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Program Overview

History

In 1999, the Public Health Division and the Department of Medical Assistance Programs (DMAP) joined efforts to improve the well-being of Oregon children and families by using a Section 1115(a) waiver to expand Medicaid coverage for family planning services to women and men. Oregon Contraceptive Care (CCare) provides contraceptive management services to Oregonians at or below 250% of the federal poverty level (FPL). CCare is renewed by the Centers for Medicare and Medicaid Services (CMS) every three years.

Project Goal and Objectives

The CCare Program aligns with national and state family planning and maternal and child health objectives, including those contained in Healthy People 2020 and Oregon benchmarks. The project goal is to improve the well-being of children and families by reducing unintended pregnancies and improving access to primary health care services. Short term and long term project objectives are:

1. Increase the number of Oregon women, men, and teens receiving services from publicly funded reproductive health clinics.
2. Increase the proportion of reproductive health clients who receive help accessing primary health care services.
3. Increase the proportion of reproductive health clients who use more effective contraceptive methods.
4. Reduce the proportion of unintended births and associated costs among Oregon women.
5. Reduce the teen pregnancy rate.
Provider Requirements and Information

Considerations for Prospective CCare Provider Agencies

Prospective CCare provider agencies should review this section carefully before applying to join the agency network. Of particular importance are the Standards of Care, beginning on the following page.

Clinics or individuals interested in becoming CCare agencies may do so in one of two ways:

1. Sub-contract with an existing CCare provider, or
2. Enroll directly with the Reproductive Health Program.

Agencies wishing to subcontract should approach the local health department or another CCare agency in their area. Those who wish to enroll directly in CCare should contact the Reproductive Health Provider Liaison for more information by calling 971-673-0355.

Key Points
CCare is a targeted family planning program in which providers:
- Offer expanded visits for clinical and preventive contraceptive management services
- Make referrals for psycho-social and primary care
- Directly dispense a full range of contraceptive methods
- Participate in a program-specific billing and data collection system
**CCare Standards of Care**

These standards set forth minimum clinical and administrative services that an agency must offer in order to participate in CCare. We recommend existing agency providers also read this section to confirm their understanding of the program.

### CCare Standards of Care

<table>
<thead>
<tr>
<th>PROGRAM ISSUE</th>
<th>DESCRIPTION</th>
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</table>
| A. Informed Consent | 1. The informed consent process, provided verbally and supplemented with written materials, must be presented in a language the client understands.  
2. A signed consent must be obtained from the individual client receiving contraceptive management services.  
3. A separate, signed contraceptive method-specific consent must be obtained from the client for each prescription contraceptive method received. |
| B. Confidentiality | 1. Clients must be assured of the confidentiality of services and of their medical and legal records.  
2. Records cannot be released without written client consent, except as required by law, or otherwise permitted by HIPAA. |
| C. Availability of Contraceptive Services | 1. If the agency’s clinical staff lack the specialized skills to provide vasectomies, intra-uterine devices (IUDs) or subdermal contraceptives, or if there is insufficient volume to ensure and maintain high skill level for these procedures, clients must be referred to another qualified agency for these procedures.  
2. Clients shall be able to get their first choice of contraceptive method during their visits unless there are specific contraindications.  
3. Contraceptive methods, including emergency contraception, must be available at the clinic site and available to the client at the time of service. See Program Issue H for exceptions. |
### D. Linguistic and Cultural Competence

All services, support and other assistance must be provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language and behaviors of the clients receiving services, and in a manner that has the greatest likelihood of ensuring maximum program participation.

1. The agency shall employ bilingual or bicultural staff, personnel or volunteers skilled or certified in the provision of medical and clinical interpretation during all clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance. All persons providing interpretation services must adhere to confidentiality guidelines.

2. The agency must assure the competency of language assistance provided to limited English proficiency clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services, unless requested by the client.

3. The agency must make interpretation services available to all clients needing or requesting such assistance at no cost to the client. The agency must notify clients in need of interpretation services of the availability of such services in accordance with the Civil Rights Act of 1964.

4. The agency shall make available easily understandable print materials available to clients and post signage in the languages of groups represented or commonly encountered in the service area.

5. All print, electronic and audiovisual materials shall be appropriate in terms of the client’s language and literacy level. A client's need for alternate formats must be accommodated.

### E. Access to Care

Services covered by CCare must be provided without cost to eligible clients. Clients must be informed of the scope of services available through the program.

1. Appointments for established clients shall be available within a reasonable time period, generally less than two weeks. New clients who cannot be seen within this time period shall be referred to other qualified provider agencies in the area.

2. Clinics with the appropriate license from the Oregon Board of Pharmacy may offer established clients the option of receiving their contraceptive methods by mail.

   a) Use of this option is at the discretion of the client; it cannot be offered as the only way in which to receive contraceptive methods.

   b) Contraceptive methods that require a written prescription may only be mailed to established clients who have been using the method(s) for at least three months with no problems or contraindications.

   c) Non-prescription methods may be mailed to any established client, regardless of the client’s previous use of the method(s).
Access to Care (Cont.)

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<tbody>
<tr>
<td>d)</td>
<td>Clients must not incur any cost for the option of receiving contraceptive methods through the mail.</td>
</tr>
<tr>
<td>e)</td>
<td>Clinics must package and mail supplies in a manner that ensures the integrity of contraceptive packaging and effectiveness of the method upon delivery.</td>
</tr>
</tbody>
</table>

3. Although not covered by CCare, treatment and supplies for sexually transmitted infections must be available at the clinic site, or by referral.

4. Clients in need of additional medical or psychosocial services beyond the scope of the agency must be provided with information about available local resources, including domestic violence and substance abuse related services. Clients must also be given a brochure listing locations of free or low-cost primary care services in the area.

5. All services must be provided to eligible clients without regard to age, marital status, race, parity, disability, gender identity, or sexual orientation.

6. All counseling and referral-to-care options appropriate to a positive or negative pregnancy test result during authorized contraceptive services must be provided in an unbiased manner, allowing the client full freedom of choice between prenatal care, adoption counseling or pregnancy termination services.

<table>
<thead>
<tr>
<th>F. Clinical and Preventive Services</th>
<th>1. The scope of contraceptive management services offered to women and female-bodied clients at each CCare clinic site must include:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>a) A comprehensive health history, including health risk behaviors and a complete obstetrical, gynecological, contraceptive, personal and family medical history and a sexual health history, in conjunction with contraceptive counseling;</td>
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<tr>
<td></td>
<td>b) An initial physical examination including cervical cancer screening as indicated, that follows a nationally recognized standard of care;</td>
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<tr>
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<td>c) Routine laboratory tests related to the decision-making process for contraceptive choices;</td>
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<td></td>
<td>d) Provision of a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception;</td>
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<td></td>
<td>e) Follow-up care for maintenance of a client's contraceptive method or for change of method;</td>
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</tbody>
</table>
| Clinical and Preventive Services (Cont.) | f) Information about providers available for meeting primary care needs and direct referral for needed medical services not covered by CCare, including management of high-risk conditions and specialty consultation if needed; and  
  
g) Preventive and control services for communicable diseases, provided within the context of a contraceptive management visit, including:  
  
i. Testing and diagnosis for sexually transmitted infections (STIs) as indicated; and  
  
ii. Reporting of STIs, as required, to appropriate public health agencies for contact management, prevention, and control.  
  
2. The scope of contraceptive management and clinical preventative services offered to men and male-bodied clients must include:  
  
a) A health history, including health risk behaviors and a sexual health history, in conjunction with contraceptive counseling and provision of contraceptive barrier methods;  
  
b) Vasectomy or referral for vasectomy;  
  
c) Vasectomy counseling, including a comprehensive health history that includes health risk behaviors and a complete contraceptive, personal and family medical history and a sexual health history;  
  
d) Physical examination if indicated within the context of a contraceptive management visit;  
  
e) Information about providers available for meeting primary care needs and direct referral for needed medical services not covered by CCare, including management of high-risk conditions and specialty consultation if needed; and  
  
f) Preventive and control services for communicable diseases, provided within the context of a contraceptive management visit, including:  
  
i. Testing and diagnosis for sexually transmitted infections (STIs) as indicated; and  
  
ii. Reporting of sexually transmitted infections (STI), as required, to appropriate public health agencies for contact management, prevention, and control.  
  
3. All services must be documented in the client’s medical record. |
| G. Education and Counseling Services | 1. The following elements comprise the required education and counseling services that must be provided to all contraceptive management clients:  
   a) Initial clinical assessment, and re-assessment as needed, of the client's contraceptive management educational needs and knowledge about reproductive health, including:  
      i. Counseling and education about a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception;  
      ii. A description of services and clinic procedures;  
      iii. Relevant reproductive anatomy and physiology;  
      iv. Preventive health care, nutrition, preconception health maintenance, and pregnancy plans, and STI and Human Immunodeficiency Virus (HIV) prevention;  
      v. Psychosocial issues, such as partner relationship and communication, risk-taking, and decision-making; and  
      vi. An explanation of how to locate and access primary care services not covered by CCare.  
   2. Initial and all subsequent education and counseling sessions must be provided in a way that is understandable to the client and conducted in a manner that respects the dignity and privacy of the client and facilitates the client's ability to make informed decisions about reproductive health behaviors and goals, and must include:  
      a) An explanation of the results of the physical examination and the laboratory tests;  
      b) Information on where to obtain 24-hour emergency care services;  
      c) The option of including a client's partner in the education/counseling session, and other services at the client's discretion; and  
      d) Effective educational information that takes into account diverse cultural and socioeconomic factors of the client and the psychosocial aspects of reproductive health.  
   3. Each client must be provided with adequate information to make an informed choice about contraceptive management methods, including:  
      a) A general verbal or written review of all FDA-approved contraceptive methods, including sterilizations and emergency contraception, along with the opportunity for |

|   |   |
### Education and Counseling Services (Cont.)

- the client to ask questions. Documentation of this method education must be maintained in the client record;
- A description of the implications and consequences of sterilization procedures, if provided;
- Specific instructions for care, use, and possible danger signs for the selected method;
- Documentation of method-specific information must be maintained in the client record;
- The opportunity for questions concerning procedures or methods; and
- Written information about how to obtain services for contraceptive management related complications or emergencies.

4. Clinicians and other agency staff persons providing education and counseling must be knowledgeable about the psychosocial and medical aspects of reproductive health, and trained in client-centered counseling techniques. Agency staff must make referrals for more intensive counseling as indicated.

### H. Exceptions

1. School-Based Health Centers are exempt from the requirement to make contraceptive methods available for on-site dispensing described in Program Issue C and Number 2 of Program Issue E. Because some school boards prohibit dispensing contraceptives on school grounds, School-Based Health Centers may offer contraceptive methods to clients either on-site or by referral. When offered by referral, School-Based Health Centers must have an established referral agreement in place, preferably with another CCare clinic. The RH Program must be notified of the parties involved in order to ensure proper billing and audit practices. When the referral clinic participates in CCare, that clinic may submit claims directly to CCare for reimbursement of the dispensed supplies. When referral clinics do not participate in CCare, payment arrangements must be made between the referring and receiving clinics. Dispensing by any clinic must not result in a charge to the client.

2. Non-School-Based Health Center clinic sites:
   - Agencies may bill CCare for individual counseling and education services conducted at a school site, Grade 12 and under, if the site meets the following criteria:
     i. The school site must have no established School-Based Health Center;
### Exceptions (Cont.)

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<tr>
<td>ii.</td>
<td>The school site must be within a program-approved distance from the enrolled CCare agency to ensure adequate access to client birth control method of choice;</td>
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<tr>
<td>iii.</td>
<td>The school site must have a dedicated, private room(s) for services to be conducted.</td>
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b) Agencies wishing to bill CCare for individual counseling and education services conducted at secondary school sites must adhere to the following standards:

| i. | The agency must notify the RH Program of the school site to be enrolled and must request from the RH Program a unique site number for the school site; |
| ii. | The agency must receive written approval from the school site to conduct services; |
| iii. | For newly enrolling clients, the agency must ensure that clients meet all eligibility criteria and are enrolled according to CCare guidelines at the school site; |
| iv. | For clients already enrolled in CCare, the agency must ensure that clients have active eligibility; |
| v. | The agency must follow all standards of care for contraceptive management services with the exception of supplies dispensed on-site and clinical and preventive services; |
| vi. | The agency must offer clients a written referral to the enrolled CCare clinic for supply pick-up and full array of clinical services; |
| vii. | The agency must submit claims for services conducted at the school site using the assigned project and site number of the school site. |
Elements of Reproductive Health Services

Reproductive health visits differ from other medical encounters in several important ways. CCare service elements and their definitions include:

**Reproductive Health Client** – An individual of reproductive capacity who receives contraceptive medical or counseling services and for whom a medical record is established.

**Reproductive Health Visit** – An encounter where medical or counseling services are provided to a client in conjunction with contraception, and the services are recorded in the medical record. This must be a face-to-face contact with a reproductive health service provider.

**Reproductive Health Service Provider** – A licensed health care provider operating within a scope of practice at an agency that is authorized by the Oregon Reproductive Health Program to bill for contraceptive management services for eligible CCare clients.

**Reproductive Health Lab Services** – The CCare encounter rate includes reimbursement for labs determined by the provider to be necessary within the context of a contraceptive management visit. Examples of reproductive health lab services include Pap smears, pregnancy tests, etc.

**Reproductive Health Services** – The scope of female and male reproductive health services is outlined in Program Issue F of the CCare Standards of Care. All services must be documented in the client’s medical record. This information comes from the administrative rules that govern CCare. The full set of those rules can be found at [www.healthoregon.org/rhmaterials](http://www.healthoregon.org/rhmaterials).
Primary Care
Referral Requirement

Clients who receive reproductive health services at CCare clinics often need to know where they can find free or low-cost primary health care. The U.S. Department of Health and Human Services (DHHS) now requires all family planning Medicaid waiver programs (including CCare) to have a primary care referral component that directs clients to Federally Qualified Health Centers and Rural Health Clinics in their state.

Exhibit 13 of this section is a brochure created to meet this requirement (in English and Spanish). It briefly details what services CCare covers and does not cover, and where to obtain information on the Oregon Health Plan. Side two allows clinics to add local provider and clinic information.

Using the Primary Care Brochure
CCare providers who do not offer primary care in their clinics must give a copy of the brochure to each client once a year, preferably at program enrollment and re-enrollment. Those who do offer primary care should make sure that all reproductive health clients are aware of it. In both cases, the fact that this information was provided must be noted on the CCare Enrollment Form in each client’s file.

National Voter Registration Act (NVRA) Requirement

As a Medicaid program, clinics participating in CCare must offer voter-registration services to CCare clients as part of the National Voter Registration Act of 1993 (NVRA). The purpose of the NVRA is to increase the number of U.S. citizens registered to vote. As such, it requires that agencies offer clients the opportunity to register to vote at each enrollment or re-enrollment in CCare. Our website describes in greater detail the policies and procedures clinic staff must follow to comply with NVRA requirements.

All enrolling and re-enrolling clients have the opportunity to answer a question asking them “Would you like to register to vote today?” on the CCare Enrollment Form (see Section C.3 for instructions on completing the
Enrollment Form). If the client marks “Yes” to this question, clinic staff should provide the client with a voter registration card. The client may take the form home to complete and mail to the elections office. If, however, the client requests help in completing and mailing the form, clinic staff should follow the procedures described on our website at http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Pages/CCareProviders.aspx#NVRA for reporting and mailing the completed registration form to the correct agency.

All forms necessary for complying with NVRA requirements can be downloaded electronically from http://oregonvotes.org/pages/publications/forms/index.html#nvra.

Notice of Privacy Practices (N OPP) Requirement

The U.S. Department of Health and Human Services (HHS) has moved forward to strengthen the privacy and security protections for health information established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The final omnibus rule greatly enhances a patient’s privacy protections, provides individuals new rights to their health information and strengthens the government’s ability to enforce the law.

As part of these HIPAA privacy implementation efforts, the Oregon DHS/OHA Information Security and Privacy Office has developed a Notice of Privacy Practices (N OPP) document that must be given to any client receiving medical or premium assistance through programs administered by OHA. This requirement applies to Oregon ContraceptiveCare (CCare) clients and all CCare providers are required to comply with this effort. The NOPP document may be accessed here: https://apps.state.or.us/Forms/Served/me2090.pdf.

- Keep a stack of printed NOPP documents at the check-in desk.
- Offer the NOPP document to every CCare client at each visit.
- You may offer the NOPP to family planning clients with other sources of coverage (e.g. private insurance; Oregon Health Plan; and no coverage with fees assessed using a sliding fee schedule) if it...
makes sense for your clinic flow. However, CCare clients are the only ones for whom you are required to offer the Notice.

- At check-in, ask the client “Have you seen the Notice of Privacy Practices Document? Please feel free to take one.” The client may decline to take the Notice. You are only required to offer the document.
Client Eligibility and Enrollment  C.3

CCare Eligibility

Oregon women and men are eligible for CCare if they meet the following criteria:

- Resident of Oregon
- Reproductive age (10 – 60 for women; 10 and older for men)
- Not sterilized
- Can provide proof of ID
- Can provide Social Security Number
- Can prove U.S. citizenship or status of a refugee/asylee, or have been lawful permanent residents for five years or more
- At or below 250% of the federal poverty level (FPL) based on family income and size. (Teens are determined eligible based on individual income).

Once determined, eligibility is effective for 12 months regardless of income or FPL changes during that period. However, enrollment into OHP will require termination of CCare eligibility.

CCare Eligibility Procedures Overview

Screening individuals for eligibility and enrolling them into CCare involves four main steps:

- Check the CCare Eligibility Database for the potential client’s current eligibility and citizenship verification status;
- Ask & assist clients who are not currently enrolled to complete the CCare Enrollment Form;
  - Please note that clients who have been auto-enrolled into CCare from OHP post-partum do not need to complete a CCare Enrollment Form (see Section C, Exhibit 1 for more information about completing the enrollment process for auto-enrollees).
• As necessary, offer clients assistance with documenting their U.S. citizenship; and
• Enter the Enrollment Form information to the CCare Eligibility Database for final determination by the system.
Completing the CCare Enrollment Form

The CCare Enrollment Form ensures accurate documentation; eases review processes; and provides the Centers for Medicare and Medicaid Services (CMS) with assurance of appropriate program eligibility screening.

The form must be completed by every client requesting CCare-covered services prior to receiving her or his first CCare service, and updated each year thereafter. During an audit, the clinic must be able to produce this form as documentation of eligibility screening and requests for special confidentiality. All boxes must be completed, even if the answer is “0” or “N/A.” No eligibility card will be issued to the client. The Enrollment Form data needs to be entered into the online CCare Eligibility Database. For instructions on using the database, see Exhibit 1 of this section.

The CCare Enrollment Form is located in Exhibit 2 of this section. In the following pages are instructions to help you and your clients fill out the Enrollment Form. Note that the standardized form may not be altered by individual agencies. However, you may print the back of the form on a separate sheet of paper as long as it is kept with the front of the form.
Instructions for Completing the CCare Enrollment Form

1: Where did you hear about us?
This section lists examples of where the client may have heard about CCare services. Please have client check all that apply.

2, 3, 4: Last Name, First Name, Middle Initial
This client information is vital for clinic records and must be complete, accurate, and legible.

5, 6, 7: Oregon Address, City, Zip

8: Have you been sterilized for more than 6 months?
Clients who have been sterilized (female sterilization, hysterectomy, or vasectomy) for more than six months are not eligible for CCare. The purpose of CCare is to prevent unintended pregnancies, so applicants must be capable of having or causing a pregnancy.

9, 10, and 11: Are you a U.S. Citizen or Lawful Permanent Resident (LPR) for at least 5 years or Refugee/Asylee?
The federal Deficit Reduction Act (DRA) of 2005 requires all CCare applicants who are U.S. citizens to provide proof of citizenship and identity prior to enrolling in CCare. Please see Exhibit 3 for examples of acceptable documents and page C4-2 for resources to help clients provide the needed documentation.

Lawful Permanent Residents do not need to show proof of citizenship or identity at the time of the application.

Clients who are refugees/asylees are required to show proof of refugee/asylee status at the time of enrollment. See Exhibit 16.

Clients must check only one box indicating their status.

Note: Clients who are eligible for Citizen/Alien-Waived Emergency Medical (CAWEM) coverage through DMAP do not qualify for CCare
because they do not meet the Lawful Permanent Resident requirement. Title X clinics should use grant resources for clients who do not meet the citizen eligibility requirement of CCare.

12: Voter Registration:
The National Voters Registration Act (NVRA) requires clinic staff to offer voter-registration services to clients at enrollment and re-enrollment in CCare.

Any client who meets the requirements to vote in Oregon may register:
- A resident of Oregon;
- At least 17 years old; and,
- A U. S. citizen (LPRs are not eligible to vote).

The client may choose one of three response options on the Enrollment Form:
- Yes – Clinic staff must provide the client with the Voter Registration Card (SEL 503). The client may take the form home to complete and mail to the elections office. If, however, the client requests help in completing and mailing the form, follow the procedure outlined in the NVRA policy on our website at http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Pages/CCareProviders.aspx#NVRA.
- No – This will serve as the official client declination as required by the NVRA.
- N/A (LPR or under 17 years old) – No further action is required.

13a: Do you have health insurance?
Applicants who have private insurance may still qualify for CCare. CCare is a Medicaid program and should be the payer of last resort. If an applicant has private health insurance, bill their insurance first. CCare will pay the difference not covered by insurance up to the maximum amount CCare would have paid in the absence of insurance.

13b: Are you on the Oregon Health Plan or Healthy Kids?
Those with the Oregon Health Plan or Healthy Kids coverage do not qualify for CCare.
14, 15: Household Size and Total Gross Monthly Household Income

This information is used to assess whether the applicant meets the financial eligibility requirements for CCare. An accurate answer requires that both you and the applicant understand what is included and what is not included in income, and precisely what constitutes a household for the purposes of CCare.

**Determining Household Size**

A household is defined as a social unit composed of one person, or two or more persons living together sharing a source of income. Household members do not need to be married to be counted in household income; dependents away at school also are included. The income of all these persons should be counted to calculate the total income of the family. Examples include:

- a married couple, with or without children
- domestic partners, with or without children
- one parent with one or more children
- a married couple sharing the home of a husband’s or wife’s parents
- two related married couples sharing a single household

Roommates living together are not considered a household; each person should be considered a household of one. However, any income received as a result of the arrangement (e.g., rent) is considered income contributed to the client and should be counted.

Foster children or other unrelated children living in a household are not considered part of the family; payments received for caring for foster children is not considered income.

**Guidelines for Determining Income**

- If the applicant is a full-time salaried employee, base the average gross monthly income on the applicant’s most recent month’s income.
- If the applicant works part time, on a commission basis, or otherwise has an unsteady income, use the average gross monthly income for the previous 12 months. If the applicant is currently working on a

**Start with Household Size**

Using the instructions in the sidebar at the left, determine how many people live in the applicant’s household.

**Determining Household Income**

Next, compute the gross monthly income (i.e., before taxes) of each of these people and enter the total amount in whole dollars in the enrollment form. See the chart on page C3-7 for the kinds of income that should and should not be included.

Make every attempt to get an actual or estimated figure. Note, however, that applicants are not required to provide proof of income for CCare eligibility.
part-time or commission basis, but has been unemployed during the previous year, divide the total dollar amount earned by the number of months worked in the previous 12 months.

- If the applicant is currently unemployed, count any unemployment benefits currently received. Do not count employment income from previous months.
- If the applicant knows only the amount of net income (take-home pay), calculate gross income by multiplying net income by 1.15.
- If the applicant is living with a partner but has no personal income, base income on financial support received from the partner.

<table>
<thead>
<tr>
<th>These sources of income should be included</th>
<th>These sources of income should NOT be included</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Salaries, wages, tips</td>
<td>• Grants</td>
</tr>
<tr>
<td>• Help from relatives and non-relatives</td>
<td>• Loans</td>
</tr>
<tr>
<td>• Public assistance*</td>
<td>• Withdrawal from savings</td>
</tr>
<tr>
<td>• Unemployment compensation</td>
<td>• Food stamps</td>
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<td>• Worker’s compensation</td>
<td>• Tax refunds</td>
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<td>• Veterans benefits</td>
<td>• Receipts from sale of possessions</td>
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<tr>
<td>• Sick pay</td>
<td>• Inheritances</td>
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<tr>
<td>• Social Security cash benefits (including</td>
<td>• Lump sum compensation for injury or legal</td>
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<td>widow’s and children’s benefits)</td>
<td>damages</td>
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<tr>
<td>• Alimony</td>
<td>• Maturity payments on insurance policies</td>
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<tr>
<td>• Child support</td>
<td>• Payments for foster parenting</td>
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<tr>
<td>• Net investment income (rent, interest,</td>
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<td>dividends)</td>
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<td>• Net earnings from self employment</td>
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<td>• Pensions, annuities</td>
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<td>• Royalties and commissions</td>
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<td>• Business profits</td>
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<td>• Deductions commonly taken out of income</td>
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<td>before the client receive it. These</td>
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<td>include:</td>
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<td>o Federal, state and local taxes</td>
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<td>o Social Security payments</td>
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<td>o Deductions for savings bonds, other</td>
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<tr>
<td>savings plans, or union dues</td>
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*Note: A client who is receiving cash assistance through TANF is likely to have OHP coverage and would not qualify for CCare. Call OHP AVR to verify OHP coverage. See page A5-4 for DMAP/OHP contact information.*
Income Eligibility

- Individuals 20 years of age and older (adults) with household incomes from 0-250% of FPL are eligible for CCare. Refer to the Medicaid Income Guidelines in Appendix F to assess whether clients qualify, based on household size and income. If an applicant is in need of special confidentiality and household income cannot be estimated without violating confidentiality, then the applicant’s own income can be used for FPL calculation.

- Individuals under 20 years of age (teens) whose household incomes exceed 250% of the federal poverty level but whose individual incomes are at or less than 250% of FPL are eligible for CCare. Teens may be screened for eligibility based on their individual income.

Providers must provide information about, and are encouraged to provide applications for OHP or FHIAP where family income is appropriate.

See Section B, Exhibit 3 or Appendix F for the Federal Poverty Level Guidelines to determine CCare income eligibility.

16: Date of Birth
CCare applicants must be of reproductive age (girls must be menstruating), generally ages 10 and older.

17: Social Security Number (SSN)
Valid social security numbers are required for all CCare applicants. If an adult claims not to have a SSN, refer the client to a local Social Security office to apply for one. Applicants who can’t remember their SSN may also be referred to get a replacement card. Another option may be to try to obtain the number from school or employment records. If the applicant is a teenager and does not know their SSN, use 477-47-7477. This will allow the teen to enroll while state staff and/or the applicant work to determine their SSN.

Be sure to give every applicant (new and renewing) a copy of the SSN statement. English and Spanish versions of this statement can be found in Exhibit 4 of this section.
18, 19: **Client Declaration, Signature and Signature Date**

The signature and date are required for program enrollment. The signature date must match or be prior to the eligibility effective date and the first date of service.

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**CLINIC STAFF USE ONLY**

20: **Special Confidentiality**

Special Confidentiality protects clients who indicate a perceived threat of physical or emotional harm if information about their CCare visit is inadvertently disclosed to parents, partners, family, or the primary insurance policy holder. If a client indicates the need for special confidentiality, private insurance should not be billed and/or the client’s income may be assessed as a household size of one. Clients can request special confidentiality regardless of insurance status. Note that the option does not apply just to teens, nor is it to be used for all teens.

Clinic staff must check the appropriate box indicating if the client requests special confidentiality or not.

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21, 22: **Agency # and Clinic/Site #**

Enter the agency number (also known as the project number) of the participating CCare agency and the specific clinic (or site) number serving the client.

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23: **Primary Care Information**

Clinic staff must indicate whether primary care information was offered to the client. Remember, offering this information is a program requirement. Your clinic may customize the primary care information brochure in Exhibit 13 of this section in order to meet this requirement.

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24: **OHP Information**

Clinic staff must indicate whether Oregon Health Plan information was given to the client. Remember, providing this information is a program
requirement. The primary care information brochure in Exhibit 13 includes contact numbers for inquiries about OHP and FHIAP coverage.

25: Title X Clinics
Title X clinic staff should document the sliding fee scale amount/percentage regardless of whether or not the client qualifies for CCare. The client may need services that are not covered by CCare, in which case Title X sliding fee scale guidelines would be applied.

26: Staff Initials
The clinic staff member who completes the “Staff Use Only” section of the form should initial this box.

CITIZENSHIP AND IDENTITY VERIFICATION
Document verification of U.S. citizenship and identity is in this section. There are different tiers of acceptable citizenship documentation. Please refer to Exhibit 3 of this section for the document checklist.

CITIZENSHIP DOCUMENTATION PENDING:

27: Oregon Birth Information Form
Check this box if the applicant was born in Oregon and completed the Oregon Birth Information Form (Exhibit 5). This information allows state staff to search the Oregon Vital Records database for the client’s electronic birth record.
- Check the box confirming that the Oregon birth record request information from the form was entered into the CCare Eligibility Database.

28: Automated SSA Electronic Citizenship Match Verification
Check this box if the applicant was born in the United States and provided a valid SSN (not for teens enrolling with the 477-47-7477 SSN). State staff will update the database if citizenship is verified using the client’s SSN.
29: Out-of-State Birth Record Request

Check this box if the applicant was born in the United States in a state other than Oregon and is a teen using the 477-47-7477 SSN or the client has had to return to complete the necessary Birth Record Request documents because the SSA match failed. State-specific birth record request forms can be downloaded from the RH Program web site. Resources for requests can also be found in Section C, Exhibit 6.

- Check the box indicating that clinic staff have called the state to request an ROP extension if the client’s SSA match failed – the client will need this extension while the state processes the birth record request.
- Check the box indicating that all the necessary forms have been mailed to the state for processing.

IDENTITY DOCUMENTATION PENDING:

30: Client will Supply Identity Document

Check this box if the applicant uses the reasonable opportunity period (see page C4-1) and states that they will bring in their identity document within 45 days.

CITIZENSHIP DOCUMENTATION VERIFIED:

31: Citizenship Listed as Verified in CCare Eligibility Database

Check this box if the applicant’s citizenship already was listed as verified in the CCare Eligibility Database prior to the date of completing this enrollment form.

32: Citizenship Document Witnessed and Copied

Check this box if a staff member witnessed and copied an original copy of the applicant’s citizenship documentation. Check the appropriate Tier (1-4) to indicate the type of documentation copied. Tier 1 documents, such as a U.S. passport, satisfy both the citizenship and identity verification. Tiers 2-4 require photo identification in addition to proof of citizenship.

- Check the box indicating that the information has been entered into the CCare Eligibility Database. The staff member should then date and initial.
IDENTITY DOCUMENTATION VERIFIED:

33: Identity Listed as Verified in CCare Eligibility Database
Check this box if the applicant’s identity was listed as verified in the CCare Eligibility Database prior to the date of completing this Enrollment Form.

34: Identity Document Witnessed and Copied
Check this box if a staff member witnessed and copied an original copy of the applicant’s identity documentation.
- Check the box indicating that the information has been entered into the CCare Eligibility Database. The staff member should then date and initial.

35: Qualifies for CCare
Clinic staff should indicate whether the client qualified for CCare only after the client has fully verified his or her citizenship and identity. For example, when a client has used the reasonable opportunity period, she has not yet qualified for CCare. In this case, clinic staff should leave box #35 blank. Once citizenship has been fully verified, then clinic staff may complete box #35 to indicate that the client qualifies for CCare.

36: CCare ID#
The CCare ID# is required for reimbursement. This number is automatically generated by the CCare Eligibility Database.

37, 38: Eligible FROM and TO Dates
Clinic staff must list the dates that CCare eligibility begins and ends. The length of eligibility is one year (12 months) from the date of initial enrollment. Any fluctuation or increase in income over guideline requirements during the 12-month period will not cancel eligibility.

Clients who use the reasonable opportunity period have only 45 days of eligibility. Do not complete boxes 35, 37 and 38 until citizenship and identity have been verified and the client is eligible for a full year of regular CCare coverage.

- Please note: If a client returns to the clinic for a visit during the 45 day reasonable opportunity period and citizenship has been verified,
enter the eligibility date as the same date the Enrollment Form was signed and dated. However, if a client is unable to verify citizenship during the 45 day period but returns later for CCare services and has citizenship documentation, ask the client to complete a new CCare Enrollment Form.

- Please note: If a client was made eligible for CCare, but comes in for a subsequent visit and has OHP, the client’s CCare eligibility is terminated. If the client’s OHP eligibility ends, a new CCare Enrollment Form must be completed with a new effective date.

- The date of the client’s first CCare visit must not be prior to the effective date of CCare eligibility. Existing CCare clients may re-enroll at a supply-only pick-up encounter. New CCare clients may not enroll at a supply-only pick-up encounter unless they are an established family planning client with the agency. An established client is considered someone with an open medical chart and who has had at least one visit with a clinician in the prior two years.

39: Clinic Use (optional)
This field is for clinic-specific use only and is not required.
Reasonable Opportunity Period

The reasonable opportunity period may be used in certain circumstances to provide services to individuals who cannot provide full documentation of their U.S. citizenship. It may only be used once per client and grants 45 days of eligibility. All other CCare eligibility criteria must still be met.

There is no need to use the reasonable opportunity period for LPR clients, since they are not U.S. citizens and therefore are not required to document their U.S. citizenship.

The reasonable opportunity period provides a temporary exemption from the citizenship documentation requirement. It does not exempt clients from the SSN requirement.

Clients who use the reasonable opportunity period will not be granted regular, full-year CCare eligibility until their U.S. citizenship is fully documented.

For clients with a valid SSN, Reproductive Health staff will attempt to find a citizenship match through the Social Security Administration (SSA) using the client’s SSN. Teen clients using the 477-47-7477 SSN will need to complete either the Oregon Birth Information form or an out-of-state birth certificate request form since SSA cannot match on an invalid SSN. Clinic staff should assist all teen clients using the 477-47-7477 SSN and the reasonable opportunity period in completing the appropriate form. More information about requesting birth certificates on behalf of clients can be found on the following page.
Birth Certificate Requests and SSA Electronic Match

There are three ways in which the state Reproductive Health Program can offer assistance to clients to obtain citizenship documentation:

1. **Oregon Birth Record Request** – For clients born in Oregon, the state Reproductive Health Program is able to access the Oregon Vital Records Electronic Birth Record Database. There are two methods for submitting a birth record request for Oregon-born applicants, depending on your needs. For detailed instructions, please refer to the CCare Eligibility Database Instructions in Exhibit 1 and see the CCare Oregon Birth Information Form in Exhibit 5.

2. **SSA Electronic Citizenship Match** – Every month, state RH staff will retrieve the SSNs for all newly enrolled clients and send them to SSA for a match. The match will be attempted only for those clients with a valid SSN (not for teens enrolling with the 477-47-7477 SSN). If a match is found, the client’s citizenship verification will be automatically updated in the Eligibility Database and the client’s eligibility extended for a full year of coverage.

Designated clinic staff will receive an eligibility report spreadsheet from the Reproductive Health Program every month. Clients who fail the SSA electronic match will need to be contacted by clinic staff to verify their SSN and return to fill out an out-of-state-birth certificate request. Clinic staff should call RH staff on the day the client returns to the clinic to complete the paperwork and ask for an ROP extension. If the ROP period ends, an extension is not possible.

3. **Out-of-State Birth Certificate Request** – The state Reproductive Health Program will order and pay for birth certificates on behalf of potential CCare clients born in states other than Oregon whose citizenship cannot be verified through the SSA electronic citizenship match. All forms necessary can also be found on our website: [www.healthoregon.org/rhmaterias](http://www.healthoregon.org/rhmaterias).
To order an out-of-state birth certificate follow the steps below:

- If the client is not yet in the Eligibility Database and will not be using the reasonable opportunity period for a visit that day, screen him/her for eligibility informally, to ensure that they are CCare eligible.

- Determine which state the client was born in and download the appropriate birth certificate request form (available on the Reproductive Health Program website).

- Check the State Matrix (available on the Reproductive Health Program website) for specific birth certificate request requirements.

- Ask the client to complete the Authorization to Release Birth Certificate form (see Exhibit 6 of this section). If notarization is required, use the space provided below the client’s signature to notarize the document.

- Make a copy of the client’s identification, as most states/counties require a photocopy of the requestor’s photo ID.

- Gather the state/county-specific birth certificate request form, authorization form, and photocopy of photo ID. Mail bundled requests to the Reproductive Health Program as needed.

- The Reproductive Health Program will mail all of the request documents and application fees to state/county vital records offices. When the birth certificate is received, Reproductive Health Program staff will mail the original birth certificate back to the requesting clinic. The Reproductive Health Program will also email status updates regarding birth certificate requests to clinics on the 1st and 3rd Tuesday of each month.

- Once the clinic receives the original birth certificate from the state office, update the individual’s citizenship documentation in the CCare Eligibility Database under the Tier 2 tab on the Client Info screen.

- Each clinic should keep the client’s birth certificate in the chart or medical record. Release the birth certificate to the client only if he or she requests a copy of medical records. Ask the client to complete your clinic-specific release of medical information form and be sure to photocopy the birth certificate to keep in the client’s
medical records before releasing the original birth certificate to the client.

For more detailed instructions and additional forms needed for ordering out-of-state birth certificates on behalf of clients, refer to Exhibit 6 of this section.
This section contains information on CCare service reimbursement; and using the CVR to bill for CCare services.

### Data & Billing

#### System History

The Reproductive Health Program has long used the Clinic Visit Record (CVR) to collect client and visit information. CVR data are used to satisfy federal reporting requirements (like the Family Planning Annual Report, or FPAR) and for program monitoring and evaluation. The Reproductive Health Program contracts with Ahlers & Associates to store and process CVR data and every clinic has access to its aggregate data via the Ahlers website. See Section D for more information on the various online reports and data manipulation functions available through Ahlers.

#### Key Points

- CCare is a Medicaid fee-for-service program, in which a standard encounter rate is paid per visit.
- Supplies are reimbursed separately.
- A CVR (Clinic Visit Record) must be completed and submitted for every CCare visit. CVR data are used both for billing and for program monitoring and evaluation.

When CCare began in 1999, Oregon’s CVR was modified to include a billing component for services provided to CCare clients.

### CCare Reimbursement

Please see Exhibit 8 for current CCare encounter rates. The CCare encounter rate is a bundled rate that includes reimbursement for all services, with the exception of the combined Chlamydia/gonorrhea test, performed within a contraceptive management visit. The combined Chlamydia/gonorrhea test is

#### The Ahlers Connection

You may sometimes come across such terms as “Ahlers system” and “Ahlers data.” These refer to Ahlers and Associates, the company that has held the contract for the state’s family planning data system since 1981, and are simply unofficial references to the Family Planning Information System.
reimbursed separately. Reimbursement is triggered by checking box #29 in the Medical Services section (13A) on the CVR. Contraceptive supplies dispensed are reimbursed at the clinic’s acquisition cost and a supply-dispensing fee is included in the encounter rate.

**Billing Guidelines**

The only visits that may be billed to CCare are medically necessary visits made by eligible clients for the purposes of contraceptive management. See Exhibit 7 of this section for what is billable to CCare. The primary diagnosis code for the visit must be in the V25 series for contraceptive initiation or management. Services covered under CCare include: annual exams for women; follow-up visits to evaluate or manage problems associated with contraceptive methods; medical procedures, lab tests, and counseling services associated with contraceptive management; and birth control supplies and devices. Please see the CCare Standards of Care in Section C.2 for a complete description of services that must be offered to eligible clients. Examples of services not covered by CCare include treatment of STIs, prenatal care, repeat Pap tests, pregnancy confirmation for the Oregon Health Plan, and birth control services delivered for reasons other than pregnancy prevention (e.g. to regulate menses).

There are no absolute limits on the number CCare visits in a given time period, but the state average is approximately two per client per year. (Women using Depo-Provera® need to be seen more frequently for injections; men typically are seen less frequently.) Agencies are subject to review if providers bill for visits substantially in excess of this average.

CCare clients may visit their providers simply to get refills of their birth control method without needing other services (beyond perhaps a brief check of vital signs and reminder of how to use the method). Such encounters are known as a supply-only pick-up encounter, and only the cost of supplies should be billed to CCare. Requests for emergency

**What about STI testing?**

STI testing may be included as part of a CCare visit if it is clinically indicated for initiation of a birth control method or because of symptoms or an identified risk discovered during an exam.

STI testing is not covered if the primary reason for the visit is STI symptoms or concerns.

Treatment for STIs is not covered under CCare.
contraception (EC) often fall into this category, especially for returning clients who have already received medical evaluation and counseling about EC at previous visits.

**Billing Insurance**

Unless a client with private insurance also indicates the need for special confidentiality, federal law requires that all reasonable efforts be taken to ensure that CCare is the payer of last resort. If a client indicates having private insurance on the CCare Enrollment Form, clinic staff should either make a photocopy of the client’s insurance card or document pertinent plan information at the time of enrollment. Private insurance should then be billed for the visit and supplies, if any.

If the client does not have her/his health insurance information at the time of the visit, clinic staff are expected to try contacting the insurance company to obtain the information necessary to bill the insurance. Otherwise, it is the expectation of the program that clinic staff follow-up with the client to obtain the insurance information and document the attempt.

Box 17A of the CVR indicates there is a Third Party Resource. Either Item 1 or Item 2 must be completed. Item 1 – *Explanation Code* indicates why no payment was made by the private insurance company by listing a TPR code. Item 2 – *Other Insurance Paid* records the amount paid by the private insurance for the family planning service. CCare will then reimburse the balance up to the maximum reimbursement rate.

- If a client with insurance requests special confidentiality, insurance should not be billed and the TPR code should be “NC”.
- If the clinic’s reasonable attempts to obtain insurance information from a client who indicated they had insurance yields no results, then CCare can be billed and the TPR code “OT” should be used.
- See Section D.3 of this Manual for a complete list of commonly used TPR codes and for more information about completing the CVR.
- Claims will be rejected if a client indicates having private insurance on the enrollment form, but no dollar amount or TPR code are supplied with the claim.
There are two exceptions to the requirement that CCare be the payor of last resort. First, if a client reports having Kaiser Permanente (Kaiser) health insurance, clinics are not required to bill Kaiser prior to billing CCare since there is no mechanism to bill Kaiser. Be sure to note that the client has Kaiser on the Enrollment Form and use TPR code “NC” on the CVR. However, be aware that Kaiser also has an employer-sponsored health insurance plan called Added Choice which allows their patients to seek care from providers outside of the Kaiser network. This plan can be billed for CCare services. Front desk staff should inquire if a client has the Added Choice Plan if they report they have Kaiser coverage. The plan has a purple insurance card to differentiate it from the traditional Kaiser blue and white card. Clinics should bill services and supplies to Kaiser first using CCare as a secondary insurance payment source as is currently done when a client has any other type of insurance coverage.

The second exception to the insurance billing requirement is for clients who have Medicare coverage. Since most family planning providers are not enrolled as Medicare providers, clinics have no way to bill Medicare. Furthermore, Medicare will not reimburse visits with a V25 family planning code. Therefore, if a client has Medicare, make sure to document this on the Enrollment Form and bill CCare for the visit.

**Supplies**

Care providers are reimbursed for contraceptive supplies at acquisition cost, up to a maximum allowable amount. See Exhibit 8 for maximum supply reimbursement rates as well as guidance for providers who qualify for public health (340B) pricing on supplies. Acquisition cost is defined as the cost to get the supply to the clinic: unit price plus shipping and handling. Costs of sorting, labeling, or bagging at the clinic are not included in the acquisition cost. Since prices fluctuate frequently, clinics should monitor their CCare claims against supplier invoices at least quarterly.
To ensure that a high quality of care is offered to CCare clients, clinics are expected to conduct and bill CCare for a face-to-face contraceptive management visit with a clinician before billing CCare for a supply-only encounter. However, if the client is newly enrolling in CCare but has had at least one face-to-face family planning visit with a clinician at your agency in the last two years OR the client is new to your agency but has been enrolled in CCare and established on a birth control method at another agency within the last year, the first claim submitted to CCare may be for a supply-only encounter. In order to do this, you must click on the button “Supply-only Encounter: Established family planning patient within your agency OR Established CCare client at another agency” in the CCare eligibility database. See Exhibit 1 of this section for more guidance about the eligibility database.

Using the CVR to bill for CCare services

The CVR is the required claim form for CCare. Paper forms are rarely submitted; instead, agencies export the CVR data elements from their in-house systems and send an electronic file to Ahlers & Associates. The CVR sections that relate directly to CCare reimbursement are: A – E, 1 - 4, 9 - 9c, 12, 17, and 17a, but all sections should be completed fully. Refer to Section D for item-by-item instructions on how to fill out a CVR and for a sample blank CVR. Refer to Exhibit 6 of Section D for file layout requirements for electronic CVR submissions.

Ahlers & Associates processes CVRs / CCare claims once a month. To be included in a given month’s processing, CVRs must be submitted by the Thursday before the 15th of that month. See Section D, Exhibit 7 for list of monthly submission deadlines.

Timely Submission

CCare claims are payable within 12 months of the date of service only. Providers should keep the monthly processing dates in mind to avoid having claims rejected for being older than 12 months. For example, a visit from May 27, 2011 that was sent to Ahlers on May 24, 2012 technically meets the 12-month requirement. But that claim will not be processed until a day or
two after the June submission deadline, at which point it would be rejected for being untimely.

**Claims Processing**

Before claims for CCare payment are accepted, they are reviewed against Oregon Medicaid eligibility records to ensure that clients are not already eligible for family planning services under regular Medicaid (OHP). If a match is found, the CCare claim is rejected and the service should be billed to DMAP instead.

CCare claims may be rejected for reasons other than a client’s OHP eligibility, although that is one of the most common causes for rejection. Other common errors that result in rejected claims include: the client was not eligible on the claim date of service; the client’s CCare number was missing or invalid; or the purpose of visit was missing or invalid. A full list of claim rejection scenarios and explanations can be found in Section D, Exhibit 8. Rejected claims can be corrected and resubmitted with the next month’s batch of CVRs. The State pays a nominal fee for each claim processed, so please be mindful and resubmit only those claims that need correction, not the entire batch.

**Remittances**

Following each month’s processing, your agency receives two reports from Ahlers & Associates: a billing Register/Remittance Advice for all successfully processed CCare claims, and a CVR Error Report showing rejected claims and explanations. A sample of each report can be found in Exhibit 12 and Section D, Exhibit 9 respectively. Electronic remittance advices, in HIPAA-compliant 835 format, are also available. If your agency is interested in electronic remittances, please contact Ahlers directly.

**Payment**

CCare reimbursement is issued once a month by the Reproductive Health Program, based on the amounts listed on each agency’s billing register. Payments are made via electronic banking transfer.
This section contains audit related policies and procedures for the CCare Program.

Purpose/Overview

The Oregon Health Authority Reproductive Health Program has an obligation to state and federal funders, as well as to Oregon taxpayers, to oversee funding for reproductive health services to assure compliance with program regulations. Outlined in this manual are the various screening and audit procedures used to assure program integrity and reduce risk of overpayment.

It is not the goal of the audit process to impose additional fees or penalties, but rather to recover payments that were made in error or to correct practices that are not in keeping with program regulations.

The Oregon Administrative Rules (OARS) pertaining to this program are 333-004-000 through 333-004-0230.

Types of CCare Audits

**MONTHLY DESK AUDIT**

- CVRs Rejected - Several automatic checks for errors (edits) are built into the Ahlers data collection/billing system used by CCare providers. These edits cause a Client Visit Record (CVR) to be rejected from the system and therefore not included in the billing summary or data. A report showing the number of CVRs rejected per agency and the associated reasons for rejection is reviewed monthly to help detect systems problems and to determine where training and technical assistance is needed.

- Billing Register Review - Ahlers & Associates provides a monthly billing summary or “billing register” to the state and to each agency which details every client transaction by date of service. This
summary includes client information, visit purpose, contraceptive method used and costs associated. Review of the monthly billing register by agency and site supplies a wealth of information for audit purposes.

Examples include:

- How much an agency is billing CCare for supplies
- Quantities of methods dispensed
- Revenue received by billing third party resources

Each month the billing register is reviewed and a Billing Register Desk Audit Chart is used to track any unusual circumstances or findings. The chart contains a space to document follow-up needed. Generally, follow-up consists of a phone call or e-mail to the specific agency to discuss the issue. It may be easily resolved over the phone or through e-mail.

If the same problem occurs in several agencies at a time, a memo is sent to providers describing the problem and the expected course of action to resolve it. The state provider liaison is also notified so that the recurring problem can be addressed in future training. The audit chart, specific to each month’s billing, is referenced in subsequent months to determine if the identified problem has been resolved.

Additionally, supply billing is monitored against purchasing data or supplier invoices to track changes in supply prices and billing accuracy.

**VISIT FREQUENCY AUDIT**

A visit frequency audit is performed by generating a separate report from Ahlers client data showing visits by date of service for a specific time period (usually one year). Review of this report helps identify clients with a high number of visits, which can indicate the need for a chart audit. A large number of clients with more visits than the statewide average of two per year (or one for males) can be an indicator of incorrect billing practice. Clients who use Depo Provera as a birth control method are not included in the visit frequency report, as the injections are required four times per year.
Agency visit frequency reports are run on an as-needed basis.

Review of a visit frequency report can lead to a chart audit of specific clients who have an unusually high amount of repeat visits.

**RANDOM SAMPLE CHART AUDIT**

The need for a random sample chart audit may be identified by any of the other audit functions described above, but is also done on a regular rotating quarterly schedule. Chart audits are done using a statistically valid random sampling, with sufficient sample size allowing a confidence interval of 95%.

Agencies will be asked to produce either random or specific charts by client number within a time period of 90 days. Usually, photocopies of the charts are sent to the state office for review but in some instances the reviewer(s) may go to the agency site to review the charts. When the reviewer(s) come to the agency site a dedicated room/office must be available for the process and entrance and exit discussions that are required.

Charts are reviewed by Reproductive Health Program reviewer(s) using the CCare Chart Review Tool (see Section C, Exhibit 15) and a matrix of findings is developed identifying the results of each chart reviewed. The findings are provided to the agency for review. Upon receipt of the matrix, the agency has a period of ten days to review and/or challenge the findings.

A primary reason for a chart audit is to substantiate whether or not visits are appropriately billed to CCare; however, other findings may also be identified. For a visit to be billed to CCare, contraceptive management for the purpose of preventing pregnancy must be the primary purpose of the visit and it must be accurately supported документed in the chart notes.

Charts determined to be billed in error are to be corrected in the Ahlers system by the agency using the void/resubmit process with the next claims submission.
**ELIGIBILITY AND ENROLLMENT FORM AUDIT**

The CCare enrollment form and its citizenship verification components are also reviewed as part of the chart audit. Examples of what reviewers will be looking for include:

- CCare Enrollment Form is complete and accurate
- Date of client signature matches the beginning eligibility date in the client eligibility database
- Citizenship and identity are verified

Enrollment forms are regularly requested and reviewed for completeness and accuracy. Proof of identify and citizenship are reviewed and monitored against the CCare database and income and SSNs are verified.

**CCARE AUDITS DURING REGULAR TITLE X REVIEW**

Agencies receiving Title X funding are reviewed for compliance with Title X Family Planning Program regulations on a triennial basis. Chart reviews are performed as part of the process. Reviewers will also follow a checklist of components to review 10 CCare charts when reviewing charts for Title X compliance. This review tool is also given to CCare clinics to encourage regular self audit.

**VASECTOMY CONSENT FORM AUDIT**

Vasectomy consent forms are sampled and reviewed for completeness and accuracy from clinics that bill CCare for this service.

**MONITORING AGENCY INSURANCE BILLING**

Unless a client with private insurance also indicates the need for special confidentiality, federal law requires that all reasonable efforts be taken to ensure that CCare is the payor of last resort.

Agency insurance billing is monitored for clients who have indicated having insurance on the CCare Enrollment Form. The process matches clients who have marked “yes” to private insurance on the CCare Enrollment Form to subsequent claims, on a quarterly basis, to determine if a dollar amount was paid by the insurance carrier or an explanation code was provided.
If there is no indication that the insurance carrier was billed, the agency will be contacted for an explanation to be provided within 30 days. Failure to bill a client’s private insurance carrier may be grounds for payment recovery or sanction.

**OTHER REQUESTS FOR INFORMATION**

The state Reproductive Health Program may request specific information on an as-needed basis.

**Types of Findings**

**ADMINISTRATIVE**

Administrative findings, identified by review or chart audit, are not related to incorrect billing or overpayment, but are program elements not being met. Examples:

- An agency consistently gives only one package of pills per visit
- An agency shows no evidence of billing third party reimbursement

**FINANCIAL**

Financial findings identified by chart audit procedure consist of incorrect billing that resulted in overpayment to the provider. The specific OAR for Recovery of Over-payments to Agencies Resulting from Review or Audit is 333-004-0150.

**Financial Finding Procedure**

- Overpayment is established through chart audit and documented in the matrix of findings.
- Amount of overpayment may be calculated by extrapolation of the random sample or may be the actual overpayment.
- A cover letter and notice of overpayment (invoice) is sent.
- Agency has a 10-day period to review the matrix/chart audit findings.
• A repayment agreement is signed by the agency OR if the agency is in disagreement, the contested case hearing procedure is followed.
• Generally the overpayment is recouped by the state within the next payment cycle. OHA has the discretion to negotiate a repayment schedule if requested.