oregon**contraceptive**care

Oregon Family Planning Medicaid Waiver

Section 1115 Quarterly Report

2nd Quarter Report

April 1, 2020 – June 30, 2020

Demonstration Year 22

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) 22 for the waiver.

TABLE 1
Family Planning Waiver
Quarterly Report Timeline Dates for DY 22

Quarter	Begin Date	End Date	Quarterly Report Due*
1	January 1, 2020	March 31, 2020	May 31, 2020
2	April 1, 2020	June 30, 2020	August 31, 2020
3	July 1, 2020	September 30, 2020	November 30, 2020
4	October 1, 2020	December 31, 2020	March 31, 2021**

*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. For the most part, there were no other noteworthy changes in administration/operations or provider participation during the second quarter of 2020. However, 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 and preserve necessary PPE. Clinics identified changes to clinic workflow and service provision including strategies such as delaying routine well woman visits and providing Depo injections in the parking lot. Between February and June of 2020, there was a nearly 35% reduction in client visits. However, towards the end of the second quarter, clinics began to increase access again, so that nearly all CCare agencies were offering the full scope of in-person visits again.

During the second quarter, many clinics increased their use of telemedicine/telehealth as the COVID-19 pandemic progressed. In response to these changes, the RH Program developed guidance for 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).

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.

It should be noted that enrollments decreased during the 2nd quarter as a result of COVID-19. However, since the RH Program granted a 3-month eligibility extension for clients enrolled between February 1st and May 31st of the prior year, the number of member months remained the same.

	Table 2 CY 2020 / DY 22			
	Q1, January 1 – March 31	**Q2, April 1 – June 30**	**Q3, July 1 – September 30**	**Q4, October 1 – December 31**
# of Total Enrollees	5,842	2,945		
# of Member Months	78,922	79,790		

IV. Services and Providers

As of the end of the 2nd quarter, 36 agencies, with 106 clinic sites, were enrolled in the full RH Program (i.e., eligible for reimbursement from the program's three funding sources: CCare, Reproductive Health General Fund (RH GF), and HB 3391). Additionally, 13 agencies, with 47 clinics were 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 2nd 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.

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 suspended audit and program monitoring efforts during the 2nd quarter to acknowledge 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 Clinical Program Administration and Monitoring 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 2nd quarter, this group discussed emerging telehealth needs and issues, supply billing and reimbursement issues, a potential reimbursement methodology for interpretation services, and future revisions to clinical practice standards.

VI. Quarterly Expenditures

Table 3 shows the quarterly expenditures through the 2nd quarter of DY 22.

TABLE 3 Quarterly Expenditures for DY 22 January 1, 2020 – December 31, 2020	
Quarter	**Total Expenditures as Reported on the CMS-64**
1	$2,490,059
2	$1,639,120
3	
4	
Annual Total	

VII. Activities for Next Quarter

RH Program staff will monitor client enrollment and service utilization in CCare during the COVID-19 pandemic. Many CCare providers are local public health authorities (LPHAs) and as such, are directly responsible for the COVID response in their communities. All CCare providers have remained open to some degree thus far and are offering, if not the full scope of services, more limited services based on priority (e.g., delaying annual well-woman visits, providing method starts and refills).

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.