oregon **contraceptive** care

Oregon Family Planning Medicaid Waiver

Section 1115 Quarterly Report

3rd Quarter Report

July 1, 2021 – September 30, 2021

Demonstration Year 23

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) 22 for the waiver.

TABLE 1 Family Planning Waiver Quarterly Report Timeline Dates for DY 23			
Quarter	**Begin Date**	**End Date**	**Quarterly Report Due***
1	January 1, 2021	March 31, 2021	May 31, 2021
2	April 1, 2021	June 30, 2021	August 31, 2021
3	July 1, 2021	September 30, 2021	November 30, 2021
4	October 1, 2021	December 31, 2021	March 31, 2022**

*60 days following the end of quarter.

**4th quarter report also serves as the annual report and is due 90 days following the end of the demonstration year.

II. Significant Program Changes

CCare continues to provide the same services as in the previous demonstration period. As described in previous quarterly reports, the COVID-19 pandemic has impacted both CCare enrollment and service utilization as clinics reduced in-person clinic access to ensure the health and safety of both clinic staff and clients. Throughout the pandemic, clinics have been able to implement creative changes to clinic workflows and service provision including strategies such as delaying routine well woman visits, providing Depo injections in the parking lot, and offering appointments via telehealth. All CCare agencies are now offering the full scope of in-person visits again.

Clinics continue to increase their capacity in their use of telemedicine/telehealth during the COVID-19 pandemic. The RH Program has maintained its policies related to the provision of telehealth services and remote enrollment (i.e., completion of RH Program Enrollment Form via telephone or video conference and obtaining verbal consent).

The RH Program updated its Oregon Administrative Rules (OARs) related to its clinical services program which include sections specific to CCare. The updated rules (333-004-3000 to 333-004-3240), effective January 1, 2021, can be found here. As part of the updated OARs for CCare, the RH Program implemented a certification process by which agencies must complete an application attesting to meeting program requirements in order to contract with the RH Program. The application was made available January 1, 2021 and existing CCare agencies had until July 15, 2021 to complete and submit the application for certification in order to remain contracted with the RH Program and be eligible to receive reimbursement for covered services.

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.

The number of enrollees and member months have both been impacted by COVID-19. The RH Program continues to grant eligibility extensions as a result of the Public Health Emergency which has both increased the number of member months, and also reduced the number of clients that needed to complete an enrollment form. Furthermore, the number of enrollees has likely been reduced by clients gaining full benefit Medicaid coverage as individuals' jobs have been lost during the pandemic.

	Table 2 **CY 2021 / DY 23**			
	Q1, January 1 – March 31	**Q2, April 1 – June 30**	**Q3, July 1 – September 30**	**Q4, October 1 – December 31**
# of Total Enrollees	2,634	2,258	2,060	
# of Member Months	95,180	98,422	101,225	

IV. Services and Providers

As of the 3rd quarter, 33 agencies, with 116 clinic sites, were certified with and enrolled into the full RH Program (i.e., eligible for reimbursement from the RH Program's three available funding sources: CCare, Reproductive Health General Fund/RH GF, and Reproductive Health Equity Act/HB 3391). Additionally, 11 agencies and 44 clinics were certified with and enrolled as CCare-only providers (i.e., not eligible to receive reimbursement under HB 3391 or RH GF). Provider training and education activities during the 3rd quarter included:

- Delivery of program news, policy updates, training opportunities, and other information to providers via the *RH Newsletter*.
- Emailing quarterly mailing to RH Program providers. Mailing includes recent research findings, informational articles, and relevant news.
- Five of six virtual trainings about data submission and billing (the first was offered in the 2nd quarter).
- One virtual orientation training.

V. Program Monitoring

The RH Program uses established program integrity and monitoring processes to assure adherence to program requirements and ensure the provision of high-quality care across all of its three funding sources. Audit and compliance components related to CCare continue to be an integral part of the program audit processes.

Typically, RH Program staff conduct several CCare audit activities each month to assure compliance with program, state, and federal requirements, including:

1. Monthly desk-audits, including reviews of data and claims to identify potential improper billing practices.
2. Random-sample chart audits to verify documentation supporting contraceptive management services, billed at the appropriate visit level.

3. Enrollment form audits to assess for completeness and accuracy. The Enrollment Forms are checked against information entered into the eligibility database.
4. Chart reviews during onsite clinic reviews where reviewers follow a checklist of components to review charts with visits billed to CCare.
5. Visit frequency audits 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 any duplicate claims inadvertently submitted to and paid by CCare.

However, as a result of COVID-19, the RH Program has suspended audit and program monitoring efforts due to the additional burden and strain placed on clinics responding to the pandemic. Many CCare providers are local public health departments who are directly responsible for disease investigation and contact tracing related to COVID-19. The RH Program continues to monitor COVID cases across the state to determine when to resume activities related to monitoring and compliance. Once the RH Program resumes monitoring and compliance activities, staff will develop a revised schedule to ensure that those agencies who were scheduled for review during the pandemic are prioritized.

The RH Program Clinical Program Administration and Monitoring (CPAM) workgroup continues to meet on a weekly basis to review processes, troubleshoot problems, and share information related to clinical operations and program monitoring. During the 3rd quarter, this group worked on revising the process and methodology for conducting routine onsite agency reviews; updating the RH Program Enrollment Form to be more linguistically and culturally responsive (i.e., more user friendly); and updating reimbursement rates for services.

VI. Quarterly Expenditures

Table 3 shows the quarterly expenditures through the 3rd quarter of DY 23. Quarter 3 expenditures include new expenditures of $730,129 and a total of -$655,781 in adjustments from previous years, thus a net expenditure of $74,348. The adjustments were for claims found to be ineligible for CCare reimbursement.

TABLE 3 Quarterly Expenditures for DY 23 January 1, 2021 – December 31, 2021	
Quarter	**Total Expenditures as Reported on the CMS-64**
1	$1,239,358
2	$1,119,048
3	$74,348
4	
Annual Total	

VII. Activities for Next Quarter

RH Program staff will continue to monitor client enrollment and service utilization in CCare. Many CCare providers are local public health authorities (LPHAs) and as such, are directly responsible for the COVID response, including contact tracing, disease investigation, and vaccination, in their communities. All CCare providers are offering in-person visits and are providing the full scope of services.

The RH Program will continue to offer guidance and technical assistance to CCare providers during the pandemic, supporting their efforts to maintain access to clinical services while also ensuring the health and safety of their staff and clients. Furthermore, the RH Program is

exploring opportunities to support clinics in their adoption and/or growth of telehealth infrastructure.

As part of the program's rulemaking (as referenced on page 4), all existing and new CCare agencies were required to attest to meeting the CCare Certification Requirements and execute a new Medical Services Agreement (contract between Oregon Health Authority and the CCare agency) in order to receive reimbursement for services. All previously contracted CCare agencies (with the exception of one small clinic) became certified under the new rules by July 15, 2021.

Finally, CCare's demonstration waiver is due to expire on December 31, 2021. As such, the RH Program, in collaboration with the Oregon Health Authority's Medicaid office, submitted its CCare waiver renewal application (using the fast track application process) at the end of the 2nd quarter with the intent of renewing the program by the end of the year. The RH Program requested a 5-year waiver renewal period with no major changes to waiver or expenditure authorities. As required by state and federal law, the RH Program engaged in all necessary public notice and comment activities as well as tribal consultation prior to submitting the application. The RH Program continues to be responsive to CMS regarding questions about the waiver renewal application.