Practice Standards (CPSs) that are based on national standards of care and best practices to ensure all clients receive the same quality and scope of reproductive health services.
    1. The RH Program must approve any modification to CPSs made by clinics.
b. The agency's Health Officer, Medical Director, or medical designee[8] must review and sign all RHCare CPSs attesting that certified RHCare clinics will follow them in all RHCare visits. The agency must then submit the RHCare Clinical Practice Standards Attestation Form (see Appendix B).
    1. A RHCare Clinical Practice Standards Re-Attestation Form must be submitted:
        i. When the agency's Health Officer, Medical Director, or medical designee who originally signed the RHCare CPSs changes. The agency's new Health Officer, Medical Director, or medical designee must review and sign all RHCare CPSs attesting that certified RHCare clinics will follow them in all RHCare visits within three months.
        ii. When the RH Program updates a CPS. Agencies' CPSs must align with the CPSs posted on the RH Program's website, therefore, agencies must update their corresponding CPS within three months of the change.
c. If a clinic does not offer a method for which there is a CPS, the clinic does not need to adopt that method's CPS.
d. Agencies must notify the RH Program within 10 business days when the agency's Health Officer, Medical Director, or medical designee changes.

[6] Inclusive means all people are included and can actively participate in reproductive health decision making, including, but not limited to people who belong to communities that have been historically marginalized such Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. (42 CFR § 59.2)

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

[8] Medical designee means a clinician who is trained and permitted by state-specific regulations to perform all aspects of the physical assessments recommended for contraceptive, related preventive health, basic infertility care. They must work at the agency on a regular basis, have prescribing and medical decision-making authority, and be familiar with RHCare requirements and the agency's staffing and clinical practices.

D.3 Clinical Services

a. Clinics must offer the full scope of services as defined by RHCare to all clients regardless of their ability to pay or insurance coverage. See Appendix A for the detailed list of services. The full scope of services includes:
    1. A broad range of contraceptive methods, including device insertion and removals;
    2. Core reproductive health services;
    3. Contraceptive services;
    4. Counseling and education services;
    5. Pregnancy testing and counseling on all pregnancy options, including parenting, abortion, and adoption;
    6. Preconception health services;
    7. Basic infertility services;
    8. Sexually transmitted infection (STI) screening and treatment, within the context of a family planning visit; and
    9. Breast and cervical cancer screening, within the context of a family planning visit.
b. Clinics must notify the RH Program within 10 business days if they are unable to provide the full scope of services (e.g. loss of clinical provider) for one month or longer.
c. Clients must be able to get their first choice of contraceptive method unless there are specific contraindications.
d. Limited exceptions to the clinical services and contraceptive supply requirements as described in D.3.a may be considered. Please see Appendix C for more information.

D.4 Counseling and Education Services

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

D.5 Referrals and Information Sharing

a. Clients must be offered information about:
    1. Where to access free or low-cost primary care services,
    2. How to obtain full-benefit health insurance enrollment assistance, public or private, as needed, and
    3. Resources available in the community to address barriers that might exist for clients, including but not limited to transportation, childcare, housing, and food insecurity, as appropriate.

b. Clinics must provide closed-loop referrals[9] for clinical services within the scope of RHCare that require follow-up to ensure continuity of care.

D.6 Telehealth Services

a. Clients must be given the option to have an in-person visit and informed of the scheduling options, services available, and restrictions of both types of visits.[10]

Section E. Data Collection and Reporting

E.1 Collection and Submission of Encounter Data

a. Clinics must collect all required visit/encounter data variables as indicated on the RH Program Clinic Visit Record (CVR) for:
    1. Visits in which the primary purpose is to prevent or achieve pregnancy,
    2. Annual visits that include services related to preventing or achieving pregnancy,
    3. Repeat cervical cancer screening visits,
    4. Follow-up visits for treatment and rescreening of GC/CT, pursuant to a visit as described in 1. or 2. above, and
    5. Visits in which the primary purpose is STI screening and the clients meets the RHEA eligibility requirements.
b. Clinics must submit CVR data to the RH Program or its data collection vendor, as directed.

E.2 Other Data and Reporting Requirements

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

Section F. Reproductive Health Access Fund

F.1 Client Enrollment

a. Clients must not be required to enroll in the RH Access Fund to receive services.
    1. Clinics must provide reproductive health services to clients with reproductive capacity who decline to enroll in the RH Access Fund.
b. Clinic staff must emphasize that alternative programs may be available for clients ineligible for the Reproductive Health (RH) Access Fund.
c. Clinic staff must support clients in completing the RH Access Fund Enrollment Form accurately and to the best of the client's knowledge.

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

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

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

F.2 Billing and Payment

a. RH Access Fund enrollees may not be charged for services covered by the RH Access Fund. See OARs 333-004-3070 and 333-004-3090 for RH Access Fund-covered services and client eligibility, respectively.
b. Enrollees may not be billed for services that would normally be covered by the RH Access Fund if not for an error on the part of clinic staff.
c. Enrollees may be billed for services that are outside of the RHCare scope of services as defined in OAR 333-004-3070.
d. Prior to the visit and in a confidential manner, enrollees receiving services not covered by the RH Access Fund must be informed that they may be expected to pay.
e. Clinics may not request a deposit from the enrollee in advance of services covered by the RH Access Fund.
f. Clinics must submit claims to the RH Program or its claims processing vendor, as directed.
g. Clinics have a legal obligation to seek third party reimbursement, if applicable, prior to billing the RH Access Fund. The clinic:
    1. Must be enrolled with and bill the Oregon Health Plan (OHP);
    2. Must be credentialed with and bill private insurance companies; and
    3. Must assure confidentiality, when indicated.
        i. Including not seeking third party reimbursement if the client requested confidentiality.
h. For services billed to the RH Access Fund, the clinic must accept RH Access Fund reimbursement as payment in full and may not charge the enrollee additional fees for those services.
i. Clinics must register and maintain 340B and Apexus Prime Vendor certification, if eligible. Reimbursement for supplies will be based on 340B drug program pricing or actual acquisition cost.

Appendix A. RHCare Scope of Services

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

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

2. Core reproductive health services:

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

Appendix A. RHCare Scope of Services

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

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

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

6. **Preconception health services:**
    - Providing individualized care to improve outcomes if a pregnancy occurs (e.g. reduce tobacco use, start taking folic acid, etc.).

7. **Basic infertility services:**
   - Medical exam, as indicated;
   - Counseling on achieving pregnancy; and
   - Referring for additional infertility services when indicated.

8. **Sexually transmitted infection (STI) services, within the context of a family planning visit:**
   - Screening for STIs per national standards, testing for STIs within the context of a RH visit based on individualized risk, and providing individualized risk reduction counseling;
   - Treatment and rescreening for gonorrhea/chlamydia pursuant to family planning visit

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

Appendix A. RHCare Scope of Services

REFERENCES:

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

Oregon Reproductive Health Program Certification Requirements for RHCare Clinics, Version 2.

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

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

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

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

Appendix B. RHCare Clinical Practice Standards Attestation

The Clinical Practice Standards (CPSs) ensure that all clients receiving reproductive health services are provided the same quality and scope of reproductive health services. To become an RHCare agency, the agency's Health Officer, Medical Director, or their medical designee[8] must review and sign the RHCare Clinical Practice Standards. By signing the CPSs, the Health Officer, Medical Director, or medical designee[8] is attesting that certified RHCare clinics will follow them in all RHCare visits. The agency must then complete the CPS Attestation Form.

All the Clinical Practice Standards are listed in the table below, and can be found on our Clinical Practice Standards webpage.

RHCare Clinical Practice Standards	
Basic Infertility Services	Pharmacy – Dispensing Medications
Coitus Interruptus (Withdrawal)	Preconception Health Visit
Combination Oral Contraceptives	Pregnancy Test Visit
Core Reproductive Health Services	Prescription Visit
Depo Provera	Progestin-Only Pills
Diaphragm and Cervical Cap	Reproductive Health Well Visit
Emergency Contraception	STI Screening, Testing, and Treatment
External Condoms	Subdermal Implant
Fertility Awareness-Based Methods	Tubal Sterilization – Counseling & Referral
Hormonal Contraceptive Patch	Vaginal Contraceptive Ring
Internal Condoms	Vaginal Spermicides and pH Modulators
Intrauterine Contraception	Vasectomy – Counseling & Referral
Lactational Amenorrhea Method (LAM)	

To complete the Clinical Practice Standards Attestation form go to:
https://app.smartsheet.com/b/form/c8663e642dae4267943ba6ad5a7e08b6

Appendix C. RHCare Clinic Exceptions

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

- D.3.a Clinics must offer the full scope of clinical services and contraceptive supply requirements as defined by the RH Program.

For an exception to be considered, the site must meet the minimum criteria below:

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

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

To view and complete the RHCare Exception Clinic Request Form go to:
https://app.smartsheet.com/b/form/cf051bd83a8f431a91536d1c34ebbd51

CCare Certification Requirements, Version 2.0

Section A. Facility, Operations, & Staffing

A.1 Clinic Space

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

A.2 Infection Control

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

A.3 Laboratory

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

A.4 Pharmacy and Contraceptive Methods

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

A.5 Medical Emergencies

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

A.6 Reproductive Health Coordinator

a. The agency must designate a staff person as a Reproductive Health Coordinator (RHC) to be the key point of contact in accordance with OAR 333-004-3040. The RHC is responsible for all the items listed in the RH Coordinator Competencies, including, but not limited to:
    1. Ensuring program compliance at all clinic sites;

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

b. If the agency's designated RHC does not comply with these responsibilities, the RH Program may require the agency to designate a different agency staff person.
c. When an RHC is designated, the designated RHC and a higher-ranking staff member (e.g. agency administrator, the RHC's supervisor) who understands the RHC's workload and job duties must sign the RH Coordinator Competencies.
d. The agency must notify the RH Program within 10 business days of when the designated RHC leaves the agency, takes a leave of absence longer than one month, or if a different staff member is being assigned the role of RHC.
    1. In the case of a leave of absence longer than one month, an interim RHC must be assigned.

A.7 Staff Training Requirements

a. Upon CCare clinic certification or new hire, clinic staff must receive training on the following topics:
    1. CCare certification requirements, policies, and processes (as applicable to staff roles);
    2. Client-centered, nondirective pregnancy options counseling (staff who provide pregnancy options counseling to CCare enrollees); and
    3. Reproductive Justice in the clinical setting (staff who interact with CCare enrollees).
b. Annually, clinic staff must receive one training focused on equity, including topics related to racism, health equity, cultural-responsiveness[1], and/or trauma-informed[2] care in providing sexual and reproductive health clinical services (staff who interact with CCare enrollees).

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

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

Section B. Equitable Access

B.1 Access to Care

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

B.2 Cultural Responsiveness

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

B.3 Linguistic Responsiveness

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

1. Medically accurate, culturally and linguistically responsive, inclusive[3], and trauma-informed appropriate health educational materials must be available for enrollees needing them.
2. All print, electronic, and audiovisual materials must use plain language[4] and be easy to understand. An enrollee's need for alternate formats must be accommodated.

Section C. Enrollees' Rights & Safety

C.1 Confidentiality

a. Safeguards must be in place to ensure confidentiality, and to protect enrollees' privacy and dignity throughout the clinic space, during clinic interactions, and in record keeping.
b. Information obtained by staff may not be disclosed without written consent, except as required by law or as may be necessary to provide services to the individual.
c. All aspects of service provision must be compliant with the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and Health Information Technology for Economic and Clinical Health (HITECH) Act.
d. For services provided via telehealth, staff must comply with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (Authority/OHA) Confidentiality and Privacy Rules and security protections for the enrollee in connection with telemedicine technology, communication, and related records.
e. A copy of a patients' bill of rights must be posted in a public area of the clinic in the languages most commonly used by enrollees.
f. Minors (under 18 years)[5] & Confidentiality
    1. Clinic staff are prohibited from requiring written consent from parents or guardians for the provision of reproductive health services to minors.
    2. Clinic staff may not notify a parent or guardian before or after a minor has requested and/or received reproductive health services.

[3] Inclusive means all people are included and can actively participate in reproductive health decision making, including, but not limited to people who belong to communities that have been historically marginalized such Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. (42 CFR § 59.2)

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

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

C.2 Noncoercion

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

C.3 Informed Consent

a. Upon establishing care, enrollees must sign an informed consent form for reproductive health services.
    1. Informed consent for reproductive health services may be incorporated into the clinic's general consent for services.
b. The informed consent process, provided verbally and supplemented with written materials by the clinic, must be presented in plain language.
c. Telehealth
    1. Clinics must obtain informed consent from the enrollee for the use of telehealth as an acceptable mode of delivering reproductive health services. The consent must be documented in the enrollee's health record or in each telehealth visit note.

C.4 Mandatory Reporting

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

Section D. Services

D.1 Service Delivery

a. Services must be provided using a trauma-informed, inclusive, culturally-responsive, and client-driven[6] approach that helps the client clarify their needs and wants, promotes personal choice and risk reduction, and takes into account the cultural and socioeconomic factors of the client and psychosocial aspects of reproductive health.

D.2 Clinical Services

a. Clinics must offer the full scope of services as defined by CCare to all CCare-eligible enrollees. See Appendix A for the detailed list of services. The full scope of services includes:
    1. A broad range of contraceptives, including device insertion and removals;
    2. Core reproductive health services;

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

3. Contraceptive services;
4. Counseling and education services;
5. Pregnancy testing in context of contraceptive management and counseling on all pregnancy options, including parenting, abortion, and adoption;
6. Sexually transmitted infection (STI) screening, within the context of a contraceptive management visit; and
7. Breast and cervical cancer screening, within the context of a contraceptive management visit.

b. Clinics must notify the RH Program within 10 business days if they are unable to provide the full scope of services (e.g. loss of clinical provider) for one month or longer.
c. Enrollees must be able to get their first choice of contraceptive method unless there are specific contraindications.
d. Limited exceptions to the clinical services and contraceptive supply requirements as described in D.2.a may be considered. Please see Appendix B for more information.

D.3 Counseling and Education Services

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

D.4 Referrals and Information Sharing

a. Enrollees must be offered information about:
    1. Where to access free or low-cost primary care services,
    2. How to obtain full-benefit health insurance enrollment assistance, public or private, as needed, and
    3. Clinics must provide information to enrollees about resources available in the community to address barriers that might exist for enrollees, including but not limited to transportation, childcare, housing, and food insecurity, as appropriate.
b. Clinics must provide closed-loop referrals[7] for clinical services within the scope of CCare that require follow-up to ensure continuity of care.

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

D.5 Telehealth Services

a. Enrollees must be given the option to have an in-person visit and informed of the scheduling options, services available, and restrictions of both types of visits.[8]

Section E. Data Collection & Reporting

E.1 Collection and Submission of Claims Data

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

E.2 Other Data and Reporting Requirements

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

Section F. Reproductive Health Access Fund

F.1 Client Enrollment

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

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

F.2 Billing and Payment

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

Appendix A. CCare Scope of Services

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

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

2. Core reproductive health services:

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

Appendix A. CCare Scope of Services

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

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

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

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

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

REFERENCES:

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

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

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

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

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

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

Appendix B. CCare Clinic Exceptions

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

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

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

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

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

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

AbortionCare Certification Requirements, Version 3.0

Section A. Facility, Operations, and Staffing

A.1 Clinic Space

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

A.2 Infection Control

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

A.3 Laboratory

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

A.4 Pharmacy and Dispensing Medications and Contraceptive Methods

a. Medications and contraceptive methods included under AbortionCare must be dispensed on-site following Oregon Board of Pharmacy rules and per appropriate licensure (OAR 855-043).
b. Clinics may offer clients the option of receiving their medication abortion pills and/or contraceptive methods by mail at no additional cost to the client.
    1. Use of this option is at the discretion of the client; it cannot be offered as the only way in which to receive medication abortion pills and/or contraceptive methods.
    2. Clinics must package and mail supplies in a manner that ensures the integrity and confidentiality of the packaging and effectiveness of the medications upon delivery.
    3. Clinics must ensure that medication abortion pills are mailed and received by the client within the timeframe determined by the clinician and client.

A.5 Clinic Licensure/Certification

a. Clinics must maintain the appropriate licensure/certification based on facility type, as needed.

A.6 Medical Emergencies

a. Clinics must maintain a written plan for medical emergencies, including, but not limited to:
    1. Anaphylaxis/Shock;

2. Vaso-vagal reaction/Syncope;
3. Cardiac Arrest/Respiratory Difficulty (if the clinic has an automated external defibrillator (AED) include protocol on how to use); and
4. Hemorrhage.

b. Clinics must maintain a written after-hours emergency policy management plan.
c. If the clinic provides procedural abortions[1], the written medical emergency plan must also include:
   1. Perforation; and
   2. Emergency transfer, including written, readily available directions for contacting external emergency assistance (e.g., an ambulance).

A.7 Reproductive Health Coordinator

a. The agency must designate a staff person as a Reproductive Health Coordinator (RHC) to be the key point of contact in accordance with OAR 333-004-3040. The RHC is responsible for all the items listed in the RH Coordinator Competencies, including, but not limited to:
   1. Ensuring program compliance at all clinic sites;
   2. Being the agency's subject matter expert on all aspects of the AbortionCare certification requirements and how they are operationalized within clinic sites;
   3. Acting as the primary contact with the Oregon RH Program; and
   4. Managing the implementation and operationalization of AbortionCare certification requirements in all participating clinics.
b. If the agency's designated RHC does not comply with these responsibilities, the RH Program may require the agency to designate a different agency staff person.
c. When an RHC is designated, the designated RHC and a higher-ranking staff member (e.g. agency administrator, the RHC's supervisor) who understands the RHC's workload and job duties must sign the RH Coordinator Competencies.
d. The agency must notify the RH Program within 10 business days of when the designated RHC leaves the agency, takes a leave of absence longer than one month, or if a different staff member is being assigned the role of RHC.
   1. In the case of a leave of absence longer than one month, an interim RHC must be assigned.

A.8 Staff Training Requirements

a. Upon AbortionCare certification or new hire, clinic staff must receive training on the following topics:
   1. AbortionCare certification requirements, policies, and processes (as applicable to staff roles);

[1] " Procedural abortions" refers to uterine aspiration and/or dilation and evacuation.

2. Personal bias and/or values clarification (staff who interact with AbortionCare enrollees); and
3. Reproductive Justice in the clinical setting (staff who interact with AbortionCare enrollees).

b. Annually, clinic staff must receive one training focused on equity, including topics related to racism, health equity, cultural-responsiveness[2], and/or trauma-informed[3] care in providing sexual and reproductive health clinical services (staff who interact with AbortionCare enrollees).

Section B. Equitable Access

B.1 Access to Care

a. All services must be provided to enrollees without regard to race, skin color, national origin, religion, sexual orientation, gender identity, age, number of pregnancies, marital status, or disability in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964, section 1557 of the ACA, the Americans with Disabilities Act (ADA) of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A.
b. Services must be provided without a referral requirement.
c. Appointments for enrollees must be available within a reasonable time period, based upon their needs and preferably within a week of initial contact. Enrollees for whom the clinic cannot meet their desired timeframe must be given the option to be referred to another contracted AbortionCare clinic, preferably within close proximity.

B.2 Cultural Responsiveness

a. Agencies must implement a written, ongoing comprehensive strategy to provide equitable, trauma-informed, culturally-responsive services. The strategy should include an assessment, action plan, and evaluation.
b. Clinics must ensure that clinical services are provided in a way that makes it easy and comfortable for youth to seek and receive the services they need.

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

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

c. Enrollees must be treated in a trauma-informed manner that is responsive to their identities, beliefs, communication styles, attitudes, languages, and behavior.

B.3 Linguistic Responsiveness

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

Section C. Enrollees' Rights and Safety

C.1 Confidentiality

a. Safeguards must be in place to ensure confidentiality, and to protect enrollees' privacy and dignity throughout the clinic space, during clinic interactions, and in record keeping.
b. Information obtained by staff may not be disclosed without written consent, except as required by law or as may be necessary to provide services to the individual.
c. All aspects of service provision must be compliant with the Health Insurance Portability and Accountability Act (HIPAA), and Health Information Technology for Economic and Clinical Health (HITECH) Act.

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

d. For services provided via telehealth, staff must comply with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (Authority/OHA) Confidentiality and Privacy Rules and security protections for the enrollee in connection with telemedicine technology, communication, and related records.
e. A copy of a patient bill of rights must be posted in a public area of the clinic in languages most commonly used by enrollees.
f. Minors & Confidentiality
    1. Clinic staff are prohibited from requiring consent from parents or guardians for the provision of abortion services for minors 15 years and older.
    2. Clinic staff may not notify a parent or guardian before or after a minor of any age has requested and/or received reproductive health services.

C.2 Noncoercion

a. All services must be voluntary. Enrollees may not be coerced to accept services or to use a particular method of birth control.

C.3 Informed Consent

a. The informed consent process, provided verbally and supplemented with written materials by the clinic, must be presented in plain language.
b. Documentation must show that the enrollee affirms understanding of the abortion process and its alternatives, the potential risks and benefits, and that their decision is voluntary. The enrollee must have the opportunity to have questions answered to their satisfaction prior to receiving abortion services.
c. Telehealth
    1. Clinics must obtain informed consent from the enrollee for the use of telehealth as an acceptable mode of delivering services. The consent must be documented in the enrollee's health record or in each telehealth visit note.

Section D. Services

D.1 Service Delivery

a. Services must be provided using a trauma-informed, inclusive[5], culturally-responsive, and client-driven[6] approach that helps the client clarify their needs and wants,

[5] Inclusive means all people are included and can actively participate in reproductive health decision making, including, but not limited to people who belong to communities that have been historically marginalized such Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. (42 CFR § 59.2)

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

promotes personal choice and risk reduction, and takes into account the cultural and socioeconomic factors of the client and psychosocial aspects of reproductive health.

D.2 Clinical Services

a. The clinic must follow evidence-based, national standards of care (e.g. The American College of Obstetricians and Gynecologists, the National Abortion Federation, Society of Family Planning, etc.).
b. Enrollees must be informed of where and how to obtain 24-hour emergency care services.
c. Core services must be offered to enrollees, as appropriate. Core services are defined as:
    1. Abortion services, including at least one, if not both, of the following:
        i. Medication abortion
        ii. Procedural abortion
        iii. If the clinic is unable to provide both of the above services, the clinic must have a referral system in place. Enrollees must be notified, prior to their appointment, of the clinic's inability to offer both services and be referred to another AbortionCare clinic, preferably within close proximity.
    2. A broad range of contraceptive drugs, devices, and supplies provided immediately following abortion services. See Appendix A.
        i. Limited exceptions to the contraceptive supply requirement may be considered. Please see Appendix B for more information.
            A. If the clinic is unable to dispense or administer contraception onsite, the clinic must have a referral system in place for the provision of contraceptive methods. Referrals should preferably be made to another AbortionCare clinic or RHCare clinic within close proximity.
            B. Enrollees must be notified, prior to the abortion, of the clinic's ability to dispense or administer contraception onsite.
d. Clinics must notify the RH Program within 10 business days if they are unable to provide the full scope of services (e.g. loss of clinical provider) for one month or longer.

D.3 Counseling and Education Services

a. The general advantages and disadvantages of medication abortion and procedural abortions must be explained early in the counseling process.
b. Prior to an abortion, enrollees should also be offered client-driven counseling and education on the following:
    1. Contraceptives
    2. STI risk reduction
        i. Assessment

ii. Prevention methods

3. Consent and healthy relationships
    i. Relationship safety
    ii. Intimate partner violence

D.4 Referrals and Information Sharing

a. Enrollees in need of additional medical or psychosocial services beyond the scope of the clinic must be provided information about available local resources, including domestic violence and substance abuse related services.

Section E. Data Collection and Reporting

E.1 Collection and Submission of Claims Data

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

E.2 Other Data and Reporting Requirements

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

Section F. Reproductive Health Access Fund

F.1 Client Enrollment

a. Clinic staff must emphasize that alternative programs may be available for clients ineligible for the Reproductive Health (RH) Access Fund.
b. Clinic staff must support clients in completing the Reproductive Health (RH) Access Fund Enrollment Form accurately and to the best of the client's knowledge.
c. Clinics must ensure that all required client enrollment data is collected using the RH Access Fund Enrollment Form, that all fields are completed, and that it is signed and dated appropriately, unless they receive written approval from the RH Program to enter client enrollment data directly into the RH Access Fund Eligibility Database. Enrollment Forms may not be backdated.
    1. If the Enrollment Form is completed remotely, either over the telephone or during a video visit, clinic staff must write the client’s name on the signature line and the day’s date with a note that consent was obtained verbally, unless the clinic receives written approval from the RH Program to enter client enrollment data directly into the RH Access Fund Eligibility Database.

d. All required enrollment data must be entered into the web-based RH Access Fund Eligibility Database.

F.2 Billing and Payment

a. RH Access Fund enrollees who are eligible for AbortionCare may not be charged for services covered by AbortionCare. See OARs 333-004-3070(4) and 333-004-3090(1)(c) for AbortionCare-covered services and client eligibility, respectively.
b. Enrollees may not be billed for services that would normally be covered by AbortionCare if not for an error on the part of clinic staff.
c. Enrollees may be billed for services that are outside of the AbortionCare scope of services as defined in OAR 333-004-3070(4).
d. Prior to the visit and in a confidential manner, enrollees receiving services not covered by AbortionCare must informed that they may be expected to pay. See OARs 333-004-3070(4) for AbortionCare-covered services.
e. Clinics must submit claims to the RH Program or its claims processing vendor, as directed.
f. Clinics may not request a deposit from an enrollee who is eligible for AbortionCare in advance of services covered by AbortionCare.
g. Clinics have a legal obligation to seek third party reimbursement, if applicable, prior to billing the RH Access Fund. The clinic:
    1. Must be enrolled with and bill the Oregon Health Plan (OHP);
    2. Must be credentialed with and bill private insurance companies; and
    3. Must assure confidentiality, when indicated.
        i. Including not seeking third party reimbursement if the enrollee requested confidentiality.
h. For services billed to the RH Access Fund, the clinic must accept RH Program reimbursement as payment in full and may not charge the enrollee additional fees for those services.

Appendix A. AbortionCare Required Contraceptive Methods

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

Appendix B. AbortionCare Clinic Exceptions

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

- D.2.c.2. Clinics must offer a broad range of contraceptive drugs, devices, and supplies provided immediately following abortion services.

For an exception to be considered, the site must provide a referral for the contraceptive supplies not available.

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

To view and complete the AbortionCare Exception Clinic Request Form go to: https://app.smartsheet.com/b/form/0ae888c37ff7490b9e1e50bf67339178.

AMEND: 333-004-3040

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3040 Clarify when agencies must notify the RH Program when a clinic immediately closes due to forces beyond the agency's control.

CHANGES TO RULE:

333-004-3040
Agency Responsibilities
(1) Agencies must designate a single agency staff person to serve as the RHC.¶
(2) Agencies must notify the RH Program within 30 calendar days of a change in address, business affiliation, clinic location or closure, licensure, ownership, certification, billing agents or Federal Tax Identification Number (TIN). Failure to notify the RH Program of a change of Federal Tax Identification Number may result in a sanction. Changes in business affiliation, ownership, and Federal Tax Identification Number may require the submission of a new application. In the event of bankruptcy proceedings, the agency must immediately notify the RH Program in writing. The RH Program may recover payments made to agencies who have not notified the RH Program of changes as required by this section.¶
(3) Agencies must notify the RH Program within 30 calendar days of any changes that will result in noncompliance with certification requirements, such as but not limited to, inability to provide full scope of clinical services, inability to purchase drugs, devices, or supplies, unless the agency has an exception that has been approved by the RH Program. Agencies must work with the RH Program to develop a corrective action plan to resolve any areas of noncompliance.¶
(4) Agencies must notify the RH Program of intent to cease operating RHCare, CCare, or AbortionCare at any clinic certified with the RH Program 30 calendar days before ceasing operations, unless immediate closure is necessary for reasons beyond the agency's control. If immediate closure is necessary, the agency must notify the RH Program within 10 business days of closure.¶
(5) Agencies are independent contractors and not officers, employees, or agents of the RH Program.¶
(6) Agencies are responsible for training staff on RHCare, CCare, or AbortionCare operations and requirements based on applicable certification within three months of signing the MSA.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec. 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec. 10

AMEND: 333-004-3050

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3050 Allow agencies to send secure email to terminate their MSA with the RH Program.

CHANGES TO RULE:

333-004-3050
Agency Termination
(1) Agency initiated termination. An agency may terminate certification. To terminate certification, the agency must¶
(a) Submit written notice to the RH Program by secure electronic mail ~~(~~to rh.program@~~dhs~~oha.~~state.or.us) and certified mail, return-receipt requested (800 NE Oregon Street, Suite 370, Portland, OR 97232)~~oregon.gov 30 calendar days prior to the termination effective date.¶
(A) The notice shall specify the termination effective date and plans for notifying and referring clients to other certified RHCare, CCare or AbortionCare clinics. This plan shall outline mechanisms used to notify clients and efforts to ensure coordination of care for clients.¶
(B) The termination effective date shall be at least 30 calendar days upon receipt of notice.¶
(b) Termination of agency certification does not terminate any obligations of the agency for dates of services during which the certification was in effect.¶
(2) RH Program initiated termination.¶
(a) The RH Program may terminate agency certification for reasons including, but not limited to:¶
(A) Failure to address compliance findings within 180 calendar days of the date of initial non-compliance notification;¶
(B) No client enrollment or claims activity for 12 months; or¶
(C) Sanctions as described in OAR 333-004-3200 (Grounds for Agency Sanctions; Sanctions).¶
(b) The RH Program will notify an agency that it or its clinic(s)' certification will be terminated via a written notice by certified mail, return-receipt requested.¶
(c) The termination effective date shall be 30 calendar days from the date the notice was mailed.¶
(d) Agencies that have been terminated due to OAR 333-004-3050(2)(a)(A) or (C) may not apply for certification for two years after termination.¶
(e) Termination notices will follow ORS chapter 183.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec. 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec. 10

AMEND: 333-004-3070

REPEAL: Temporary 333-004-3070 from PH 50-2022

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3070 Replace RH GF with Title X

CHANGES TO RULE:

333-004-3070
RH Access Fund Covered Services by Funding Source
(1) Each of the funding sources that make up the RH Access Fund may only be used to cover the services defined in this rule and only for enrollees who meet the funding source's eligibility requirements as defined in OAR 333-004-3090 (Client Eligibility for the RH Access Fund).¶
(2) ~~RH GF~~Title X covers preventive reproductive health and related services.¶
(a) Covered services include:¶
(A) Annual visits that include education, counseling, or clinical services related to preventing or achieving pregnancy;¶
(B) Contraceptive drugs, devices, and supplies;¶
(C) Clinically indicated follow-up visits to evaluate effectiveness of a contraceptive method, including but not limited to, management of side effects related to a contraceptive method; and, changing a contraceptive method if medically necessary or requested by the enrollee, including the removal of contraceptive devices;¶
(D) Counseling and education related to pregnancy intention, including effective contraceptive use or preconception care;¶
(E) Health screenings, laboratory tests, medical procedures, and pharmaceutical supplies and devices directly related to preventing or achieving pregnancy;¶
(F) Treatment and rescreening for GC/CT pursuant to a family planning visit;¶
(G) Repeat Pap tests pursuant to a family planning visit; and¶
(H) Vasectomy services.¶
(b) Each enrollee may receive up to a one-year supply of contraceptives per date of service.¶
(3) CCare covers a specific set of family planning services to prevent unintended pregnancies.¶
(a) Covered services include:¶
(A) Annual visits that support contraceptive use;¶
(B) Contraceptive drugs, devices, and supplies;¶
(C) Clinically indicated follow-up visits to evaluate effectiveness of a contraceptive method, including but not limited to, management of side effects related to a contraceptive method; and, changing a contraceptive method if medically necessary or requested by the enrollee, including the removal of contraceptive devices;¶
(D) Counseling and education to support contraceptive use;¶
(E) Health screenings, laboratory tests, medical procedures, and drugs, devices, and supplies directly related to contraceptive use; and¶
(F) Vasectomy services.¶
(b) Each enrollee may receive up to a one-year supply of contraceptives per date of service.¶
(4) RHEA covers services, drugs, devices, products, and procedures related to reproductive health. Covered services include:¶
(a) Reproductive health services, drugs, devices, products or medical procedures per ORS 743A.067.¶
(b) Abortion services including:¶
(A) Pre-abortion visits;¶
(B) Abortion procedures, including medication abortion (MAB) and therapeutic abortion (TAB) procedures performed in an outpatient setting;¶
(C) Abortion-related medical services, including but not limited to laboratory tests, ultrasounds, and pain management;¶
(D) Contraceptive drugs, devices, and supplies provided immediately following abortion procedures; and¶
(E) Post-abortion follow-up visits.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec 10

AMEND: 333-004-3080

REPEAL: Temporary 333-004-3080 from PH 50-2022

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3080 Replace RH GF with Title X

CHANGES TO RULE:

333-004-3080
RH Access Fund Excluded Services by Funding Source
(1) ~~RH GF~~Title X does not cover:¶
(a) Sterilizations for enrollees assigned female at birth;¶
(b) Treatment for STIs not pursuant to a family planning visit;¶
(c) Stand-alone visits for repeat Pap tests not pursuant to a family planning visit;¶
(d) Hysterectomies or abortions;¶
(e) Transportation to or from a clinic appointment;¶
(f) Procedures performed for medical reasons, whether or not the procedure results in preventing or delaying pregnancy or restoring fertility;¶
(g) Human papillomavirus (HPV) vaccinations; or¶
(h) Any other medical service or laboratory test that is not described in OAR 333-004-3070(2) (RH Access Fund Covered Services by Funding Source) and whose primary purpose is other than preventing or achieving pregnancy.¶
(2) CCare does not cover:¶
(a) Sterilizations for enrollees assigned female at birth;¶
(b) Treatment for STIs;¶
(c) Preconception or prenatal care, including pregnancy confirmations;¶
(d) Stand-alone visits for repeat Pap tests;¶
(e) Hysterectomies or abortions;¶
(f) Transportation to or from a clinic appointment;¶
(g) Procedures performed for medical reasons, whether or not the procedure results in preventing or delaying pregnancy or restoring fertility;¶
(h) Human papillomavirus (HPV) vaccinations; or¶
(i) Any other medical service or laboratory test that is not described in OAR 333-004-3070(3) (RH Access Fund Covered Services by Funding Source), and whose primary purpose is other than preventing unintended pregnancy.¶
(3) RHEA does not cover:¶
(a) Treatment for STIs;¶
(b) Stand-alone visits for repeat Pap tests;¶
(c) Hysterectomies;¶
(d) Transportation to or from a clinic appointment;¶
(e) Human papillomavirus (HPV) vaccinations;¶
(f) Any other medical service or laboratory test that is not described in ORS 743A.067;¶
(g) Mammography services. These services are available through the ScreenWise program (OAR 333-010-0120(2)(a) (Covered Services));¶
(h) Abortion services not occurring in clinics certified by the RH Program. These services, for individuals with a household income and size at or below 185 percent of the FPL, are available under the benefit package for this population in OAR 410-120-1210(4)(e) (Medical Assistance Benefit Packages and Delivery System); or¶
(i) Sterilization procedures. These services, for individuals with a household income and size at or below 138 percent of the FPL, are available under the benefit package for this population in OAR 410-120-1210(4)(e) (Medical Assistance Benefit Packages and Delivery System).
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec 10

AMEND: 333-004-3090

REPEAL: Temporary 333-004-3090 from PH 50-2022

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3090 Replace RH GF with Title X

CHANGES TO RULE:

333-004-3090
Client Eligibility for the RH Access Fund
(1) To be considered eligible for the RH Access Fund, an enrollee must meet the eligibility requirements for ~~RH GF~~Title X, CCare, or RHEA.¶
(a) ~~RH GF~~Title X. To qualify for ~~RH GF~~Title X, an enrollee must:¶
(A) Have a household size and personal income at or below 250 percent of the FPL; and¶
(B) Have reproductive capacity.¶
(b) CCare. For an enrollee's services to be reimbursed using CCare funds, they must meet the eligibility requirements stated in OAR 333-004-3090(1)(a) (Client Eligibility for the RH Access Fund), and:¶
(A) Reside in Oregon as described in OAR 461-120-0010 (Residency Requirements);¶
(B) Provide a valid Social Security Number (SSN) as required by 42 USC 1320b-7; and¶
(C) Be a citizen of the United States, with acceptable proof of citizenship verification and identity; or¶
(D) Hold eligible immigration status with acceptable proof of eligible immigration verification and identity.¶
(c) RHEA. For an enrollee's services to be reimbursed using RHEA funds, they must meet the eligibility requirements stated in OAR 333-004-3090(1)(a) (Client Eligibility for the RH Access Fund); and¶
(A) Be able to become pregnant;¶
(B) Reside in Oregon as described in OAR 461-120-0010 (Residency Requirements); and¶
(C) Be ineligible for medical assistance because of 8 U.S.C. 1611 or 1612.¶
(2) Eligibility for CCare does not constitute eligibility for any other medical assistance program.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec 10

AMEND: 333-004-3110

REPEAL: Temporary 333-004-3110 from PH 50-2022

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3110 Replace RH GF with Title X

CHANGES TO RULE:

333-004-3110
RH Access Fund Billing and Claims
(1) Only agencies providing services pursuant to an approved MSA, and who have been assigned a project number and site number may submit claims for reproductive health or abortion services.¶
(2) An agency may bill for reproductive health or abortion services by submitting appropriate CVR data to the RH Program via the RH Program's contracted data and claims processor. A claim is considered valid only if all required data are submitted.¶
(3) An agency may bill the RH Program for supplies at acquisition cost through the CVR.¶
(a) Reimbursement for supplies billed by RHCare and CCare Clinics will be based on 340B program pricing if the agency is eligible to purchase supplies under 340B pricing. Otherwise, reimbursement for supplies will be based on acquisition cost.¶
(b) Reimbursement for supplies billed by AbortionCare Clinics will be based on acquisition cost.¶
(4) All billings for reproductive health services must be coded with International Classification of Diseases, 10th Revision (ICD-10). Up to six diagnosis codes (one primary and five secondary) may be included. Billings for abortion services do not require any codes from the International Classification of Diseases.¶
(a) ~~RH GF~~Title X: All claims must be coded with a diagnosis code in either the Z30 Contraceptive Management series, the Z31 Procreative Management series, or Z32.0 Pregnancy Testing series, with the exception of STI treatment and rescreening and stand-alone repeat Pap testing that is pursuant to a previous family planning visit.¶
(b) CCare: All claims must be coded with a diagnosis code in the Z30 Contraceptive Management series. The Z30 code must be the primary diagnosis code for all claims with the exception of a comprehensive annual visit in which the Z30 code may be a secondary diagnosis code. Comprehensive annual visits may not be billed more frequently than once every eleven months and one day.¶
(c) RHEA: All claims must be coded with a diagnosis code that corresponds to one or more of the covered services listed under OAR 333-004-3070(4) (RH Access Fund Covered Services by Funding Source), and as listed in the Allowable Diagnosis Codes section of the RH Program's website.¶
(5) Laboratory services are included in the RH Access Fund reimbursement rates. The exception to this is the combined GC/CT test. The combined GC/CT test shall be reimbursed separately from the fixed rate only if the appropriate medical service is indicated on the CVR.¶
(6) Language assistance provided shall be reimbursed separately from the fixed rate only if appropriately indicated on the CVR.-¶
(7) Ultrasound services, sedation and anesthesia services, and certain other services associated with abortion are reimbursed separately from the bundled abortion procedure rates.¶
(8) An agency must ensure that all laboratory tests done at the clinic site or by an outside clinic are conducted by a CLIA certified laboratory.¶
(9) Covered services provided by telehealth technology may be billed to the RH Program, as appropriate. The CVR must indicate that the visit was conducted via telehealth. All telehealth visits must adhere to applicable state and federal telehealth regulations.¶
(10) An agency certified with the RH Program must not seek payment from an enrollee, or from a financially responsible relative or representative of that enrollee, for any services covered by the RH Access Fund. The agency shall accept RH Access Fund reimbursement for any covered services as defined in OAR 333-004-3070 (RH Access Fund Covered Services by Funding Source), drugs, devices, or supplies as payment in full.¶
(a) If an agency has misrepresented client eligibility for enrollment into the RH Access Fund, the agency must assume responsibility for the full cost of services provided.¶
(b) An enrollee may be billed for services that are not covered by the RH Access Fund, unless the clinic misrepresented coverage of the service to the client.¶
(c) Enrollees must be informed prior to their visit that they may be billed for services not covered by the RH Access Fund.¶
(d) Agencies may not request a deposit from the enrollee in advance of services covered by the RH Access Fund.¶
(11) By submitting a claim to the RH Program for payment, the agency is attesting that it has complied with all rules of the RH Program and is certifying that the information is true, accurate, and complete.-¶

(a) All billings must be for services provided within the agency and its provider's licensure or certification, with the following exceptions:¶
(A) Services performed by a CLIA certified laboratory outside of the clinic;¶
(B) Procedures performed by contracted vasectomy providers; or¶
(C) RH-approved procedures performed by contracted facilities.¶
(b) A claim may not be submitted prior to providing services.¶
(12) An agency may not submit to the RH Program:¶
(a) Any false claim for payment;¶
(b) Any claim altered in such a way as to result in a payment for a service that has already been paid; or¶
(c) Any claim upon which payment has already been made by the RH Program or another source unless the amount paid is clearly entered on the claim form.¶
(d) Any claim or written orders contrary to generally accepted standards of medical practice;¶
(e) Any claim for services that exceed what has been requested or agreed to by the client or the responsible relative or guardian or requested by another medical practitioner;¶
(f) Any claim for services provided to persons who were not eligible;¶
(g) Any claim using procedure codes that overstate or misrepresent the level, amount or type of health care provided.¶
(13) An agency is required to correct the billing error or to refund the amount of the overpayment, on any claim where the agency identifies an overpayment made by the RH Program.¶
(14) Third party resources. The following subsections apply only to enrollees with private insurance coverage.¶
(a) All reasonable efforts must be taken to ensure that the RH Program is the payor of last resort, unless an enrollee requests special confidentiality which must be documented on the RH Access Fund Enrollment Form. An enrollee's request for special confidentiality ensures that the agency must not bill third party resources, but instead must bill the RH Program directly. This option does not apply just to minors, nor is it to be used for all teens.-¶
(b) An agency must make reasonable efforts to obtain payment from other resources before billing the RH Program. For the purposes of this rule reasonable efforts include:-¶
(A) Determining the existence of insurance or other coverage by asking the enrollee.¶
(B) Billing a third party resource when third party coverage is known to the agency, prior to billing the RH Program.¶
(c) If the enrollee has private insurance that has been billed for reproductive health or abortion services and the reimbursement from the insurance is less than the RH Program reimbursement rate, the balance may be billed to the RH Program¶
(d) An agency must report the reimbursement received from insurance, including services, drugs, devices, and supplies. The exact amount received from the insurance company for services, drugs, devices, and supplies must be reported in total.¶
(e) The RH Program payment to the agency, after the agency has received third party payment, may not exceed the total of what the RH Program would pay for both services, drugs, devices, and supplies. The total amount of services, drugs, devices, and supplies, minus the amount paid by the primary insurance is the amount the agency shall be reimbursed.-¶
(f) If third party payment is received after the RH Program has been billed, agencies are required to submit a billing correction showing the amount of the third party payment or to refund the amount received from another source within 60 calendar days of the date the payment is received. Failure to submit a billing correction within 60 calendar days of receipt of the third party payment or to refund the appropriate amount within this time frame is considered concealment of material facts and grounds for recovery or sanction.-¶
(15) No agency shall submit claims for payment to the RH Program for any services or supplies provided by a person or agency that has been suspended or terminated from participation in a federal or state-administered medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, except for those services or supplies provided prior to the date of suspension or termination.¶
(16) An agency or any of its providers who have been suspended, terminated, or excluded from participation in a federal or state-administered medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, shall not submit claims for payment, either personally or through claims submitted by any billing agency or other agency, for any services or supplies provided under the RH Program, except those services or supplies provided prior to the date of suspension or termination.¶
(17) No agency shall submit claims that result in:¶
(a) Receiving payments for services provided to persons who were not eligible; or¶
(b) Establishing multiple claims using procedure codes that overstate or misrepresent the level, amount, or type of health care provided.

Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec 10

AMEND: 333-004-3140

REPEAL: Temporary 333-004-3140 from PH 50-2022

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3140 Replace RH GF with Title X

CHANGES TO RULE:

333-004-3140
Use of Funds
(1) Final determination of funding source is made by the RH Program based on information recorded in the RH Access Fund eligibility database and claims data submitted by the agency.¶
(2) Use of ~~RH GF~~Title X Funds. ~~RH GF~~Title X funds may only be used for the reimbursement of family planning services and supplies or related preventive services as defined in OAR 333-004-3070(2) (RH Access Fund Covered Services by Funding Source), provided to enrollees as defined in OAR 333-004-3090(1)(a) (Client Eligibility for the RH Access Fund).¶
(3) Use of CCare Funds. CCare funds may only be used for the reimbursement of CCare services, drugs, devices, and supplies as defined in OAR 333-004-3070(3) (RH Access Fund Covered Services by Funding Source) provided to enrollees as defined in OAR 333-004-3090(b) (Client Eligibility for the RH Access Fund). CCare funds may not be used for an enrollee:¶
(a) Who is in the custody of a law enforcement, corrections, or youth detention agency.¶
(b) Who receives or who is eligible for the Citizen/Alien-Waived Emergency Medical benefit package under Title XIX.¶
(c) Who is enrolled in another Medicaid program that provides family planning benefits.¶
(4) Use of RHEA Funds. RHEA funds may only be used for the reimbursement of reproductive health or abortion services as defined in OAR 333-004-3070(4) (RH Access Fund Covered Services by Funding Source), provided to enrollees as defined in OAR 333-004-3090(c) (Client Eligibility for the RH Access Fund).¶
(5) Federal funds may not be used for abortion services.¶
(6) To the extent funding is available, the RH Program may provide funding to agencies, on an equitable basis, to assist with covering administrative costs incurred by agencies in adhering to these rules and program requirements.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec 10

AMEND: 333-004-3150

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3150 Prohibit agencies from sharing client information unless required by an order from a court of competent jurisdiction.

CHANGES TO RULE:

333-004-3150
RH Access Fund Requirements for Financial, Health, and Other Records
(1) The RH Program is responsible for analyzing and monitoring the operation of the RH Access Fund, and for auditing and verifying the accuracy and appropriateness of payment and utilization of services. An agency shall:¶
(a) Develop and maintain adequate financial and health records and other documentation that supports the services, drugs, devices, and supplies for which payment has been requested from the RH Program. Documentation shall be completed before the service, drug, device, or supply is billed to the RH Program.¶
(b) Document the specific services provided, diagnosis codes for the services, the date on which the service was provided, and the agency staff who provided the services in every health record. Enrollee account and financial records must also include documentation of charges, identification of other payment resources pursued, the date and amount of all debit or credit billing actions, and must support the appropriateness of the amount billed and paid. The records must be accurate and in sufficient detail to substantiate the data reported.¶
(c) Sufficiently document that the purpose of the visit was for reproductive health or abortion services and that the diagnosis codes are included on the list of allowable codes on the RH Program's website. The enrollee's health record must be annotated each time a service is provided and signed or initialed by the agency staff that provided the service or must clearly indicate the agency staff that provided the service. Information contained in the record must meet the requirements for reproductive health or abortion services as described in OAR 333-004-3030 (Agency Certification Requirements) and must be appropriate in quality and quantity to meet the professional standards applicable to the provider and any additional standards for documentation found in this rule.¶
(2) An agency must have and implement policies and procedures that ensure personal health information is kept secure and confidential in accordance with applicable federal and state security and privacy laws.¶
(3) Agencies are prohibited from sharing client information with federal or state law enforcement officials unless required by an order from a court of competent jurisdiction. ¶
(~~3~~4) An agency must retain health records for seven years and financial and other records described in this rule for at least five years from the date of service. Original RH Access Fund enrollment records must be retained for seven years.¶
(~~4~~5) Upon written request from the RH Program, the Health Systems Division, the Authority, or the Oregon Department of Justice Medicaid Fraud Unit, an agency must furnish requested documentation, without charge, immediately or within the timeframe specified in the written request. Copies of the documents may be furnished unless the originals are requested. Alteration of clinical or billing records that have been requested by the RH Program or a designated requestor is prohibited.¶
(~~5~~6) If an agency fails to comply with requests for records within the specified timeframes it may result in the Authority deeming those records not to exist for purposes of verifying appropriateness of payment, medical appropriateness, the quality of care, and the access to care in an audit or overpayment determination, and accordingly subjects the agency to possible denial or recovery of payments made by the Authority, or to sanctions.¶
(~~6~~7) Upon the written request of the agency, the RH Program may, at its sole discretion, modify or extend the time for providing records if, in the opinion of the RH Program, good cause for an extension is shown. Factors used in determining whether good cause exists include:¶
(a) Whether the written request was made in advance of the deadline for production;¶
(b) If the written request is made after the deadline for production, the amount of time elapsed since that deadline;¶
(c) The efforts already made to comply with the request;¶
(d) The reasons the deadline cannot be met;¶
(e) The degree of control that the agency had over its ability to produce the records prior to the deadline; and¶
(f) Other extenuating factors.¶
(~~7~~8) Access to records by the RH Program, including personal health information and RH Access Fund financial records does not require authorization or release from the enrollee if the purpose is:¶
(a) To perform billing review activities;¶
(b) To perform utilization review activities;¶
(c) To review quality, quantity, and medical appropriateness of care, items, and services provided;¶

(d) To facilitate payment authorization and related services;¶
(e) Related to a client's contested case hearing for enrollment denial; or¶
(f) To facilitate investigation by the RH Program related to compliance with these rules.¶
(~~8~~9) The agency, and any officers, employees, agents, and subcontractors of the agency shall comply with the following requirements for the RH Access Fund eligibility database:¶
(a) Complete and submit to the RH Program and its contracted data and claims processing vendor a User ID/Password Request Form to gain access to the RH Access Fund eligibility database.¶
(b) Implement security measures that reasonably and appropriately provide administrative, physical, and technical safeguards that protect the confidentiality and integrity of the RH Access Fund eligibility database. The agency's security measures must be documented in writing and be available for review by the RH Program upon request. RH Program reviews of the reasonableness of security measures, as well as the agency's compliance with RH Program-assigned access control or security requirements, shall take into account the agency's physical, administrative, and technical capabilities related to security measures and the potential risk of unauthorized use or disclosure of the RH Access Fund eligibility database by the agency, its officers, employees, agents or subcontractors;¶
(c) Prevent any unauthorized access to or disclosure of information from the RH Access Fund eligibility database;¶
(d) Take necessary actions to comply with RH Program determinations of the level of access that may be granted, as well as changes in level of access, or suspension or termination of access as determined by the RH Program;¶
(e) Keep any RH Program-assigned access control requirements such as identification of authorized users and access-control information in a secure location until access is terminated; monitor and securely maintain access by the agency and its agents or subcontractors in accordance with security requirements or access controls assigned by the RH Program; and make available to the RH Program upon request all information about the agency's use or application of the RH Access Fund eligibility database; and¶
(f) Report any privacy or security incidents by the agency, its officers, employees, agents or subcontractors that compromise, damage, or cause a loss of protection to the RH Access Fund eligibility database, as follows:¶
(A) Report to the RH Program in writing within five business days of the date on which the agency becomes aware of such incident; and¶
(B) Provide the RH Program the results of any incident assessment findings and resolution strategies.¶
(~~9~~10) The agency must comply with RH Program requests for corrective action concerning a privacy or security incident, and with laws requiring mitigation of harm caused by the unauthorized use or disclosure of confidential information, if any.¶
(1~~0~~1) If the RH Program determines that the agency's security measures or actions required under section (~~9~~10) of this rule are inadequate to address the security requirements, the RH Program shall notify the agency. The RH Program and the agency may meet to discuss appropriate security measures or action. If security measures or corrective actions acceptable to the RH Program cannot be agreed upon, the RH Program reserves the right to take such actions as it determines appropriate under the circumstances. Actions may include, but are not limited to, restricting access, or amending or terminating the agency agreement.¶
(1~~1~~2) The RH Program reserves the right to request additional information from the agency related to security measures, and to change, suspend or terminate access to or use of the RH Access Fund eligibility database by the agency, its officers, employees, agents or subcontractors.¶
(1~~2~~3) Wrongful use or disclosure of the RH Access Fund eligibility database by the agency, officers, its employees, agents or its subcontractors may cause the immediate suspension or revocation of any access granted, in the sole discretion of the RH Program. The RH Program may also pursue any other legal remedies provided under the law.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec. 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec. 10

AMEND: 333-004-3200

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3200 Make unauthorized or unlawful disclosure of client information grounds for a sanction and clarify that the RH Program will consider the nature of a violation or offense when considering if and when to impose a sanction.

CHANGES TO RULE:

333-004-3200
Grounds for Agency Sanctions; Sanctions
(1) The following may result in the imposition of a sanction against an agency:¶
(a) Interference with the investigation of health care fraud;¶
(b) Conviction for unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;¶
(c) An action by a state licensing authority relating to a provider's professional competence, professional conduct, or financial integrity, that results in the provider either:¶
(A) Having their license suspended or revoked; or¶
(B) Surrendering the license while a formal disciplinary proceeding was pending before a licensing authority.¶
(d) Suspension or exclusion from participation in a federal or state-administered health care program for reasons related to professional competence, professional performance, or other reason;¶
(e) Threatening, intimidating or harassing clients or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and the RH Program;¶
(f) Participation in collusion that resulted in an inappropriate money flow between the parties involved, for example, referring clients unnecessarily to another provider;¶
(g) For claims paid using CCare funds, any sanctions outlined in OAR 410-120-1400 (HSD Medicaid Programs, General Administrative Rules); ¶
(h) Unauthorized or unlawful disclosure of client information; and¶
(~~h~~i) Failure to comply with these rules.¶
(2) The RH Program shall consider the following factors in determining whether to issue a sanction and the sanction to be imposed:¶
(a) ~~Seriousness of the~~Nature of the violation or offense;¶
(b) Extent of the violations by the agency;¶
(c) History of prior violations by the agency;¶
(d) Prior imposition of sanctions;¶
(e) Prior notification of compliance findings; and¶
(f) Cooperation with an investigation.¶
(3) Sanctions may include one or more of the following:¶
(a) Termination of certification;¶
(b) Imposition of a Corrective Action Plan;¶
(c) A requirement to attend provider education sessions at the expense of the sanctioned agency;¶
(d) A requirement that payment for certain services are made only after the RH Program has reviewed documentation supporting the services; and¶
(e) For claims paid using CCare funds, any action authorized under OAR 410-120-1460 (HSD Provider Sanctions).
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec. 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec. 10

AMEND: 333-004-3230

REPEAL: Temporary 333-004-3230 from PH 50-2022

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3230 Replace RH GF with Title X

CHANGES TO RULE:

333-004-3230
Discretionary Use of Funds
The RH Program may, at its discretion, use RH GF or Title X instead of CCare to reimburse an agency for CCare-covered services, referenced in OAR 333-004-3070(3)(a) (RH Access Fund Covered Services by Funding Source), provided to clients who may otherwise be eligible for CCare, in which case OAR 333-004-3~~1~~090(1)(b) (Client Eligibility for the RH Access Fund) will not apply.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec 10

AMEND: 333-004-3240

REPEAL: Temporary 333-004-3240 from PH 50-2022

NOTICE FILED DATE: 08/26/2022

RULE SUMMARY: Amend 333-004-3240 Repeal outdated rule language. Specify that agencies must apply for recertification under the revised Certification Requirements for RHCare Clinics, CCare Clinics, and/or AbortionCare clinics before February 1, 2023 or the agency's certification and MSA will be terminated. Clarify use of RH GF funds for claims with dates of service prior to May 1, 2022 and use of Title X funds for claims with dates of service on or after May 1, 2022.

CHANGES TO RULE:

333-004-3240
Effective Date; Applicability
(1) ~~OAR 333-004-3000 to 333-004-3230, go in effect on January 1, 2021. ¶~~
~~(2)~~ An agency certified by the RH ~~p~~Program before ~~January 1~~October 27, 202~~1~~2 shall continue to operate under ~~its MSA and OAR 333-004-0000 to 333-004-2192~~the Certification Requirements for RHCare Clinics Version 2, Certification Requirements for CCare Clinics Version 1, and/or Certification Requirements for AbortionCare Clinics Version 2, incorporated by reference, until: ¶
(a) The agency applies for recertification under the ~~new rules,~~version of OAR 333-004-30~~0~~10 to OAR 333-004-32~~30, and is certified under OAR 333-004-3020~~40 effective October 27, 2022; or¶
(b) ~~Jul~~February 1~~5~~, 202~~1~~3, ~~in~~at which ~~case OAR 333-004-0000 to 333-004-2192 are repealed and~~time the agency's certification and MSA ~~ar~~will be terminated. ¶
(~~3~~2) An agency's certification that is terminated under subsection ~~(2~~of (1)(b) of this rule may apply for certification under the new rules at any time.¶
(3) Agencies that submitted claims to the RH Program on or after May 1, 2022, or that submit claims for services provided on or after May 1, 2022, if eligible for Title X reimbursement, will be paid out of Title X funds, in accordance with the RH Program rules that were in effect on May 1, 2022.
Statutory/Other Authority: ORS 413.042, ORS 414.432, ORS 431.147, ORS 431.149, OL 2022, ch. 45, sec. 10
Statutes/Other Implemented: ORS 414.432, ORS 431.147, ORS 413.032, OL 2022, ch. 45, sec. 10