CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00142/0**

TITLE: **Oregon Family Planning Expansion Project (FPEP)**

AWARDEE: **Oregon Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Oregon for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration, be regarded as expenditures under the State's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authority and the provisions specified as "not applicable" enable Oregon to operate its section 1115 Medicaid FPEP demonstration through October 31, 2012, unless otherwise stated.

Expenditures for extending Medicaid eligibility for family planning services to:

1. Women of childbearing age losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum; and,
2. Men and women of childbearing age with income up to and including 250 percent of the FPL.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Amount, Duration, and Scope of Services (Comparability) **Section 1902(a)(10)(B)**

To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of approved family planning services.

2. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics **Section 1902(a)(15)**

The State will establish reimbursement levels to these clinics that will compensate them solely for family planning services.

3. Eligibility Procedures **Section 1902(a)(17)**

Parental income will not be included when determining a minor's (individual under age 18) eligibility for the family planning demonstration.

4. Retroactive Coverage **Section 1902(a)(34)**

Individuals enrolled in the family planning demonstration will not be retroactively eligible.

5. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) **Section 1902(a)(43)(A)**

The State will not furnish or arrange for EPSDT services to the demonstration population.

Centers for Medicare & Medicaid Services

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00142/0**

TITLE: **Oregon Family Planning Expansion Project (FPEP)**

AWARDEE: **Oregon Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Oregon's family planning section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Oregon Department of Human Services and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective April 1, 2010, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through October 31, 2012.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits and Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and the Service Code List which is captioned Attachment A.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Oregon FPEP section 1115(a) Medicaid Demonstration expands the provision of family planning services to men and women of childbearing age who have family income at or below 250 percent of the Federal poverty level (FPL) and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). The objective of the program is to decrease the number of Medicaid paid deliveries which will result in a decrease in annual Medicaid expenditures for prenatal, delivery, newborn, and infant care.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, court order, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration .

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in Federal law, regulation, court order, or policy affecting the Medicaid programs that occur during this Demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

   a) To the extent that a change in Federal law, regulation, final court order, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

   b) If mandated changes in Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, covered under this Demonstration, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the Demonstration. Changes to the Service Code List, Attachment A, outside of STC 27 (Annual Submission of Service Code Listing) also require an amendment. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 6 below. The State will notify CMS of proposed Demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

6. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the State consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit. Such analysis must include current "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration.** States that intend to request demonstration extensions must submit to CMS a complete application at least 6 months prior to the expiration of the current section 1115(a) extension period. The chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 8.

   As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in paragraph 14, as well as include the following supporting documentation:

   a) Demonstration Summary and Objectives: The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

   b) Special Terms and Conditions: The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

   c) Draft report with Evaluation Status and Findings: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

8. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a

phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 9, a phase-out plan shall not be shorter than 6 months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

9. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 8, during the last 6 months of the Demonstration, individuals must not be enrolled into the Demonstration unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other Demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009 (ARRA), when any program changes to the Demonstration, including (but not limited to) those referenced in STC 7, are proposed by the State. In States with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of

advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this Demonstration.

15. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

16. **Citizenship Documentation Requirements.** For individuals who have declared that they are United States citizens or nationals, the State must only enroll individuals into the Demonstration who document citizenship or nationality in accordance with sections 1902(a)(46) and 1903 of the Act. The State may establish citizenship or nationality using the process set out in section 1902(ee) in lieu of the documentation requirements set forth in sections 1902(a)(46) and 1903 of the Act to the extent permitted by that section.

17. **Implementation Plan**. If the renewal expands or restricts eligibility or services, the State must submit an implementation plan within 30 days from the date of approval. To the extent the renewal affects the evaluation design the State must also submit a revised evaluation plan.

IV. ELIGIBILITY

18. **Eligibility Requirements.** The State must enroll only individuals meeting the following eligibility criteria into the Demonstration:

    1. Women of childbearing age losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum; and,
    2. Men and women of childbearing age with income up to and including 250 percent of the FPL.

    The State must comply with third party liability (TPL) requirements as specified in 42 CFR 433.138 for any woman who has health insurance coverage.

19. **Redeterminations.** The State must ensure that redeterminations of eligibility for the Demonstration are conducted at least every 12 months. The process for eligibility redetermination must not be passive in nature, but will require that an action be taken by the recipient. Oregon may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.

20. **Integrity.** The State must comply with Medicaid regulations regarding initial eligibility determinations and redeterminations. The State must also participate in the Payment Error Rate Measurement (PERM) program and the Federal Medicaid Eligibility Quality Control (MEQC) program to ensure the integrity of initial eligibility determinations and redeterminations of individuals covered under the family planning program.

21. **Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the Demonstration, she may be determined eligible for Medicaid under the State plan. If an

individual becomes sterilized and completes all follow-up procedures/visits related to the sterilization, the individual will no longer require any family planning services, and system edits will prohibit reimbursement for other services. The State must have systems in place to prohibit an individual who becomes sterilized and completes all necessary follow-up procedures/visits from reenrolling into the Demonstration. The State has 1 year from the date of the approval of the renewal to modify its policies, procedures, and forms to comply with this requirement. An individual who is enrolled in a Medicaid State plan eligibility category will not be eligible for services under the Demonstration. The State must not submit claims under the Demonstration for any individual who is found to be eligible under the Medicaid State plan.

22. **Primary Care Referral.** The State assures CMS that providers of family planning services will make appropriate referrals to primary care providers as medically indicated. The State also assures that individuals enrolled in this Demonstration receive information about how to access primary care services.

IV. BENEFITS AND DELIVERY SYSTEMS

23. **Benefits.** Family planning services are medically necessary services and supplies related to contraception, pregnancy prevention, and preventive services listed in Attachment A, including:

- Approved methods of contraception;
- Sexually transmitted infection testing and treatment, including Pap tests and pelvic exams;
- Drugs, supplies, or devices related to women's health services described above that are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements);
- Contraceptive management, patient education, and counseling; and,
- Primary care referrals to other social service and health care providers as medically indicated; however, the costs of those primary care services are not covered for enrollees of this Demonstration.

24. **Services.** Services provided through this Demonstration are paid fee for service.

VI. GENERAL REPORTING REQUIREMENTS

25. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section VII.

26. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.

27. **Annual Submission of Service Code Listing.** Oregon will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding

Systems (HCPCS) codes covered under the Demonstration on January 31 of each demonstration year. The revised code list should reflect only changes due to updates in service codes for those services for which the State has already received approval and submitted on a template provided by CMS.

28. **Monitoring Calls.** CMS and the State will participate in quarterly conference calls following the receipt of the quarterly reports, unless CMS determines that more frequent calls are necessary to adequately monitor the Demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments the State is considering submitting. The State and CMS will discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS will update the State on any amendments under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.

29. **Quarterly Operational Reports.** The State must submit progress reports no later than 60 days following the end of each quarter.

    The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the Demonstration. These quarterly reports must include, but are not limited to:

    a) Expenditures including administrative costs;
    b) Total number of enrollees (male and female);
    c) The number of unduplicated demonstration enrollees who became sterilized and completed all necessary follow-up procedures/visits during the quarter in which the State learned of the sterilization;
    d) Total number of participants (male and female) (Participants include all individuals who obtain one or more covered family planning services through the Demonstration);
    e) Number of demonstration enrollees who have health insurance coverage;
    f) TPL collections for demonstration participants who have health insurance coverage;
    g) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, benefits, enrollment, grievances, quality of care, access, pertinent legislative activity, eligibility verification activities, and other operational issues;
    h) Action plans for addressing any policy and administrative issues identified; and,
    i) Evaluation activities and interim findings.

30. **Annual Report.** The annual report is due 90 days following the end of the fourth quarter of each demonstration year and must include a summary of the year's preceding activity as well as the following:

a) The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)
b) The number of actual births that occur to family planning demonstration participants. (Participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year.)
c) An updated cumulative budget neutrality spreadsheet that includes the "Annual Budget Limit (ABL)."

a) The ABL will be the estimated cost savings of the births averted (BA) calculated as follows:

ABL = BA x MCB (Medicaid cost of birth)

- Births Averted will be estimated by the following equation:

  - Births Averted: BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of female demonstration participants during DY). The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the Demonstration. At its option, the State may also adjust the fertility rates for ethnicity.

  - The Base-Year Fertility Rate reflects fertility rates during 1998 for individuals in families with income at or below 185 percent of the FPL and ineligible for Medicaid except for pregnancy. The fertility rates are limited to births paid for by Medicaid. The State submitted to CMS base-year fertility rates and a methodology for calculating the fertility rates. Preliminary base-year fertility rates met the following requirements by:
    a) Reflecting fertility rates during the Base Year, for women in families with income at or below 185 percent of the FPL, and ineligible for Medicaid except for pregnancy.
    b) Adjusting for the age of all potential demonstration participants.
    c) Include births paid by Medicaid.
    d) Allowing up to 6 months after the end of the first demonstration year to finalize these preliminary rates. Following the conclusion of each year of the Demonstration, a demonstration year fertility rate will be determined by computing an age-weighted average fertility rate during the DY, unless the State demonstrates that the age distribution is consistent with the prior demonstration year(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates. At its option, the State may also adjust the fertility rates for ethnicity.

b) Medicaid Cost of Birth: (MCB) = (cost of prenatal services + delivery and pregnancy related costs + costs for infants up to 1 year of life)/number of deliveries, where the costs and number of deliveries pertain to the Oregon Medicaid program.

31. **Final Report.** No later than 90 days prior to the end of the demonstration award period, Oregon must submit a draft final report to CMS for comments. The final report will incorporate all CMS comments and evaluation findings. The final report must also contain a disclaimer that the opinions expressed are those of the State and do not necessarily reflect the opinions of CMS. The final report is due 90 days after the end of the demonstration award period.

VII. GENERAL FINANCIAL REQUIREMENTS

32. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS must provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section VIII.

33. **Reporting Expenditures Under the Demonstration.** In order to track expenditures under this Demonstration, Oregon must report Demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in sections 2115 and 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in paragraph 34. The State must report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:

a) Allowable family planning expenditures and other expenditures subject to the budget neutrality limit (see paragraph 34) that are eligible for reimbursement at the State's Federal medical assistance percentage (FMAP) rate should be entered in Column (B) on the appropriate waiver sheets (see paragraph 38). Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets (see paragraph 38).

b) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.

b) For each Demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for Demonstration populations and Demonstration services.

34. **Expenditures Subject to the Budget Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all title XIX expenditures provided to individuals who participate in this Demonstration. All expenditures that are subject to the budget neutrality agreement must be reported on Forms CMS 64.9 Waiver and/or 64.9P Waiver. A participant is any person that enrolls into this Demonstration and receives one or more covered family planning services through the Demonstration. Participation in the Demonstration and expenditures are further described as follows:

    a) A participant is any person that enrolls into this Demonstration and receives one or more covered family planning services through the Demonstration. Persons that enroll in the Demonstration and who subsequently have a Medicaid-covered delivery are still considered a participant in the Demonstration.

    b) Expenditures incurred by the State on behalf of participants for either family planning expenditures as defined in paragraph 38 and subsequent expenditures for Medicaid covered delivery and postpartum cost, as well as first year of cost of their infant are also demonstration expenditures and are expenditures subject to the budget neutrality limit.

35. **Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10.

36. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

37. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration

expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

38. **Extent of FFP for the Demonstration.** CMS shall provide FFP for CMS-approved services (including prescriptions) provided to women and men at the following rates and as described in Attachment A.

    a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management, and sterilizations) and which are provided in a family planning setting, FFP will be available at the 90 percent Federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service. Note: The laboratory tests performed during an initial family planning visit for contraception include a Pap smear, screening tests for sexually transmitted infections STIs/sexually-transmitted diseases (STDs), blood counts, and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or needed during an inter-periodic family planning visit for contraception.

    b) In order for family planning-related services to be reimbursed at the FMAP rate they must be defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a "family planning-related" problem was identified/diagnosed during a routine/periodic family planning visit. Three kinds of family planning related services are recognized:

        i. A colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit. Only those colposcopies which can generally be performed in the office or clinic setting are coverable as a family planning-related service under this Demonstration. Colposcopies which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital are not covered under these waivers as family planning-related services.

ii. Treatment/drugs for STIs, except for HIV/AIDS and hepatitis, where the STDs/STIs are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/ encounter for the treatment/drugs may be covered at the applicable Federal matching rate for the State. Subsequent follow-up visits to rescreen for chlamydia based on the Centers for Disease Control and Prevention guidelines may be covered at the applicable Federal matching rate for the State.

iii. Treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered at the applicable Federal matching rate for the State.

iv. Treatment for disorders/conditions such as hypertension, hypercholesterolemia, diabetes, upper genital tract disorders are not covered under these waivers because they are not considered "family planning-related," even though they may be identified/diagnosed as a result of family planning visit/encounter.

c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, (e.g., those provided at a public STI clinic), no FFP will be available.

d) CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.

e) In order for male annual family planning exams to be reimbursed at FMAP, exams must be limited to family planning-related services.

39. **Sources of Non-Federal Share.** The State must certify that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds must not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

b) Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

40. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

41. **Monitoring the Demonstration.** The State must provide CMS with information to

effectively monitor the Demonstration, upon request, in a reasonable time frame.

VIII. MONITORING BUDGET NEUTRALITY

42. The following is the method by which budget neutrality will be monitored for the Oregon section 1115 Family Planning Demonstration.

    a) The State will be subject to a limit on the amount of Federal title XIX funding it will receive for extending Medicaid eligibility for family planning services during the demonstration renewal period. This limit will be determined using a pre/post comparison of fertility rates for demonstration participants. Thus, Oregon will be at risk for the cost of family planning services (including traditional family planning services at the enhanced match rate and ancillary services at the FMAP rate described in the STCs that are not offset by the demonstration intervention.

    b) The Demonstration will provide family planning services to uninsured women and men of child bearing age who have family income at or below 250 percent of the FPL, who are not otherwise eligible for Medicaid or CHIP. The Demonstration will not change the current division of Federal and State responsibility for costs of the current Medicaid program. CMS will confirm that the demonstration expenditures do not exceed the levels that would have been in the absence of the Demonstration.

    c) Budget Limit: To calculate the overall expenditure limit for the Demonstration, separate budget limits will be calculated for each year, and will be on a demonstration year (DY) basis. These annual estimates will then be added to obtain an expenditure estimate over the entire demonstration period. The Federal share of the estimate will represent the maximum amount of FFP that the State can receive during the expanded family planning services demonstration. For each DY, the Federal share will be calculated using the FMAP rate(s) for that 12-month period.

    d) Annual Budget Limit (ABL) The annual budget limit will be the estimated cost-savings of the births averted (BA) calculated as follows:

        - ABL = BA x MCB (Medicaid cost of a birth)

    e) Births averted (BA) will be estimated by the following equation:

        - BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of female demonstration participants during DY). The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the Demonstration. At its option, the State may also adjust the fertility rates for ethnicity.

f) Medicaid Cost of Birth (MCB) is calculated as follows:

- MCB = (cost of prenatal services) + delivery and pregnancy related costs + costs for infants up to 1 year of life)/number of deliveries, where the costs and number of deliveries pertain to the Oregon Medicaid program.

g) Base-Year Fertility Rate The State submitted to CMS base-year fertility rates and a methodology for calculating the fertility rates. The base-year fertility rate reflected fertility rates during 1998 for individuals in families with income at or below 185 percent of the FPL and ineligible for Medicaid except for pregnancy. Preliminary base-year fertility rates met the following requirements by:

- Reflecting fertility rates during the Base Year, for women in families with income at or below 185 percent of the FPL, and ineligible for Medicaid except for pregnancy.

- Adjusting for the age of all potential demonstration participants.

- Including births paid by Medicaid.

- Following the conclusion of each year of the Demonstration, a demonstration year fertility rate will be determined by computing an age-weighted average fertility rate during the DY, unless the State demonstrates that the age distribution is consistent with the prior demonstration year(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates. At its option, the State may also adjust the fertility rates for ethnicity.

h) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures, as reported by the State on the CMS-64 forms. If at the end of the Demonstration period, the costs of the Demonstration services exceed the budget limit, the excess Federal funds will be returned to CMS.

i) Expenditure Review. CMS will enforce budget neutrality over the life of the demonstration, rather than annually. However, no later than 6 months after the end of each DY or as soon thereafter as the data are available, the State will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these targets, it will submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative Target Expenditures	Percentage
2010	DY 12 budget limit amount	+4 percent
2011	DY 12 and 13 combined budget limit amount	+2 percent
2012	DYs 12 through 14 combined budget limit amount	+0 percent

j) Failure to meet budget Neutrality Goals. The State, whenever it determines that the Demonstration is not budget neutral or is informed by CMS that the Demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which must include submitting a corrective action plan to CMS within 21 days of the date the State is informed of the problem. While CMS will pursue corrective actions with the State, CMS will work with the State to set reasonable goals that will ensure that the State is in compliance.

k) Definition of With and Without Waiver Demonstration Costs. The "with" and "without" demonstration costs (Federal share) follow. The "without" demonstration costs are estimates of the costs of births that would occur in the absence of the Demonstration. The "with" Demonstration costs are estimates of family planning services provided with the demonstration in effect.

State Plan Costs (Federal share)			
YEAR	WOW	WW	Estimated Annual Budget Limit
CY 2010	$177,510,580	$79,134,579	$98,376,000
CY 2011	$167,524,672	$73,003,091	$94,521,581
CY 2012	$182,263,255	$77,278,811	$104,984,444
Demonstration Costs (Federal share)			
	WOW	WW	Estimated Annual Budget Limit – WW
CY 2010		$26,610,255	$71,765,745
CY 2011		$31,130,280	$63,391,301
CY 2012		$36,937,031	$68,047,413
Total Costs (Federal share)			
	WOW	WW	Projected Margin
CY 2010	$177,510,580	$105,744,834	$71,765,746
CY 2011	$167,524,672	$104,133,371	$63,391,301
CY 2012	$182,263,255	$114,215,842	$68,047,413
3 Year Total	$527,298,507	$324,094,047	$203,204,460

IX. PRIMARY CARE REFERRAL AND EVALUATION

43. **Access to Primary Care Services.** The State must facilitate access to primary care services for enrollees in the Demonstration. The State must assure CMS that written materials

concerning access to primary care services are distributed to the Demonstration participants. The written materials must explain to the participants how they can access primary care services.

44. **Final Evaluation Design.** A draft evaluation design report must be submitted to CMS for approval within 30 days from the award of the demonstration extension. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the Demonstration will be isolated from those of other initiatives occurring in the State. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the Demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the Demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. The State must implement the evaluation design and report its progress in each of the demonstration's quarterly reports.

45. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 44, within 60 days of receipt of CMS comments.

    a) The State must implement the evaluation designs and report its progress on each in the quarterly reports.

    b) The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

46. **Federally Contracted Evaluation**. In addition, a federally-contracted evaluation has examined the appropriateness of the budget neutrality methodology of these demonstrations by assessing the births that have been averted as a result of the demonstrations, the data sources currently used to assess averted births and budget neutrality, and expenditures overall. Based on the evaluation findings and other information, CMS reserves the right to negotiate a new budget neutrality methodology, if CMS deems appropriate. Such a methodology change could range from a change in data sources used to determine budget neutrality, to a total change in methodology, such as incorporating a per capita cap. Any and all changes to the budget will be made in full consultation with the State, including expenditure data used in the methodology.

47. **Independent Evaluation**. Should CMS conduct further independent evaluations of section 1115 family planning demonstrations the State must cooperate fully with CMS or the independent evaluator selected by CMS, to assess the impact of the Medicaid demonstrations and/or to further examine the appropriateness of the averted birth budget neutrality methodology. The State must submit the required data to CMS or its contractor.

48. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

Attachment A

Oregon Family Planning Section 1115 Demonstration Approved Code List For Women

ICD-9-CM, Code, or Drug Class	Description	90% FFP	90% FFP with V25 Diagnosis or FP Modifier	Always at FMAP	At FMAP if associated with a follow-up procedure	Approved
T1015-FP	Family Planning Visit		X			Previous
58600, 58605, 58615	Tubal ligation (division of fallopian tube)		X			Previous
58565	Essure (hysteroscopy, sterilization)		X			Current
58340	Catherization and introduction of saline or contrast material for saline infusion sonohysterography or hysterosalpingography (implant post-procedure confirmatory test)		X			Current
74740	Hysterosalpinography radiological supervision and interpretation		X			Current
Please note: Specific family planning medical services and supplies associated with T1015-FP are captured for each visit through check-boxes on the client's Clinic Visit Record when submitted for billing.						
80061	Lipid panel		X			Current
81000	24 - Dipstick / urine dipstick		X			Previous
81002	Urinalysis qualitative / dipstick		X			Previous
81025	Neg & Pos pregnancy tests		X			Previous
82270	Fecal blood (occult)		X			Current
82947	Fasting glucose		X			Current
83001	FSH		X			Previous
84146	Prolactin		X			Previous
84443	TSH		X			Previous
84702	Serum pregnancy test		X			Current
85014	Hemocrit		X			Previous
85018	Hemoglobin		X			Previous
86592	VDR-RPR qualitative		X			Previous
86695	Herpes I serology		X			Current
86696	Herpes II serology		X			Current
86703	HIV test		X			Previous
87088	Urinalysis quantitative		X			Previous
87205	Gram stain		X		X	Previous
87207	Herpes culture		X			Current
87210	Wet mount		X			Current
87491	Chlamydia test		X		X	Current
87591	Gonorrhea test		X			Current
87621	HPV test		X		X	Current
87801	Gonorrhea/Chlmaydia test		X		X	Current
88142	Cytology test, liquid based		X		X	Current
88150	Pap smear		X		X	Previous
36451	Venipuncture		X			Current
Q0091	Obtaining/preparing Pap test		X			Current
96372	Injection - subcutaneous or intramuscular		X			Current
84450	SGOT/ALT		X			Current

Attachment A

Oregon Family Planning Section 1115 Demonstration Approved Code List For Women

ICD-9-CM, Code, or Drug Class	Description	90% FFP	90% FFP with V25 Diagnosis or FP Modifier	Always at FMAP	At FMAP if associated with a follow-up procedure	Approved
S4993-FP	Contraceptive Pills		X			Previous
S4993-FP	Emergency Contraception		X			Previous
J3490-FP	Sponge		X			Previous
J7304-FP	Patch		X			Previous
J7303-FP	Ring		X			Previous
J7302-FP	Mirena IUD		X			Previous
J7300-FP	Copper IUD		X			Previous
58300	IUD/IUS Insertion		X			Current
58301	IUD/IUS Removal		X			Current
J1055-FP	Depo Provera		X			Previous
A4266-FP	Diaphragm		X			Previous
A4269-FP	Spermicide		X			Previous
A4267-FP	Condoms - male		X			Previous
A4268-FP	Condoms - female		X			Previous
J7307-FP	Sub-dermal implants/Implanon		X			Previous
11975	Sub-dermal implant insertion		X			Current
11976	Sub-dermal implant removal		X			Current
A4261-FP	Cervical Cap		X			Previous
A9999-FP	Cycle Beads (supply not otherwise specified)		X			Previous
11420	Excision, benign lesion including margins, excised diameter 0.5 cm or less			X		Current
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions			X		Current
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions			X		Current
46916	Destruction of lesion(s), cryosurgery			X		Current
57452	Colposcopy of the cervix incllluding upper vagina			X		Current
57455	Colposcopy of the cervix including upper vagina; with biopsy(s) of the cervix			X		Current
57511	Cautery of cervix; cryocautery, initial or repeat			X		Current
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy			X		Current
87620	Papillomavirus human direct probe technique		X		X	Current
87621	Papillomavirus human amplified probe technique		X		X	Current

Attachment A

Oregon Family Planning Section 1115 Demonstration Approved Code List For Women

ICD-9-CM, Code, or Drug Class	Description	90% FFP	90% FFP with V25 Diagnosis or FP Modifier	Always at FMAP	At FMAP if associated with a follow-up procedure	Approved
87622	Papillomavirus human quantification		X		X	Current
88141	Cytopathology cervical or vaginal		X		X	Current
99212	Office or other outpatient visit for an established patient which requires at least 2 of these 3 key components: an expanded problem focused on history, an expanded problem focused on examination, straightforward medical decision making. 10 minutes		X		X	Current
99213	Office or other outpatient visit for the evaluation and management of an established patient, wich requires at least 2 of these 3 key components: an expanded problem focused history, an expanded problem focused examination, medical decision making of low complexity 15 minutes		X		X	Current
99214	Established client, outpatient visit 25 minutes		X		X	Current
99215	Established client, outpatient visit 40 minutes		X		X	Current
99201	New Client, outpatient visit, 10 minutes		X		X	Current
99202	New client, outpatient visit, 20 minutes		X		X	Current
99203	New client, outpatient visit, 30 minutes		X		X	Current
99204	New cleint, outpatient visit, 45 minutes		X		X	Current
99205	New client, outpatient visit, 60 minuts		X		X	Current
99211	Established client, Non-clinician outpatient visit - 5 minutes		X		X	Current
J0580	Penicillin G Benzathine up to 2,400,000 units (Bicillin LA)			X		Current
Q0144	Azithromycin dihydrate, oral, capsules/ powder, 1 gm			X		Current
99070	Doxycycline			X		Current
99070	Cefpodoxime (Vantin)			X		Current
99070	Cefixime (Suprax)			X		Current
J0696	Ceftriaxone Sodium (Rocephin) Injection			X		Current
99070	Erythromycin Base/Ethylsuccinate			X		Current
99070	Metronidazole-tablet and gel			X		Current
99070	Tinidazole			X		Current
99070	Miconazole			X		Current
99070	Terconazole			X		Current
99070	Fluconazole			X		Current
99070	Trimethoprim Sulfamethoxazole (Bactrim)			X		Current
99070	Pyridium			X		Current
99070	Aldara Cream			X		Current
99070	Trichloroacetic acid (TCA)			X		Current

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Oregon Family Planning Section 1115 Demonstration Approved Code List For Women

ICD-9-CM, Code, or Drug Class	Description	90% FFP	90% FFP with V25 Diagnosis or FP Modifier	Always at FMAP	At FMAP if associated with a follow-up procedure	Approved
99070	Podophyllin			X		Current
99070	Acyclovir			X		Current
99070	Nitrofurantoin			X		Current

Key: "90% FFP with V25 Diagnosis or FP Modifier" indicates that 90 percent FFP is available for codes that are accompanied on the claim by an FP (family planning) modifier or the claim has a primary ICD-9-CM diagnosis code in the V25 (contraception management) series. Previous = previously approved; Current = currently being approved. Tests and visits routinely provided pre- and post-operative to a sterilization procedure are also reimbursable at the 90 percent matching rate. Note: The Family and Children's Health Programs Group (FCHPG) will provide approval, as needed, to add codes, including codes associated with new technologies, that appear on the master code list.

Attachment A
Oregon Family Planning Section 1115 Demonstration Approved Code List For Men

ICD-9-CM, Code, or Drug Class	Description	90% FFP	90% FFP with V25 Diagnosis or FP Modifier	FMAP	Approved
63.70	Male sterilization procedure; not otherwise specificied	X			Previous
63.71	Ligation of vas deferens, unilateral or bilateral	X			Previous
63.72	Ligation of spermatic cord	X			Previous
63.73	Vasectomy	X			Previous
55250	Vasectomy, unilateral or bilateral (including postop semen examinations(s))	X			Previous
55450	Ligation of vas deferens, unilateral or bilateral	X			Previous
A4267	Condoms	X			Previous
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular			X	Previous
99201-99204	New patient or established patient - office or other outpatient visit			X	Current
99211-99215	New patient or established patient - office or other outpatient visit			X	Current
10060	Incision and drainage of abscess; simple or single			X	Current
10140	Incision and drainage of hematoma, seroma or fluid collection			X	Current
11420	Excision, benign lesion including margins, excised diameter 0.5 cm or less			X	Current
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions			X	Current
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions			X	Current
J0580	Injection, penicillin G benzathine, up to 2,400,000 units			X	Current
J0696	Injection, ceftriaxone sodium, per 250 g			X	Current
Q0144	Azithromycin dihydrate, oral, capsules/ powder, 1 gm			X	Current
81000	Urinalysis by dipstick/ tablet reagent; non-automated with microscopy			X	Current

Attachment A
Oregon Family Planning Section 1115 Demonstration Approved Code List For Men

ICD-9-CM, Code, or Drug Class	Description	90% FFP	90% FFP with V25 Diagnosis or FP Modifier	FMAP	Approved
81002	Urinalysis by dip stick/tablet reagent; non-automated without microscopy (CLIA waiver list)			X	Current
36451	Venipuncture			X	Current
86592	Syphilis test qualitative			X	Current
86689	Antibody; HTLV OR HIV antibody confirmatory test (EG western blot)			X	Current
86703	Antibody; HIV-1 and HIV-2 single assay			X	Current
86781	Antibody; treponema pallidum confirmatory test			X	Current
87205	Smear primary source with interpretation routine stain			X	Current
87207	Herpes culture			X	Current
86695	Herpes I serology			X	Current
86696	Herpes II serology			X	Current
87491	Chlamydia test			X	Current
87591	Gonorrhea test			X	Current
87801	Gonorrhea/Chlamydia test			X	Current
99070	Doxycycline			X	Current
99070	Cefpodoxime			X	Current
99070	Cefixime (Suprax)			X	Current
99070	Erythromycin Base/Ethylsuccinate			X	Current
99070	Miconazole			X	Current
99070	Terconazole			X	Current
99070	Tinidazole			X	Current
99070	Aldara cream			X	Current
99070	Trichloroacetic acid (TCA)			X	Current
99070	Podophyllin			X	Current
99070	Acyclovir			X	Current

Key: "90% FFP with V25 Diagnosis or FP Modifier" indicates that 90 percent FFP is available for codes that are accompanied on the claim by an FP (family planning) modifier or the claim has a primary ICD-9-CM diagnosis code in the V25 (contraception management) series. Previous = previously approved; Current = currently being approved. Tests and visits routinely provided pre- and post-operative to a sterilization procedure are also reimbursable at the 90 percent matching rate. Note: The Family and Children's Health Programs Group (FCHPG) will provide approval, as needed, to add codes, including codes associated with new technologies, that appear on the master code list.