oregon**contraceptive**care

Oregon Family Planning Medicaid Waiver

Section 1115 Quarterly Report

3rd Quarter Report

July 1, 2018 – September 30, 2018

Demonstration Year 20

Oregon Health Authority

I. Introduction

The Oregon Health Authority, Public Health Division, Reproductive Health (RH) Program administers Oregon's 1115 family planning Medicaid demonstration waiver entitled Oregon ContraceptiveCare or "CCare" (Project Number 11-W-00142/0). First approved in October 1998 by the Centers for Medicare and Medicaid Services (CMS) (previously the Health Care Financing Administration), the program began providing services in January of 1999. CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). The goal of the program is to improve the well-being of children and families by reducing unintended pregnancies and improving access to primary health care services. Clients are enrolled in CCare at the point of service (clinic site) but final determinations of eligibility are made by state staff. CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client has lost CCare eligibility for some reason (e.g., acquired and then lost regular Medicaid coverage) and is seeking to reestablish it. CCare covers office visits for contraceptive management services, limited laboratory services, contraceptive devices, and pharmaceutical supplies. There is no cost-sharing for coverage and services are provided through a statewide network of providers. Participating providers abide by the program's Standards of Care. One of these is the requirement to provide all clients with information and resources to help them access primary care services and health coverage on an ongoing basis.

The overall outcomes of CCare can grouped into three categories: (A) immediate outcomes for CCare clients; (B) intermediate outcomes for both CCare clients and the waiver's target population; and, (C) long-term outcomes for Oregon's reproductive-age population as a whole.

(A) Immediate Outcomes

- Outcome 1: The program will result in an increase in the proportion of clients who use a highly effective or moderately effective contraceptive method.

- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage. Data source: RH Program Data System

(B) Intermediate Outcomes

- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.
- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.

(C) Long-term Outcomes

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.
- Outcome 6: The program will result in a decrease in the unintended pregnancy rate in Oregon.
- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.

Table 1 shows the quarters for demonstration year (DY) 20 for the waiver.

TABLE 1
Family Planning Waiver
Quarterly Report Timeline Dates for DY 20

Quarter	Begin Date	End Date	Quarterly Report Due*
1	January 1, 2018	March 31, 2018	May 31, 2018
2	April 1, 2018	June 30, 2018	August 31, 2018
3	July 1, 2018	September 30, 2018	November 30, 2018
4	October 1, 2018	December 31, 2018	February 28, 2018

*60 days following the end of quarter.

II. Significant Program Changes

The RH Program implemented a newly integrated structure based on its three sources of funding, CCare, Title X, and HB 3391, on April 1, 2018. Leveraging its existing model of FFS claims-based reimbursement through CCare, the RH Program developed three bundled reimbursement rates based on a weighted average of the different office visits and laboratory services conducted within typical reproductive health visits. These rates are based on Medicaid FFS reimbursement rates and are intended to accommodate the range of typical visits provided for both new and established clients. Clinics select the appropriate visit type for each encounter which triggers the corresponding reimbursement rate. Using a set of system rules based on each funding source's client eligibility and service coverage requirements, the RH Program determines the appropriate fund source to draw from. This ensures that funding is maximized based each fund source's unique eligibility and coverage requirements. CCare funds continue to be used solely for CCare-eligible individuals for CCare-covered services (i.e., services to prevent unintended pregnancy).

CCare-enrolled agencies not interested in participating in the newly integrated program were permitted to remain enrolled as CCare-only providers. CCare-only providers include University student health centers and small community-based health centers.

III. Enrollment and Renewal

CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client has lost CCare eligibility for some reason (e.g., acquired and then lost regular Medicaid coverage) and is seeking to reestablish it.

As part of the newly integrated RH Program structure, all active CCare clients had their eligibility ended as of March 31, 2018 and were reenrolled the next time they sought services at a CCare clinic. As a result of these reenrollments, the number of CCare enrollees during Q2 increased since Q1 and the number of member months decreased. Q3 enrollments have begun to level off and the number of members months are beginning to increase.

	Table 2 CY 2018 / DY 20			
	Q1, January 1 - March 31	**Q2, April 1 – June 30**	**Q3, July 1 – September 30**	**Q4, October 1 – December 31**
# of Total Enrollees	7,251	11,210	7,594	
# of Member Months	81,762	23,088	47,872	

IV. Service and Providers

As of September 30, 38 agencies, with 111 clinic sites, were enrolled in the full RH Program (CCare, Title X, and HB 3391). An additional 12 agencies chose to remain enrolled as CCare-only providers (i.e., not eligible to receive reimbursement under HB 3391 or Title X). Provider training and education activities during the 2nd quarter included:

- Delivery of program news, policy updates, training opportunities, and other information to providers via the biweekly *RH Newsletter*.

V. Program Monitoring

During the 3nd quarter, RH Program staff started using the updated program integrity and monitoring processes and revised review tools developed to incorporate RH Program changes that began April 1. The existing audit and compliance components related to CCare were maintained and enhanced as part of the integration with the RH Program's two other funding

sources (Title X and HB 3391). The following auditing activities of agencies receiving CCare reimbursement began in the 3rd quarter:

1. Monthly desk-audit, including review of data and claims to identify potential improper billing practices.
2. Random-sample chart audits to substantiate appropriate billing to CCare.
3. Eligibility and enrollment form audit to assess for completeness and accuracy.
4. Chart reviews during onsite clinic reviews. Reviewers follow a checklist of components to review charts with visits billed to CCare. The review tool is also given to providers to encourage regular self-auditing.
5. Visit frequency audit to help identify clients with a high number of visits within the year, which may indicate the need for a chart audit.
6. Monthly duplicate claims audit process to identify and correct duplicate claims inadvertently submitted to and paid by CCare.

Seven specific agencies were reviewed using the audit processes noted above in Q3, including four University Student Health Centers.

VI. Quarterly Expenditures

Table 3 shows the quarterly expenditures during the 1st, 2nd, and 3rd quarters of DY 20.

TABLE 3
Quarterly Expenditures for DY 20
January 1, 2018 – December 31, 2018

Quarter	Total Expenditures as Reported on the CMS-64
1	$2,805,561
2	$2,225,398
3	$1,649,913*

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Annual Total	

*3rd quarter expenditures are lower than previous quarters because September claims didn't get paid until October, so only two months of payments are included.

VII. Activities for Next Quarter

RH Program staff will continue to monitor the newly integrated program for quality assurance and improvement opportunities.

RH Program staff participate in the Oregon Preventive Reproductive Health Advisory Council (OPRHAC), a collaborative effort of state, local, private and public health sectors. Over the course of three years, OPRHAC members developed and finalized the *Oregon Guidance for the Provision of High-Quality Contraception Services: A Clinic Self-Assessment Tool* and *Strategies and Resource Guide*. The purpose of the tool is to use to define and encourage the adoption of standards for the provision of high-quality contraception services in both primary care and family planning clinical settings throughout Oregon. The RH Program, in support of the OPRHAC tool, developed a website that allows users to track their assessment results and subsequent improvement work plans: https://oregoncontraceptiontool.org/. The website was completed in September 2017. RH Program staff involved in this effort continue to promote the tool across providers and health systems.

During October, the RH Program will hold its annual, statewide Reproductive Health Coordinators' Meeting. Participants include staff from RH Program and CCare only clinics. The two-day meeting will include presentations and roundtables featuring RH Program staff and external experts on a number of reproductive health-related topics. The goals of this year's meeting are: (1) providing equitable and accessible services throughout Oregon and (2) taking care of ourselves, our staff, and our clients in a changing world.