



Reproductive Health Program Manual for Oregon

A Guide for Title X and CCare Clinics

**Center for Prevention and Health Promotion
Oregon Health Authority—Public Health**

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Oregon
Health
Authority

Reproductive Health Program Manual
January 2016

Section A

**The Oregon Reproductive
Health Program**

Center for Prevention and Health Promotion
Oregon Health Authority – Public Health

The Oregon Reproductive Health Program

A.1

Purpose

The purpose of the Oregon Reproductive Health (RH) Program is to:

- Develop and support programs, policies and research to promote and normalize sexual and reproductive health across the lifespan;
- Help individuals attain their reproductive life goals to maximize their educational, economic, emotional and physical health outcomes/potential;
- Promote healthy, well-timed pregnancies;
- Foster healthy relationships and strong families; and
- Advance the evidence and knowledge base for reproductive policies and services.

Funding

The Reproductive Health Program receives funding from two principal sources:

- Title X grant from the U.S. Department of Health and Human Services-Office of Population Affairs (HHS-OPA); and
- Medicaid (Title XIX) reimbursement through the Oregon ContraceptiveCare (CCare) Program.

Please note that operational guidelines, eligibility and funding requirements, services, and definitions often differ between the two funding sources. These distinctions have been highlighted throughout this manual, starting here and with the comparison chart on pages A1-3 and A1-4.

Services

Title X

Title X grant funds provide basic support to a system of reproductive health clinics throughout the state. These clinics serve low-income Oregonians with a range of reproductive health services: contraceptive methods; screening, testing, treatment and counseling for STIs; cervical cancer screenings; pregnancy testing and counseling; infertility services; reproductive health education and referrals.

Clinics that receive Title X grant funds must follow Title X requirements. See [Section B](#) for a complete copy of the Title X requirements.

Oregon ContraceptiveCare (CCare)

In 1999, Oregon received a waiver to expand Medicaid coverage for contraceptive services. The result of the waiver is the Oregon ContraceptiveCare (CCare) Program which serves Oregonians not enrolled in the Oregon Health Plan (OHP) with incomes at or below 250% of the federal poverty level (FPL). CCare services are limited to those related to preventing unintended pregnancy and may include: annual exams; follow-up visits to evaluate or manage problems associated with contraceptive methods; medical procedures, lab tests, and counseling services associated with contraceptive management; and contraceptive supplies and devices.

Many OHP enrollees can and do receive services at Title X and CCare clinics. Benefits are managed by the Health Systems Division, not the Public Health Division. However, every effort is made to coordinate OHP and CCare. CCare requirements are based on Title X requirements and can be found in [Section C](#).

Outcomes

In 1998, the Oregon Reproductive Health Program served over 50,000 people in more than 90 clinics. By 2014, more than 150 clinics in 34 counties were providing services to 75,000 Oregonians, at just \$218 per client per year. The 2014 investment averted an estimated 13,000 unintended pregnancies, resulting in over \$100 million in federal and state savings.

Estimates show that nationally, every \$1.00 invested in reproductive health results in more than \$7.09 in savings from averting unintended pregnancies as well as from early cancer detection and prevention, and treatment of sexually transmitted infections.

Oregon Reproductive Health Program Specifics

Program Requirement	Title X Federal Family Planning Grant	Oregon Contraceptive Care (Title XIX Medicaid Waiver)
Client Definition	Any person of reproductive age who is seeking reproductive health or related preventive health services.	A person of reproductive capacity who is not seeking pregnancy.
Client Eligibility	<p>There are no eligibility requirements.</p> <p>Clients may not be denied services or subject to any variation of services due to:</p> <ul style="list-style-type: none"> • Income / Inability to pay • Citizenship • Residency • Insurance status 	<p>Clients qualify based on:</p> <ul style="list-style-type: none"> • U.S. citizenship or eligible immigration status • Oregon residency • ≤ 250% FPL • Reproductive capacity • Not enrolled in OHP
Income and Fee Assessment	<p>FPL</p> <ul style="list-style-type: none"> • Based on # in household. • Minors (under 18): may use minor's income only if receiving confidential services. <p>Fees</p> <ul style="list-style-type: none"> • 100% of FPL or below = no fee • 101%-250% FPL = sliding fee • 251% FPL or above = full fee • <i>Agencies may establish policies to waive fees for specific circumstances.</i> 	<p>FPL</p> <ul style="list-style-type: none"> • Based on tax filing (see Exhibit C-9) • Clients qualify on own income even if not requesting confidential services. <p>Fees</p> <ul style="list-style-type: none"> • No charge to client.
Services Offered	Broad range of reproductive health services.	Narrow definition of services: only for the prevention of pregnancy.
Key Points	<p>Must serve all clients seeking reproductive health services.</p> <p>Determine pay source separately from services</p>	Eligible clients receive free family planning services & supplies that prevent unintended pregnancies.

Oregon Reproductive Health Program Specifics (cont.)

Program Requirement	Title X Federal Family Planning Grant	Oregon Contraceptive Care (Medicaid Waiver Title XIX)
Infertility/STDs	<ul style="list-style-type: none"> STI/HIV screening required when clinically indicated. Follow-up services must occur within the Title X program for positive STI/HIV results. Infertility Level 1 services (interview, exam, education, counseling, and referral) required. 	<ul style="list-style-type: none"> GC/CT tests if indicated, according to national standards. No separate reimbursement for other STI screenings which may be offered either separately or as part of a routine reproductive health visit or related to the prevention of pregnancy. No infertility/STI treatment reimbursement.
Third-Party Resources	<ul style="list-style-type: none"> Collect insurance information at each visit. Must bill all third-party payers for total charge unless client requests confidential services. 	<ul style="list-style-type: none"> Collect insurance information at each visit. Must bill all third-party payers for total charge unless client requests confidential services. Contraceptive visits and supplies not covered by third-party payers can be billed to CCare as payer-of-last-resort.
Federal Agency	U.S. Department of Health and Human Services (HHS), Office of Population Affairs (OPA)	U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS)
Funding source	100% federal funds	10% state general funds 90% federal fund match
Fund Distribution	Funds distributed based on formula	Funds reimbursed as fee-for-service
Funding process	Competitive 3-year grant	5-year waiver renewal

Reproductive Health Coordinator

Every agency in Oregon’s Reproductive Health Program network must appoint a Reproductive Health (RH) Coordinator who serves as the primary point of contact between the agency and state Reproductive Health Program staff.

The RH Coordinator is expected to attend trainings and meetings provided by the RH Program and is responsible for updating the RH Program of any changes to clinics or personnel, and conveying pertinent information and updates from the RH Program to personnel at all clinic sites, including subcontracted sites. See [Exhibit A-7](#).

Training and Resources

The [Reproductive Health Provider Resources](#) section of the Oregon RH Program website offers provider resources, including required Title X administration, fiscal and clinical policy and procedures, as well as associated documents.

The RH Newsletter includes training announcements and policy updates. State program staff are also available to assist with policy, operations and billing questions.

For additional resources contact the [Oregon RH Program](#).

Terminology

Throughout this manual the phrases *family planning* and *reproductive health*, and *birth control* and *contraceptive* are used interchangeably. A few years ago, Oregon RH Program staff decided that *reproductive health* more accurately reflects both the range of services available through the program and the mission of the program to prevent unintended pregnancies. However, some statutes or policies referenced in this manual use the phrase *family planning*, so when referencing these specific statutes and policies, the language *family planning* is used.

Additionally, the term *contraceptive* is used in lieu of *birth control* wherever possible, except when referencing a statute or policy that uses the phrase *birth control*.

Resources and Contacts

A.2

The Reproductive Health Program website features useful resources. They include:

- Reproductive Health Program Manual
- Administrative rules for CCare
- Training announcements
- Posters, fact sheets, brochures
- CCare provider resources including enrollment packets, provider standards, and tools to assist clients with eligibility requirements
- Title X provider resources including requirements and site review tools
- A list of reproductive health clinics in Oregon
- Social marketing resources including, promotional tools, newsletters, quality improvement information, and other resources
- Internet links to reproductive health websites
- Bi-monthly RH Newsletters with the latest information, training announcements, and resources

<http://www.healthoregon.org/rhmaterials>

OHA Reproductive Health Program

800 NE Oregon Street, Suite #370
Portland, OR 97232-2162
Phone: (971) 673-0355
Fax: (971) 673-0371

Contact information for specific aspects of the Oregon Reproductive Health Program can be found in [Appendix B](#).

Policy, Administration, and Organization

A.3

The information in this sub-section provides an overview of functions and the chain of responsibilities that govern Oregon's Reproductive Health Program.

Federal Level: National

U.S. Congress: Created/amends the law (Title X) that authorizes the National Family Planning Program and appropriates grant funds for family planning projects. Creates and amends laws affecting Medicaid benefits for family planning.

U.S. Department of Health and Human Services (HHS), Office of Assistant Secretary for Health, Office of Population Affairs (OPA): Provides national Title X program administration, including issuance of regulations and requirements within the authorizing legislation.

U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS): Administers Medicaid programs, including demonstration or waiver programs for family planning benefits, such as CCare.

Federal Level: Regional

Region X HHS Office, Seattle, WA: Reviews state applications for Title X grants and for Medicaid state plans and waivers; distributes funding; and provides technical assistance to Alaska, Idaho, Oregon, and Washington.

State Level:

Oregon Legislature: Creates and amends laws and appropriates funds for the Reproductive Health Program.

Oregon OHA, Public Health Division, Reproductive Health Program: Allocates and distributes federal and state dollars to local health care agencies. Administers Title X and Oregon ContraceptiveCare (CCare) programs, and conducts site visits and program reviews for quality assurance and program integrity. Develops, reviews and approves program protocols and practice standards.

Local Level:

Local Agencies: County health departments and other healthcare agencies provide reproductive health services as Title X sub-recipients and/or as CCare providers.

Who Writes Regulations

Federal Statutes originate in Congress and are signed into law by the president. Examples include the Americans with Disabilities Act of 1990 (ADA) and the Public Health Services Act (1944).

Federal Administrative Rules or Regulations are written by a federal agency, to provide governmental agencies and others with detailed information on how to comply with an act passed by Congress. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), released by the Department of Health and Human Services.

Federal Guidelines are also written by a federal agency. Unlike statutes and regulations, they are not subjected to a rule-making or legislative process. Federal guidelines help interpret federal laws and regulations in operational terms and provide assistance with compliance.

Oregon Revised Statutes (ORS) are originated in the state legislature and signed into law by the governor. For example, a state statute created the Oregon Health Plan.

Oregon Administrative Rules (OARs) are written by a state agency to explain how to comply with state statutes. Examples are the Oregon Administrative Rules specific to CCare or the general rules written by the Division of Medical Assistance Programs.

Oregon Laws Regarding Family Planning

A.4

The statutes and regulations referred to in this sub-section are subject to revision by the Oregon Legislature. Local reproductive health agencies' primary resource for specific legal questions should be their respective agency's attorney (county health departments should consult their county counsel).

Issues addressed include:

- Mandate for family planning services
- Services to minors
- Sterilization
- Informed consent
- Confidentiality
- Dispensing
- Emergency Contraception for Victims of Sexual Assault
- Mandatory Reporting Requirements

For more details on Oregon laws related to birth control and sterilization, refer to Chapters 435 and 436 of the Oregon Revised Statutes, available online at: <http://www.oregonlegislature.gov>.

Mandate for Family Planning Services

ORS 435.205, passed in 1967, authorized the establishment of family planning and contraceptive services by the then Oregon Health Division (now OHA) and county health departments.

Family planning health services include: client centered counseling by trained personnel on the spacing and timing of pregnancies; provision of a broad range of birth control methods and supplies; and physical exam and lab testing related to contraception and/or reproductive health as indicated by national standards of care.

All sub-recipients of the Oregon Reproductive Health Program's Title X grant are subject to the requirements outlined in [Program Element 41](#) (PE 41), part of OHA's financial assistance contract with each local public health authority for the purposes of delivering Title X services. PE 41 requires that all reproductive health services supported in whole or in part with funds provided under the contract must be delivered to the satisfaction of OHA and in compliance with the requirements of the federal Title X Program as detailed in statutes and regulations.

Services to Minors

Birth Control Services

Any physician or nurse practitioner may provide birth control information and services to any person without regard to the age of the person. ([ORS 109.640](#)).

Who is a minor?

In Oregon, an individual is considered a minor until the age of 18 or until marriage ([ORS 109.510](#) and [109.520](#)).

Other Reproductive Health Services

A minor 15 years of age or older may give consent to:

- Hospital care, medical or surgical diagnosis or treatment by a licensed physician; and
- Diagnosis and treatment by a licensed nurse practitioner who is acting within the scope of practice for a nurse practitioner without the consent of a parent or guardian, except as may be provided by [ORS 109.640](#).

In addition, a minor of any age who may have come into contact with a reportable sexually transmitted infection (STI) may consent to hospital, medical, or surgical care related to the diagnosis or treatment of the infection. The consent of parent(s) or legal guardian is not necessary; however, having not given consent, they shall not be liable for payment for care provided ([ORS 109.610](#)). Reportable conditions are defined by OHA and listed in Chapter [333-018-0015](#) of the Oregon Administrative Rules.

Parental Notification

A hospital or any physician or nurse practitioner may advise the parent(s) or legal guardian(s) of any minor of the care, diagnosis or treatment or the need for any treatment without the consent of the patient. In such cases, the hospital, physician or nurse practitioner is not liable for advising the parent, parents or legal guardian without the legal consent of the patient ([ORS 109.650](#)).

NOTE: The above parental notification practice is *not* recommended.

Title X family planning grant requirements (as well as other community practice standards) require that client consent be obtained before disclosure of any medical information or record (See Sub-Section B.1, Title X Program Requirements). Although Oregon law permits disclosure of a minor's record, it does not require such disclosure. Requirements relating to patient confidentiality must be maintained for all clinics receiving Title X funds or operating under Title X standards.

Sterilization

A person may be sterilized upon his or her request and upon the advice of a physician licensed by the Oregon Medical Board. The person must give his or her informed consent to the procedure, however, Oregon law is specific about the way in which informed consent must be obtained. ([ORS 436.225](#) and [435.305](#)) No physician or hospital may be held liable for performing a sterilization without obtaining the consent of the spouse of the person sterilized.

Informed Consent

Informed consent is a fundamental aspect of medical care. The basic elements of informed consent are described in [ORS 677.097](#) but certain procedures, such as sterilization, carry specific informed consent requirements. Title X sub-recipients should refer to *Program Requirements for Title X Funded Family Planning Projects* ([Section B](#)) for requirements regarding general informed consent.

Confidentiality

In 2015, the Oregon Legislature passed HB 2758 requiring health insurance plans to honor a member's request for confidential communications. The new law allows individuals of any age to request that protected health information (e.g. explanation of benefits or EOB) be sent directly to them instead of the person who pays for the health insurance policy. The Oregon Insurance Division created a standardized [form](#) for individuals to send to their health insurance company indicating how they would like to be contacted. Clinic staff are encouraged to inform clients about this law and assist them in the process of requesting confidential communications from their health insurance company. More information about this law and an individual's right to privacy can be found on the Oregon Insurance Division's [website](#).

Many other statutes, cases, and rules confirm the right of medical patients to confidentiality and the obligations of providers to honor that right. A broad policy in support of confidentiality of health information is contained in [ORS 192.553](#). State licensure laws also place a duty of confidentiality on providers.

Two suggested references for summaries of laws and rules related to confidentiality are:

1. Confidentiality Reference for Oregon County Health Departments: <http://public.health.oregon.gov/ProviderPartnerResources/LocalH>

[ealthDepartmentResources/Documents/RESOURCES/Confidentiality_RefDec2002.pdf](#); and

2. *Oregon Health Law Manual, Volume 1: Consent, Confidentiality and Reporting*. Published by the Oregon State Bar.

Specific information about issues related to confidentiality should be explored with legal counsel. Title X sub-recipients should also refer to *Program Requirements for Title X Funded Family Planning Projects* ([Section B](#)) for requirements regarding confidentiality and medical records and the Office of Population Affairs Program Policy Notice ([Exhibit B-9](#)) for clarification regarding confidential services to adolescents under Title X. CCare providers should refer to the OARs specific to [CCare](#).

Dispensing

The Board of Pharmacy sets rules regarding required policies and procedures; who may dispense; prescription labeling and storing requirements, and yearly inspection. Download and read the Board of Pharmacy's rules page and make sure you can fulfill any applicable requirements.

In particular, please note that any Oregon public healthcare facility that utilizes a Registered Nurse to dispense medications requires registration with the Oregon Board of Pharmacy as a Community Health Clinic (CHC). Oregon Administrative Rule 855-043-0700 states that a CHC Drug Outlet must:

- Employ a medical director who is an Oregon practitioner with prescriptive and dispensing authority;
- Designate a representative employee who will be the contact person for the Oregon Board of Pharmacy and must be onsite the majority of the CHC's normal operating hours;
- Conduct and document an annual review of the outlet. The completed report form must be filed in the clinic and be available to the Board for inspection for three years.

Emergency Contraception for Victims of Sexual Assault

Hospitals providing care to a female victim of a sexual assault must:

- Promptly provide the victim with unbiased, medically and factually accurate written and verbal information about emergency contraception (materials must be approved by OHA);

- Promptly verbally inform the victim of her option to be provided emergency contraception at the hospital; and
- If requested by the victim and if not medically contraindicated, provide the victim with emergency contraception immediately at the hospital. ([OAR 333-505-0120](#))

Mandatory Reporting Requirements

All reproductive health agency staff are considered mandatory reporters for purposes of Oregon’s Mandatory Child Abuse Reporting statutes ([ORS 419B.005 to .050](#)). As such, each agency is required to have policies in place to regulate staff compliance with these reporting statutes. Refer to [Exhibit A-4](#) for information about policy requirements.

OHP Family Planning

A.5

This sub-section provides specific information on Medicaid family planning benefits and billing procedures for clients eligible for the Oregon Health Plan (OHP), which is administered through the Division of Medical Assistance Programs (OHP). Clients must be screened for private insurance and OHP eligibility, and any covered reimbursement must be collected from these entities before CCare or Title X family planning funds may be used for payment.

OHP Eligibility for Family Planning Services

- OHP clients may seek family planning services from any family planning provider enrolled with OHP, even if the client is enrolled in a coordinated care organization (CCO). See [Birth control methods and reimbursements covered under the Oregon Health Plan](#) (pdf) for more details.
- Oregon Health Plan (OHP) clients with CCO coverage *do not need a referral* from a primary care provider or primary care manager in order to obtain family planning services.
- Providers should verify a client's OHP eligibility or coverage before submitting family planning bills. Go to <https://www.or-medicaid.gov> or call 1-866-692-3864.
- Clients who may be eligible for OHP but have not yet been determined eligible should be offered an OHP enrollment application (see OHP/OHP contact information on page A5-4).

OHP Covered Family Planning Services

A broad range of reproductive health services are covered for clients of childbearing age (including minors who are considered to be sexually active). Services covered by OHP may include:

- Annual exams
- Contraceptive education and counseling
- Laboratory tests
- Radiology services
- Medical and surgical procedures, including tubal ligations and vasectomies
- All FDA approved contraceptive methods and supplies
- Emergency Contraception (EC)

Billing for Family Planning Visits

Reimbursement for family planning services is made either by the client's coordinated care organization (CCO) or by OHP, as per the following:

- If the provider is contracted with the client's CCO for family planning services, the provider *must* bill the CCO.
- If the provider is an enrolled OHP provider, but is *not* contracted with the client's CCO for family planning services, the provider may bill OHP directly. When submitting the claim to OHP, be sure to:
 - Enter "Y" in the family planning box (24H) on the CMS-1500 claim form.
 - Add the FP modifier after all CPT and HCPCS codes. See [Exhibit A-1](#) for family planning diagnosis and HCPCS codes accepted by OHP.
- If there is a possibility that the client has private insurance, in addition to OHP, and she or he has requested special confidentiality, enter "N/C, Confidential" in box 9 on the CMS-1500 claim form. Then, submit a hard-copy claim directly to: Attn: Judy Brazier, PSU Lead Worker, Division of Medical Assistance Programs, 500 Summer Street, NE E-44, Salem, OR 97301. This will prevent OHP from pursuing third party payment from the client's private insurance plan which could result in an explanation of benefits (EOB) being sent to the policy holder.

Billing for Lab Services

- Only the provider who performs the test(s) may bill OHP.
- OHP will not reimburse separately for collection and/or handling of specimens such as Pap or other cervical cancer screening tests, voided urine samples, or stool specimens. Reimbursement is bundled in the reimbursement for the exam and/or lab procedures and is not payable in addition to the laboratory test.
- Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinic are not covered for payment and are not to be billed to OHP.
- Clinical Laboratory Improvement Amendments (CLIA) Certification:
 - Laboratory services are reimbursable only to providers who are CLIA certified by the Centers for Medicare and Medicaid Services (CMS). CLIA requires all entities that perform even

one test, including waived tests on “materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings” to meet certain federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory.

- Providers must notify OHP of the assigned ten-digit CLIA number; payment is limited to the level of testing authorized by the CLIA certificate at the time the test is performed.
- Please refer to [Appendix F](#) for Monthly Income Guidelines for Medicaid Coverage.

Medicaid Resources and Information

- OHA OHP Provider Services 1-800-336-6016
- [OHA OHP General Rulebook](#) (OAR 410-120):
<http://www.oregon.gov/oha/healthplan/Pages/general-rules.aspx>
- [OHA OHP Medical-Surgical Services Rulebook](#) (OAR 410-130):
<http://www.oregon.gov/oha/healthplan/Pages/medical-surgical.aspx>
- Guidance on use of ICD, CPT, HCPCS, and FP modifier codes:
 - OARS 410-130-0585 for general family planning service providers;
 - OARS 410-130-0680 for laboratory and radiology services;
 - OARS 410-130-0587 for enrolled family planning clinics only.

OHP Contact Points

Program	Phone/E-mail	Web site
OHP Reception	1-800-527-5772	http://www.oregon.gov/OHA/healthplan
Provider Resources		
OHP Eligibility Verification Check patient eligibility, TPR, benefit packages, managed care, reimbursement for specific procedures	1-866-692-3864	http://www.oregon.gov/oha/hhealthplan/Pages/verify.aspx
OHP AVR User Guide		https://apps.state.or.us/Forms/Served/oe3162.pdf
OHP Benefit RN Hotline OHP diagnosis/treatment	1-800-393-9855	
OHP Provider Services Unit Medical assistance details, billing questions, claims payment, claim status Billing tips and instruction books	1-800-336-6016 OHP.providerservices@state.or.us	http://www.oregon.gov/oha/hhealthplan/pages/providers.aspx http://www.oregon.gov/oha/hhealthplan/pages/billing.aspx
OHP Provider Enrollment	1-800-422-5047 provider.enrollment@state.or.us	http://www.oregon.gov/oha/hhealthplan/Pages/providerenroll.aspx
OHP Provider Contact List		https://apps.state.or.us/Forms/Served/oe3046.pdf
OHP Policies, Rules & Guidelines		http://www.oregon.gov/oha/hhealthplan/pages/policies.aspx
Client Resources		
OHP Application Center New client application and other information	1-800-359-9517	http://www.oregon.gov/oha/hhealthplan/pages/apply.aspx
OHP Customer Service Existing/pending client information, assistance	1-800-699-9075 (TTY 711)	
OHP Client Services Special needs, complaints	1-800-273-0557 (TTY 711)	http://www.oregon.gov/oha/hhealthplan/pages/csu.aspx
OHP Client Handbook		https://apps.state.or.us/Forms/Served/he9035.pdf

Purchasing Family Planning Supplies

A.6

Broad Range of Methods

CCare and Title X providers must offer a broad range of acceptable and effective FDA approved contraceptive methods on-site. This includes:

- IUD and IUS*
- Sub-dermal implant*
- Hormonal injection
- A choice of combination oral contraceptives (phasic and monophasic)
- A progestin-only pill
- At least one non-oral combination contraceptive (ring or patch)
- Diaphragm* or cervical cap* (plus appropriate spermicide)
- Latex and non-latex male condoms
- Female condoms
- A second type of spermicide
- Fertility Awareness Method (FAM)
- Information about abstinence and withdrawal
- Information and referral for sterilization*
- Emergency contraception pills (ECP)

** It is understood that not all agencies have the capacity to provide some methods. If this is the case, approval from the RH Program is required, and specific referrals must be given to clients who want a method not available at the clinic.*

340B Public Health Pricing

The Federal Office of Pharmacy Affairs (OPA) manages the 340B supply purchasing program which limits the cost of outpatient drugs for certain covered entities. Title X sub-recipients and Federally Qualified Health Centers (FQHCs) are covered entities eligible for 340B public health pricing.

When setting up contracts with supply manufacturers, distributors or vendors, the agency's 340B ID number is required to access the discount pricing. The ID# can be located in the OPA 340B covered entities database: <http://opanet.hrsa.gov/opa/Default.aspx>.

A complete list of distributors can be found through the 340B Prime Vendor Program:

- Apexus 340B Prime Vendor Program: www.340Bpvp.com
Phone: 888-340-2787

Supply Purchasing Resource

See [Exhibit A-2](#) for a list of companies that manufacture or distribute contraceptive products and supplies for both 340B and non-340B.

Sterilizations: Vasectomies

A.7

Male sterilization (vasectomy) services are covered under both CCare and the Oregon Vasectomy Project (OVP), formerly known as the Title X Oregon Vasectomy Project. Both Title X sub-recipients and CCare-only agencies are eligible to provide vasectomy services and receive reimbursement through OVP. All sterilization services provided by agencies through the Oregon Reproductive Health (RH) Program must comply with federal regulations, including those that are required for Oregon Health Plan (OHP) clients. The following are additional references and resources for sterilization services:

- Exhibit A-3: Consent for Sterilization ([English](#) and [Spanish](#))
- [Exhibit A-5: Vasectomy Referral Form](#)
- [Exhibit A-6: Services Rendered Form](#)
- [Exhibit D-11: Sample Vasectomy CVRs with OVP as SOP](#)
- [Exhibit D-10: Instructions for Billing OVP](#)
- [Exhibit B-4: Title X Service and Supply Discount Schedule](#)
- [Exhibit B-5: Reproductive Health Program Sliding Fee Scale](#)
- [Section C: Oregon CCare Program](#)
- [Exhibit C-14: Reimbursement Rates for CCare Visits and Supplies](#)

Contracting with a Local Vasectomy Provider

While some agencies have the capacity to provide vasectomies on site, most do not. Agencies may contract with a local vasectomy provider to perform vasectomy procedures for a set fee.

Any locally-contracted vasectomy provider must agree to the reimbursement amount set forth in the contract or agreement with the agency and must not charge the client any additional fees, including no-show fees, lab fees for the follow-up semen analysis, or fees for a post-procedure follow-up visit. The contracted reimbursement amount should be considered a global payment for the provision of the vasectomy and all routine follow-up.

Screening and Eligibility

Men seeking vasectomy services must be at least 21 years of age by the date of the procedure. Agencies should screen clients for CCare eligibility using established CCare processes. Clients requiring assistance with citizenship documents *may* be enrolled and receive services, including the vasectomy procedure, under the one-time reasonable opportunity period (ROP) until citizenship can be verified. Clients not eligible for CCare should be provided services through OVP. Prior authorization from the RH Program is not required. CCare and

OVP vasectomy eligibility and service requirements are summarized in the table on page A7-6.

Vasectomy Counseling and Informed Consent

Once enrolled in CCare or assessed for OVP, clients must receive a sterilization counseling visit. Clients wishing to pursue the vasectomy procedure at the conclusion of the visit will be asked to review and sign a consent form (Exhibit A-3: Consent for Sterilization – [English](#) and [Spanish](#)).

The counseling and consent process must assure that the client's decision to undergo sterilization is completely voluntary and made with full knowledge of the permanence, risks, and benefits associated with male sterilization procedures. Federal regulations require that the procedure be provided at least 30 days *after* the day the client signs the consent form and no more than 180 days from the signature date.

Federal regulations also require that all boxes be checked and all blank lines be filled-in on the consent form in order for the form to be considered complete and compliant. Note that a specific doctor must be named in the client's portion of the form and that name must match the "Physician's Signature" on the bottom of the form.

Note: If the original vasectomy provider listed on the consent form is unable to perform the vasectomy, the performing provider and the client should complete a new consent form and attach it to the original. (In this event, it is not required to wait an additional 30 days before the procedure is provided).

Referral for Procedure

If the client wishes to pursue a vasectomy at the conclusion of his counseling visit, the agency should:

Locally-Contracted Vasectomy Provider: Forward a copy of the consent form to the contracted vasectomy provider. Depending on the preference of the contracted vasectomy provider, either the client or the agency should schedule the vasectomy appointment with the vasectomy provider.

In-House Vasectomy Provider: Follow normal clinic flow to schedule a vasectomy appointment for the client.

Procedure and Follow-Up

During the medical visit, the client should be instructed on the process for collection and submission of a semen sample for the post-procedure semen analysis.

In the rare event a post-vasectomy visit is required to follow-up with a potential medical complication; the agency may bill CCare or OVP for a contraceptive management office visit. However, treatment of medical complications is not covered under CCare or OVP.

Billing

Separate CVRs must be submitted for the counseling visit and the medical procedure for payment to be rendered. For detailed instructions on how to bill OVP see [Exhibit D-10](#). Instructions include how to balance bill OVP, and how to bill for the Vasectomy Referral Fee.

Vasectomy Referral Fee

In recognition of the administrative work related to facilitating vasectomy referrals, the Oregon RH Program allows agencies that refer clients to vasectomy providers to recoup a \$50 Vasectomy Referral Fee, regardless of the client's source of pay. To be eligible for the referral fee, the reimbursement rates for both the counseling visit and the vasectomy procedure must be passed on, in full, to the contracted provider who performed the services. For instructions on how to bill for the Referral Fee see [Exhibit D-10](#).

See [Exhibit D-11](#) for an example Vasectomy Referral Fee CVR.

Vasectomy Eligibility and Billing Processes by Payer

Process	CCare	OVP
Eligibility Criteria	<ul style="list-style-type: none"> • Male ≥ 21 years • Income $\leq 250\%$ FPL • Not enrolled in OHP, may have private insurance • Social Security Number • Proof of U.S. citizenship or eligible immigration status <ul style="list-style-type: none"> * Clients ≥ 19 must have had LPR status for 5+ years. • Oregon resident • Proof of ID 	<ul style="list-style-type: none"> • Male ≥ 21 years • Income $\leq 250\%$ FPL • Not eligible for CCare • May be enrolled in OHP or have private insurance
Charges to Client	No Charges	Use Title X Sliding Fee Scale – See Exhibit B-4
CVR	<i>Normal CVR instructions should be followed (see Section D). In addition, the following items must be completed in order to receive payment:</i>	
	<p><u>Counseling Visit CVR</u></p> <ul style="list-style-type: none"> • Check box 08-CCare in Section 9 (Source of Pay) • Check box 4-Counseling Only in Section 12 (Purpose of Visit) • Check box 03-Sterilization in Section 14A (Assessment / Education / Counseling) <p><u>Sterilization Procedure CVR</u></p> <ul style="list-style-type: none"> • Check box 08-CCare in Section 9 (Source of Pay) • Check box 3-Other Medical in Section 12 (Purpose of Visit) • Check box 20-Sterilization Procedure in Section 13A (Medical Services) 	<p><u>Counseling Visit CVR</u></p> <ul style="list-style-type: none"> • Check box 11-OVP in Section 9 (Source of Pay) • Check box 4-Counseling Only in Section 12 (Purpose of Visit) • Check box 03-Sterilization in Section 14A (Assessment / Education / Counseling) <p><u>Sterilization Procedure CVR</u></p> <ul style="list-style-type: none"> • Check box 11-OVP in Section 9 (Source of Pay) • Check box 3-Other Medical in Section 12 (Purpose of Visit) • Check box 20-Sterilization Procedure in Section 13A (Medical Services)
CVR Submission Deadlines	12 months from date of service	12 months from date of service
Reimbursement Rates	<ul style="list-style-type: none"> • See Exhibit C-14 for current vasectomy reimbursement rates • Less payment received from private insurance (if any) 	

Resources for Planning and Evaluation

A.8

Planning and evaluation are critical aspects of our work. They allow us to learn how well our communities are being served and where improvements can be made. This information is critical for helping to demonstrate to partners and stakeholders the great value of family planning services.

We understand that the day-to-day demands of serving clients may leave little time and resources for in-depth evaluation or planning. Fortunately, many sources of data and technical assistance (TA) are available to help agencies regularly assess and improve the quality and scope of their family planning programs.

Technical Assistance Sources

For questions or help on assessing client and community needs, monitoring services provided, or measuring the program's impact, contact the Oregon Reproductive Health Program.

Among other things, Reproductive Health Program staff can:

1. Offer training on topics ranging from clinical practice to billing operations.
2. Provide assistance with access to data and/or data analysis.
3. Offer help implementing the Culturally and Linguistically Appropriate Services (CLAS) standards.

Even when program staff cannot directly assist, they often know who to contact for further information and resources.

Data Sources

OREGON REPRODUCTIVE HEALTH DATA

Oregon Reproductive Health Information System (Ahlers data): An enormous amount of CVR data on clients and services provided are available from Ahlers & Associates. Data are accessible in three main formats: standardized reports, customized tables, and "raw" visit-level records. See the CVR Manual in [Section D](#) for more information and instructions on each of these formats.

Oregon Reproductive Health Client Satisfaction Survey (CSS): Every two years, state staff work with local agencies to conduct a multi-clinic client satisfaction survey. Statewide results

are useful, even for clinics/agencies that do not participate in the CSS. The most recent report is available online at <http://www.healthoregon.org/rhmaterials>. Contact Oregon Reproductive Health Program staff for more information or a copy of the latest CSS report.

Title X Local Agency Review: State reproductive health nurse consultants conduct triennial reviews of agencies that receive Title X funding. The reviews cover both clinical and administrative practices (for more details see page B6-2, Agency Reviews), and offer an opportunity for agencies to improve program services and processes.

OREGON POPULATION DATA

The Center for Health Statistics in the Oregon Health Authority (OHA) maintains records for every vital event (birth, abortion, marriage, divorce, death) that occurs in Oregon. A wide array of statistics, such as teen pregnancy data, are published in annual statewide and county reports, available online at: <http://public.health.oregon.gov/BIRTHDEATHCERTIFICATES/VITALS/TATISTICS/Pages/index.aspx>
Or contact the Center for Health Statistics by phone at (971) 673-1190.

The Population Research Center at Portland State University publishes an annual report containing detailed estimates of Oregon's population by age, sex, and geographic location. <http://www.pdx.edu/prc/annual-population-estimates>.

The center also conducts demographic and economic analyses and publishes reports on a variety of other topics including housing, school enrollment, and population change. For more information, contact the Population Research Center at (503) 725-3922.

OREGON SURVEY DATA

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing telephone survey to capture behavioral risk factor data for the adult population (18 years and over) living in households. It typically includes a number of questions related to family planning and sexual behavior. Year-by-year tabulations of data by topic are available at: <http://www.healthoregon.org/brfss>.

Note: Single-year BRFSS data is too small to generate county-specific estimates; however, every few years, the Center for Health Statistics combines 4 years of BRFSS data to examine

selected topic areas by county. The most recent county-specific data tabulations are available at:

<http://public.health.oregon.gov/BirthDeathCertificates/Surveys/AdultBehaviorRisk/county/Pages/index.aspx>

Oregon Healthy Teens (OHT) is an annual, voluntary, school-based survey of risk and protective factors for healthy youth development. About one-third of the state's eighth and eleventh graders are surveyed each year; a smaller sample of ninth through twelfth graders is surveyed every other year. Topics covered on the questionnaire include: sexual activity and HIV/AIDS knowledge; tobacco, alcohol and other drug use; personal safety behaviors and perceptions; violence-related behaviors; diet and exercise; extracurricular activities; health conditions and access to care; and individual, peer, community, and family influences on risk behaviors and health. Year-by-year tabulations of data by topic (and by county, in most cases) are at:

<http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx> or by calling the Center for Health Statistics at (971) 673-1190.

Oregon's **Pregnancy Risk Assessment Monitoring System (PRAMS)** is an ongoing mail- and telephone-based survey of post-partum women in Oregon. PRAMS collects data on maternal attitudes and experiences prior to, during, and immediately after pregnancy, including pregnancy intent and contraceptive behavior. Year-by-year data and copies of the questionnaire are at:

<http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/Pages/index.aspx>

For more information call (971) 673-0237.

Note: The PRAMS sample is designed to be representative of the state target population, so the number of respondents is generally not large enough to generate county-specific estimates.

NATIONAL FAMILY PLANNING-RELATED DATA

The Guttmacher Institute (GI), formerly the Alan Guttmacher Institute, is a nonprofit organization focused on sexual and reproductive health research, policy analysis, and public education. The GI website features hundreds of data tables, reports, and research articles, as well as a custom table maker.

<http://www.guttmacher.org>

GI also produces periodic estimates of the number of Women In Need of contraceptive services and supplies at national, state, and

county levels. Estimates can be broken down further by age, poverty status, and race/ethnicity. The Oregon Reproductive Health Program uses these estimates regularly, for example, when requesting annual plans from counties. See the website at: <http://www.guttmacher.org/pubs/win/>

The **CDC Division of Reproductive Health** provides a wealth of reproductive health-related data at: http://www.cdc.gov/reproductivehealth/Data_Stats/index.htm

The **National Center for Health Statistics** administers an in-person nationwide survey every five to seven years called the National Survey of Family Growth (NSFG). The NSFG asks women and men aged 15–44 many in-depth questions about sexual activity, marriage, divorce and cohabitation, fertility and infertility, pregnancy and childbearing, contraceptive use, and use of family planning services. Data are not broken out for Oregon specifically, but the national-level reports may still be useful. See <http://www.cdc.gov/nchs/>.

Section A: Exhibits

[Exhibit A-1: Family Planning ICD-10 Codes](#)

[Exhibit A-2: Purchasing Family Planning Supplies](#)

Exhibit A-3: Consent for Sterilization Form ([English](#) and [Spanish](#))

[Exhibit A-4: RH Program Mandatory Reporting Standard](#)

[Exhibit A-5: Vasectomy Referral Form](#)

[Exhibit A-6: Services Rendered Form](#)

[Exhibit A-7: Reproductive Health Coordinator Description](#)



Oregon
Health
Authority

Reproductive Health Program Manual
January 2016

Section B

**Federal Title X
Regulations and
Requirements**

Center for Prevention and Health Promotion
Oregon Health Authority – Public Health

Federal Title X Requirements

B.1

Introduction

Title X was enacted as the Family Planning Services and Population Research Act of 1970 (Public Law 91-572) to assist individuals in determining the number and spacing of their children through the provision of affordable, voluntary family planning services.

The Title X Family Planning Program is the only Federal program dedicated solely for the provision of family planning and related preventive health services. The program is designed to provide contraceptive supplies and information to all who want and need them, with priority given to persons from low income families.

All Title X funded projects (sub-recipients) are required to offer a broad range of acceptable and medically effective FDA-approved contraceptive methods, and related services, on a voluntary and confidential basis. Title X services include the delivery of related preventive health services, such as patient education and counseling; cervical and breast cancer screening; sexually transmitted infection (STI) and human immunodeficiency virus (HIV) prevention education, testing, and referral; and pregnancy diagnosis and counseling. By law, Title X funds may not be used in programs where abortion is a method of family planning.

Title X Definitions

Family Planning: When an individual can determine freely the number and spacing of children.

Reproductive Health Services: Clinical, informational, educational, social, and referral services offered to anyone of reproductive age requesting family planning and reproductive health care.

The Title X Family Planning Program is federally administered by the Office of Population Affairs (OPA), Office of the Assistant Secretary for Health (OASH), within the U.S. Department of Health and Human Services (HHS).

The Title X Family Planning Guidelines consist of two parts, 1) Program Requirements for Title X Funded Family Planning Projects (hereafter referred to as Title X Program Requirements), and 2) Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs (hereafter referred to as QFP) ([Exhibit B-1](#)).



Program Requirements for Title X Funded Family Planning Projects

Version 1.0 April 2014

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Links

Title X Statute <http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/statutes-and-regulations/>

Title X Regulations <http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/statutes-and-regulations/>

Appropriations Language/Legislative Mandates <http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/legislative-mandates/>

Sterilization of Persons in Federally Assisted Family Planning Projects Regulations

<http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/statutes-and-regulations/>

Department of Health and Human Services Regions <http://www.hhs.gov/opa/regional-contacts/>

ACRONYMS

The following is a list of acronyms and abbreviations used throughout this document.

ACRONYM/ ABBREVIATION	
CFR	Code of Federal Regulations
FDA	U.S. Food and Drug Administration
FPL	Federal Poverty Level
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
I&E	Information and Education
NOA	Notice of Award
OASH	Office of the Assistant Secretary for Health
OGM	Office of Grants Management
OMB	Office of Management and Budget
OPA	Office of Population Affairs
OSHA	Occupational Safety and Health Administration
PHS	U.S. Public Health Service
STD	Sexually Transmitted Disease

COMMONLY USED REFERENCES

As a Federal grant program, requirements for the Title X Family Planning Program are established by Federal law and regulations. For ease of reference, the law and regulations most cited in this document are listed below. Other applicable regulations and laws are cited throughout the document.

Law	Title X Public Law ("Family Planning Services and Population Research Act of 1970")	Public Law 91-572
Law	Title X Statute ("Title X of the Public Health Service Act")	42 U.S.C.300, <i>et seq.</i>
Regulation	Sterilization Regulations ("Sterilization of persons in Federally Assisted Family Planning Projects")	42 CFR part 50, subpart B
Regulation	Title X Regulations ("Project Grants for Family Planning Services") (42 CFR part 59, subpart A
Regulation	HHS Grants Administration Regulations	45 CFR parts 74

	(“Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations” (part 74) and “Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments” (part 92))	and 92
Regulation	“Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-profit Organizations”	2 CFR 215 (OMB Circular A-110)
OMB Circular	“Grants and Cooperative Agreements with State and Local Governments”	OMB Circular A-102

INTRODUCTION

To assist individuals in determining the number and spacing of their children through the provision of affordable, voluntary family planning services, Congress enacted the Family Planning Services and Population Research Act of 1970 (Public Law 91-572). The law amended the Public Health Service (PHS) Act to add Title X, "Population Research and Voluntary Family Planning Programs." Section 1001 of the PHS Act (as amended) authorizes grants "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)."

The Title X Family Planning Program is the only Federal program dedicated solely to the provision of family planning and related preventive health services. The program is designed to provide contraceptive supplies and information to all who want and need them, with priority given to persons from low-income families. All Title X-funded projects are required to offer a broad range of acceptable and effective medically (U.S. Food and Drug Administration (FDA)) approved contraceptive methods and related services on a voluntary and confidential basis. Title X services include the delivery of related preventive health services, including patient education and counseling; cervical and breast cancer screening; sexually transmitted disease (STD) and human immunodeficiency virus (HIV) prevention education, testing, and referral; and pregnancy diagnosis and counseling. By law, Title X funds may not be used in programs where abortion is a method of family planning.

The Title X Family Planning Program is administered by the Office of Population Affairs (OPA), Office of the Assistant Secretary for Health (OASH), within the U.S. Department of Health and Human Services (HHS). OASH is responsible for facilitating the process of evaluating applications and setting funding levels according to the criteria set forth in 42 CFR 59.7(a). Final award decisions are made by the Regional Health Administrator for the applicable Public Health Service Region in consultation with the Deputy Assistant Secretary for Population Affairs and the Assistant Secretary for Health or their designees. The HHS Regional Offices monitor program performance of Title X grantees in each respective region.

The Title X Family Planning Guidelines consist of two parts, 1) *Program Requirements for Title X Funded Family Planning Projects* (hereafter referred to as *Title X Program Requirements*) and 2) *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*.

These documents have been developed to assist current and prospective grantees in understanding and implementing the family planning services grants program authorized by Title

X of the PHS Act (42 U.S.C. 300 *et seq.*). These documents also form the basis for monitoring projects under the Title X program.

OVERVIEW OF PROGRAM REQUIREMENTS

This document is organized into 16 sections that describe the various requirements applicable to the Title X program, as set out in the Title X statute and implementing regulations (42 CFR part 59, subpart A), and in other applicable Federal statutes, regulations, and policies. Links to the Title X statute and implementing regulations, other statutory provisions that are applicable to the Title X program, regulations related to sterilization, and additional resources to maximize the quality of services offered by Title X projects are provided on page 2 of this document.

The concise explanation of general program requirements that follows can be used to help prepare a grant application or monitor funded programs for compliance with Title X requirements. In addition, prospective applicants and grantees should consult all of the resources and references identified in this document for more complete information and to ensure that the project application and program operations comply with these and other Federal requirements.

Additional documents, including the annual *Announcement of Anticipated Availability of Funds for Family Planning Services Grants* (Title X Funding Opportunity Announcement), other Funding Opportunity Announcements for OPA priority areas, and relevant language in Federal appropriations laws, contain the most current information about Title X program requirements and are generally updated annually. The Title X Funding Opportunity Announcement includes the most recent list of program priorities and key issues, and identifies geographic areas where there will be a grant competition for the applicable fiscal year. Subject to the availability of funds, the funding announcement is published annually and posted on the HHS [Grants.gov](http://www.hhs.gov/grants) Website Portal. The *Program Requirements for Title X Funded Family Planning Projects* is posted on the OPA website (<http://www.hhs.gov/opa>). In general, the requirements that apply to the direct recipients of Title X funds also apply to sub-recipients and contractors (HHS Grants Policy Statement, 2007).

1. APPLICABILITY

As stated above, the requirements set forth in this document apply to the award of grants under section 1001 of the PHS Act (42 U.S.C. 300) to assist in the establishment and operation of voluntary family planning projects. These projects consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children (42 CFR 59.1).

2. DEFINITIONS

Terms used throughout this document include:

TERM	DEFINITION
The Act or Law	Title X of the Public Health Service Act, as amended
Family	A social unit composed of one person, or two or more persons living together, as a household
Low-income family	A family whose total annual income does not exceed 100% of the most recent Federal Poverty Guidelines; also includes members of families whose annual family income exceeds this amount, but who, as determined by the project director, are unable, for good reasons, to pay for family planning services. Unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources
Grantee	The entity that receives Federal financial assistance via a grant and assumes legal and financial responsibility and accountability for the awarded funds and for the performance of the activities approved for funding
Nonprofit	Any private agency, institution, or organization for which no part of the entity's net earnings benefit, or may lawfully benefit, any private stakeholder or individual.
Project	Activities described in the grant application and any incorporated documents supported under the approved budget. The "scope of the project" as defined in the funded application consists of activities that the total approved grant-related project budget supports.
Secretary	The Secretary of Health and Human Services and any other officer or employee of the U.S. Department of Health and Human Services to whom the authority involved has been delegated.
Service Site	The clinics or other locations where services are provided by the grantee or sub-recipient.
Sub-recipients	Those entities that provide family planning services with Title X funds

	under a written agreement with a grantee. May also be referred to as delegates or contract agencies.
State	Includes the 50 United States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, the U.S. Outlying Islands (Mid-way, Wake, et. al), the Marshall Islands, the Federated States of Micronesia and the Republic of Palau.

3. ELIGIBILITY

Any public or nonprofit private entity located in a state (which includes the 50 United States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, the U.S. Outlying Islands (Mid-way, Wake, et. al), the Marshall Islands, the Federated States of Micronesia and the Republic of Palau) is eligible to apply for a Title X family planning services project grant (42 CFR 59.2, 42 CFR 59.3).

Even where states apply for a family planning services grant, local and regional entities may also apply directly to the Secretary for a family planning services grant. Faith-based organizations and American Indian/Alaska Native/Native American organizations are eligible to apply for Title X family planning services grants. Private nonprofit entities must provide proof of nonprofit status during the application process.

Although State agencies are eligible for funding, the Title X statute specifically protects the right of local and regional entities to apply directly to the Secretary for a family planning services grant (Section 1001(b), PHS Act).

4. APPLICATION

The Office of Population Affairs publishes, at a minimum, an annual announcement of the availability of Title X family planning services grant funds that sets forth specific application requirements and evaluation criteria. Applications must be submitted to OASH, Office of Grants Management (OGM) on the forms required by HHS, in the manner required, and approved by an individual authorized to act for the applicant. The application process is conducted through an electronic grants system.

If an application relates to consolidation of service areas or health resources or would otherwise affect the operations of local or regional entities, the applicant must document that these entities have been given, to the maximum feasible extent, an opportunity to participate in the development of the application. Local and regional entities include existing or potential sub-

recipients that have previously provided or propose to provide family planning services to the area to be served by the applicant (42 CFR 59.5 (a)(10)(i)).

Unless otherwise instructed, applicants should respond to the standard instructions contained in the grant application package as well as any HHS supplemental instructions.

Successful applications must include:

- a narrative description of the project and the manner in which the applicant intends to conduct the project and comply with all requirements of the law and regulations;
- a budget that includes an estimate of project income and costs, with justification of the amount of grant funds requested (42 CFR 59.4(c)(2)) and which is consistent with the terms of Section 1006(a) of the Act, as implemented by regulation (42 CFR 59.7(b));
- a description of the standards and qualifications the project will use for all personnel and facilities; and
- other pertinent information as may be required by the Secretary (42 CFR 59.4(c)(4)).

Title X grant funds cannot constitute 100% of a project's estimated costs; therefore, applicants must clearly specify all other sources of funding that will be used to support the Title X project (42 CFR 59.7(c)).

5. CRITERIA FOR FUNDING

Within the limits of funds available for these purposes, grants are awarded for the establishment and operation of projects that will best promote the purposes of Section 1001 of Title X of the PHS Act. The application must address all seven points contained in section 59.7(a) of the regulations. These are the criteria HHS uses to determine which family planning projects to fund and in what amount.

In making funding decisions, HHS takes into account:

- the number of patients, and, in particular, the number of low-income patients to be served;
- the extent to which family planning services are needed locally;
- the relative need of the applicant;
- the capacity of the applicant to make rapid and effective use of the Federal assistance;
- the adequacy of the applicant's facilities and staff;
- the relative availability of non-Federal resources within the community to be served and the degree to which those resources are committed to the project; and
- the degree to which the project plan adequately provides for the requirements set forth in the Title X regulations.

Funding of applications that propose to rely on other entities to provide services will take into

consideration the extent to which the applicant indicates it will be inclusive in considering all entities that are eligible to receive Federal funds to best serve individuals in need throughout the anticipated service areas.

6. NOTICE OF AWARD

The Notice of Award (NOA) is the document that informs the grantee of the duration of HHS support for the project without requiring it to re compete for funds (42 CFR 59.8 (a)). This period of funding is called the “project period.” The project is generally funded in increments known as “budget periods.” Each budget period is typically 12 months, although shorter or longer budget periods may be established for compelling administrative or programmatic reasons.

Decisions regarding whether and at what level to continue awards are based on factors such as the adequacy of the grantee’s programmatic progress, management practices, compliance with the terms and conditions of the previous award, program priorities, and the availability of appropriations. In all cases, subsequent budget periods, also known as non-completing continuation awards, require a determination by HHS that continued funding is in the best interest of the government.

The U.S. government is not obligated to make any additional, supplemental, continuation, or other award with respect to any approved application or portion of an approved application (42 CFR 59.8(c)).

Grantees must provide the awarding agency with timely and unrestricted access to examine all records, books, papers, and documents related to the award (45 CFR 74.53 and 92.42). Records must be maintained generally for 3 years from submission of the final federal financial report (45 CFR 74.53)

7. USE OF GRANT FUNDS

All funds granted for Title X family planning services projects must be expended only for the purpose for which the funds were awarded and in accordance with the approved application and budget. Funds may not be used for prohibited activities, such as abortion as a method of family planning, or lobbying. The Notice of Award (NOA) provides other stipulations regarding the use of funds. Funds must be used in accordance with the Title X family planning services projects regulations, the terms and conditions of the award, and the HHS grants administration regulations set out at 45 CFR parts 74 and 92.

8. PROJECT MANAGEMENT AND ADMINISTRATION

All projects receiving Title X funds must provide services of high quality and be competently and efficiently administered.

8.1 Voluntary Participation

Family planning services are to be provided solely on a voluntary basis (Sections 1001 and 1007, PHS Act; 42 CFR 59.5 (a)(2)). Clients cannot be coerced to accept services or to use or not use any particular method of family planning (42 CFR 59.5 (a)(2)).

A client's acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in any other program that is offered by the grantee or sub-recipient (Section 1007, PHS Act; 42 CFR 59.5 (a)(2)).

Personnel working within the family planning project must be informed that they may be subject to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure (Section 205, Public Law 94-63, as set out in 42 CFR 59.5(a)(2) footnote 1).

8.2 Prohibition of Abortion

Title X grantees and sub-recipients must be in full compliance with Section 1008 of the Title X statute and 42 CFR 59.5(a)(5), which prohibit abortion as a method of family planning. Grantees and sub-recipients must have written policies that clearly indicate that none of the funds will be used in programs where abortion is a method of family planning. Additional guidance on this topic can be found in the July 3, 2000, Federal Register Notice entitled *Provision of Abortion-Related Services in Family Planning Services Projects*, which is available at 65 Fed. Reg. 41281, and the final rule entitled *Standards of Compliance for Abortion-Related Services in Family Planning Services Projects*, which is available at 65 Fed. Reg. 41270.

Grantees are also responsible for monitoring sub-recipients' compliance with this section.

8.3 Structure and Management

Family planning services under a Title X grant may be offered by grantees directly and/or by sub-recipient agencies operating under the umbrella of a grantee. However, the grantee is accountable for the quality, cost, accessibility, acceptability, reporting, and performance of the grant-funded activities provided by sub-recipients. Where required services are provided by referral, the grantee is expected to have written agreements for the provision of services and reimbursement of costs as appropriate.

8.3.1 The grantee must have a written agreement with each sub-recipient and establish written standards and guidelines for all delegated project activities consistent with the appropriate section(s) of the Title X Program Requirements, as well as other applicable requirements (45 CFR parts 74 and 92).

8.3.2 If a sub-recipient wishes to subcontract any of its responsibilities or services, a written agreement that is consistent with Title X Program Requirements and approved by the grantee must be maintained by the sub-recipient (45 CFR parts 74 and 92).

- 8.3.3 The grantee must ensure that all services purchased for project participants will be authorized by the project director or his designee on the project staff (42 CFR 59.5(b)(7)).
- 8.3.4 The grantee must ensure that services provided through a contract or other similar arrangement are paid for under agreements that include a schedule of rates and payment procedures maintained by the grantee. The grantee must be prepared to substantiate that these rates are reasonable and necessary (42 CFR 59.5(b)(9)).
- 8.3.5 Sub-recipient agencies must be given an opportunity to participate in the establishment of ongoing grantee policies and guidelines (42 CFR 59.5 (a)(10)).
- 8.3.6 The grantee and each sub-recipient must maintain a financial management system that meets Federal standards, as applicable, as well as any other requirements imposed by the Notice of Award, and which complies with Federal standards that will support effective control and accountability of funds. Documentation and records of all income and expenditures must be maintained as required (45 CFR parts 74.20 and 92.20).

8.4 Charges, Billing, and Collections

The grantee is responsible for the implementation of policies and procedures for charging, billing, and collecting funds for the services provided by the projects. Clients must not be denied project services or be subjected to any variation in quality of services because of inability to pay.

Projects should not have a general policy of no fee or flat fees for the provision of services to minors, or a schedule of fees for minors that is different from other populations receiving family planning services

- 8.4.1 Clients whose documented income is at or below 100% of the Federal Poverty Level (FPL) must not be charged, although projects must bill all third parties authorized or legally obligated to pay for services (Section 1006(c)(2), PHS Act; 42 CFR 59.5(a)(7)).

Within the parameters set out by the Title X statute and regulations, Title X grantees have a large measure of discretion in determining the extent of income verification activity that they believe is appropriate for their client population. Although not required to do so, grantees that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on clients self-report.

- 8.4.2 A schedule of discounts, based on ability to pay, is required for individuals with family

incomes between 101% and 250% of the FPL (42 CFR 59.5(a)(8)).

- 8.4.3 Fees must be waived for individuals with family incomes above 100% of the FPL who, as determined by the service site project director, are unable, for good cause, to pay for family planning services (42 CFR 59.2).
- 8.4.4 For persons from families whose income exceeds 250% of the FPL, charges must be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services. (42 CFR 59.5(a)(8)).
- 8.4.5 Eligibility for discounts for unemancipated minors who receive confidential services must be based on the income of the minor (42 CFR 59.2).
- 8.4.6 Where there is legal obligation or authorization for third party reimbursement, including public or private sources, all reasonable efforts must be made to obtain third party payment without the application of any discounts(42 CFR 59.5(a)(9)).

Family income should be assessed before determining whether copayments or additional fees are charged. With regard to insured clients, clients whose family income is at or below 250% FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied.

- 8.4.7 Where reimbursement is available from Title XIX or Title XX of the Social Security Act, a written agreement with the Title XIX or the Title XX state agency at either the grantee level or sub-recipient agency is required (42 CFR 59.5(a)(9)]
- 8.4.8 Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.
- 8.4.9 Voluntary donations from clients are permissible; however, clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies.

8.5 Project Personnel

Title X grantees must have approved personnel policies and procedures.

- 8.5.1 Grantees and sub-recipients are obligated to establish and maintain personnel policies that comply with applicable Federal and State requirements, including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title I of the Americans with Disabilities Act, and the annual appropriations language. These policies should include,

but are not to be limited to, staff recruitment, selection, performance evaluation, promotion, termination, compensation, benefits, and grievance procedures.

- 8.5.2 Project staff should be broadly representative of all significant elements of the population to be served by the project, and should be sensitive to, and able to deal effectively with, the cultural and other characteristics of the client population (42 CFR 59.5 (b)(10)).
- 8.5.3 Projects must be administered by a qualified project director. Change in Status, including Absence, of Principal Investigator/Project Director and Other Key Personnel requires pre-approval by the Office of Grants Management. For more information, see HHS Grants Policy Statement, 2007 Section II-54.
- 8.5.4 Projects must provide that family planning medical services will be performed under the direction of a physician with special training or experience in family planning (42 CFR 59.5 (b)(6)).
- 8.5.5 Appropriate salary limits will apply as required by law.

8.6 Staff Training and Project Technical Assistance

Title X grantees are responsible for the training of all project staff. Technical assistance may be provided by OPA or the Regional Office.

- 8.6.1 Projects must provide for the orientation and in-service training of all project personnel, including the staff of sub-recipient agencies and service sites (42 CFR 59.5(b)(4)).
- 8.6.2 The project's training plan should provide for routine training of staff on Federal/State requirements for reporting or notification of child abuse, child molestation, sexual abuse, rape or incest, as well as on human trafficking
- 8.6.3 The project's training plan should provide for routine training on involving family members in the decision of minors to seek family planning services and on counseling minors on how to resist being coerced into engaging in sexual activities.

8.7 Planning and Evaluation

Grantees must ensure that the project is competently and efficiently administered (42 CFR 59.5 (b) (6) and (7)). In order to adequately plan and evaluate program activities, grantees should develop written goals and objectives for the project period that are specific, measurable, achievable, realistic, time-framed, and which are consistent with Title X Program Requirements. The program plan should be based on a needs assessment. Grantee project plans must include an evaluation component that identifies indicators by which the program measures the

achievement of its objectives. For more information on quality improvement, see *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*.

9. PROJECT SERVICES AND CLIENTS

Projects funded under Title X are intended to enable all persons who want to obtain family planning care to have access to such services. Projects must provide for comprehensive medical, informational, educational, social, and referral services related to family planning for clients who want such services.

- 9.1 Priority for project services is to persons from low- income families (Section 1006(c)(1), PHS Act; 42 CFR 59.5(a)(6)).
- 9.2 Services must be provided in a manner which protects the dignity of the individual (42 CFR 59.5 (a)(3)).
- 9.3 Services must be provided without regard to religion, race, color, national origin, disability, age, sex, number of pregnancies, or marital status (42 CFR 59.5 (a)(4)).
- 9.4 Projects must provide for social services related to family planning including counseling, referral to and from other social and medical services agencies, and any ancillary services which may be necessary to facilitate clinic attendance (42 CFR 59.5 (b)(2)).
- 9.5 Projects must provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs (42 CFR 59.5 (b)(8)).
- 9.6 All grantees should assure services provided within their projects operate within written clinical protocols that are in accordance with nationally recognized standards of care, approved by the grantee, and signed by the physician responsible for the service site.
- 9.7 All projects must provide for medical services related to family planning and the effective usage of contraceptive devices and practices (including physician's consultation, examination, prescription, and continuing supervision, laboratory examination, contraceptive supplies) as well as necessary referrals to other medical facilities when medically indicated (42 CFR 59.5(b)(1)). This includes, but is not limited to emergencies that require referral. Efforts may be made to aid the client in finding potential resources for reimbursement of the referral provider, but projects are not responsible for the cost of

this care.

- 9.8 All projects must provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents). If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of family planning services. (42 CFR 59.5(a)(1)).
- 9.9 Services must be provided without the imposition of any durational residency requirement or requirement that the client be referred by a physician (42 CFR 59.5(b)(5)).
- 9.10 Projects must provide pregnancy diagnosis and counseling to all clients in need of this service (42 CFR 59.5(a)(5)).
- 9.11 Projects must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:
- prenatal care and delivery;
 - infant care, foster care, or adoption; and
 - pregnancy termination.

If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any options(s) about which the pregnant woman indicates she does not wish to receive such information and counseling (42 CFR 59.5(a)(5)).

- 9.12 Title X grantees must comply with applicable legislative mandates set out in the HHS appropriations act. Grantees must have written policies in place that address these legislative mandates:

“None of the funds appropriated in the Act may be made available to any entity under Title X of the Public Health Service Act unless the applicant for the award certifies to the Secretary of Health and Human Services that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.”

“Notwithstanding any other provision of law, no provider of services under Title X of the Public Health Service Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.”

10. CONFIDENTIALITY

Every project must have safeguards to ensure client confidentiality. Information obtained by the project staff about an individual receiving services may not be disclosed without the individual's documented consent, except as required by law or as may be necessary to provide services to the individual, with appropriate safeguards for confidentiality. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual (42 CFR 59.11).

11. COMMUNITY PARTICIPATION, EDUCATION, AND PROJECT PROMOTION

Title X grantees are expected to provide for community participation and education and to promote the activities of the project.

- 11.1 Title X grantees and sub-recipient agencies must provide an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served; and by persons in the community knowledgeable about the community's needs for family planning services (42 CFR 59.5(b)(10)).
- 11.2 Projects must establish and implement planned activities to facilitate community awareness of and access to family planning services (42 CFR 59.5(b)(3)). Each family planning project must provide for community education programs (42 CFR 59.5(b)(3)). The community education program(s) should be based on an assessment of the needs of the community and should contain an implementation and evaluation strategy.
- 11.3 Community education should serve to enhance community understanding of the objectives of the project, make known the availability of services to potential clients, and encourage continued participation by persons to whom family planning may be beneficial (42 CFR 59.5 (b)(3)).

12. INFORMATION AND EDUCATION MATERIALS APPROVAL

Every project is responsible for reviewing and approving informational and educational materials. The Information and Education (I&E) Advisory Committee may serve the community participation function if it meets the requirements, or a separate group may be identified .

- 12.1 Title X grantees and sub-recipient agencies are required to have a review and approval process, by an Advisory Committee, of all informational and educational materials developed or made available under the project prior to their distribution (Section 1006

(d)(2), PHS Act; 42 CFR 59.6(a)).

- 12.2 The committee must include individuals broadly representative (in terms of demographic factors such as race, color, national origin, handicapped condition, sex, and age) of the population or community for which the materials are intended (42 CFR 59.6 (b)(2)).
- 12.3 Each Title X grantee must have an Advisory Committee of five to nine members, except that the size provision may be waived by the Secretary for good cause shown (42 CFR 59.6(b)(1)). This Advisory Committee must review and approve all informational and educational (I&E) materials developed or made available under the project prior to their distribution to assure that the materials are suitable for the population and community for which they are intended and to assure their consistency with the purposes of Title X (Section 1006(d)(1), PHS Act; 42 CFR 59.6(a)).
- 12.4 The grantee may delegate I&E functions for the review and approval of materials to sub-recipient agencies; however, the oversight of the I&E review process rests with the grantee.
- 12.5 The Advisory Committee(s) may delegate responsibility for the review of the factual, technical, and clinical accuracy to appropriate project staff; however, final responsibility for approval of the I&E materials rests with the Advisory Committee.
- 12.6 The I&E Advisory Committee(s) must:
- consider the educational and cultural backgrounds of the individuals to whom the materials are addressed;
 - consider the standards of the population or community to be served with respect to such materials;
 - review the content of the material to assure that the information is factually correct;
 - determine whether the material is suitable for the population or community to which it is to be made available; and
 - establish a written record of its determinations (Section 1006(d), PHS Act; 42 CFR 59.6(b)).

13. ADDITIONAL ADMINISTRATIVE REQUIREMENTS

This section addresses additional requirements that are applicable to the Title X program and are set out in authorities other than the Title X statute and implementing regulations.

13.1 Facilities and Accessibility of Services

Title X service sites should be geographically accessible for the population being served. Grantees should consider clients' access to transportation, clinic locations, hours of operation, and other factors that influence clients' abilities to access services.

Title X clinics must have written policies that are consistent with the HHS Office for Civil Rights policy document, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (August 4, 2003) (HHS Grants Policy Statement 2007, II-23).

Projects may not discriminate on the basis of disability and, when viewed in their entirety, facilities must be readily accessible to people with disabilities (45 CFR part 84).

13.2 Emergency Management

All grantees, sub-recipients, and Title X clinics are required to have a written plan for the management of emergencies (29 CFR 1910, subpart E), and clinic facilities must meet applicable standards established by Federal, State, and local governments (e.g., local fire, building, and licensing codes).

Health and safety issues within the facility fall under the authority of the Occupational Safety and Health Administration (OSHA). Disaster plans and emergency exits are addressed under 29 CFR 1910, subpart E. The basic requirements of these regulations include, but are not limited to:

- Disaster plans (e.g. fire, bomb, terrorism, earthquake, etc.) have been developed and are available to staff.
- Staff can identify emergency evacuation routes.
- Staff has completed training and understand their role in an emergency or natural disaster.
- Exits are recognizable and free from barriers.

13.3 Standards of Conduct

Projects are required to establish policies to prevent employees, consultants, or members of governing/advisory bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private financial gain for themselves or others (HHS Grants Policy Statement 2007, II-7).

13.4 Human Subjects Clearance (Research)

Research conducted within Title X projects may be subject to Department of Health and Human Services regulations regarding the protection of human subjects (45 CFR Part 46). The grantee/sub-recipient should advise their Regional Office in writing of any research projects that involve Title X clients (HHS Grants Policy Statement 2007, II-9).

13.5 Financial and Reporting Requirements

Audits of grantees and sub-recipients must be conducted in accordance with the HHS grants administration regulations (45 CFR parts 74.26 and 92.26), as applicable, by auditors meeting established criteria for qualifications and independence (OMB A-133).

Grantees must comply with the financial and other reporting requirements set out in the HHS grants administration regulations (45 CFR parts 74 and 92), as applicable. In addition, grantees must have program data reporting systems which accurately collect and organize data for program reporting and which support management decision making and act in accordance with other reporting requirements as required by HHS.

Grantees must demonstrate continued institutional, managerial, and financial capacity (including funds sufficient to pay the non-Federal share of the project cost) to ensure proper planning, management, and completion of the project as described in the award (42 CFR 59.7(a)).

Grantees must reconcile reports, ensuring that disbursements equal obligations and drawdowns. HHS is not liable should the recipient expenditures exceed the actual amount available for the grant.

14. ADDITIONAL CONDITIONS

With respect to any grant, HHS may impose additional conditions prior to or at the time of any award, when, in the judgment of HHS, these conditions are necessary to assure or protect advancement of the approved program, the interests of public health, or the proper use of grant funds (42 CFR 59.12).

15. CLOSEOUT

Within 90 days of the end of grant support, grantees must submit:

- a final Federal Financial Report (FFR)
- a final progress report

Following closeout, the recipient remains obligated to return funds due as a result of later refunds, corrections, or other transactions, and the Federal Government may recover amounts based on the results of an audit covering any part of the period of grant support (HHS Grants Policy Statement, II-90).

For a complete list of requirements, grantees should review the HHS Grants Policy Statement, available at <http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf>

16. OTHER APPLICABLE HHS REGULATIONS AND STATUTES

Attention is drawn to the following HHS Department-wide regulations that apply to grants under Title X. These include:

- 37 CFR Part 401: Rights to inventions made by nonprofit organizations and small business firms under government grants, contracts, and cooperative agreements;
- 42 CFR Part 50, Subpart D: Public Health Service grant appeals procedure;
- 45 CFR Part 16: Procedures of the Departmental Grant Appeals Board;
- 45 CFR Part 74: Uniform administrative requirements for awards and sub-awards to institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations; and certain grants and agreements with states, local governments, and Indian tribal governments;
- 45 CFR Part 80: Nondiscrimination under programs receiving Federal assistance through HHS effectuation of Title VI of the Civil Rights Act of 1964;
- 45 CFR Part 81: Practice and procedure for hearings under Part 80 of this Title;
- 45 CFR Part 84: Nondiscrimination on the basis of disability in programs and activities receiving or benefitting from Federal financial assistance;
- 45 CFR Part 91: Nondiscrimination on the basis of age in HHS programs or activities receiving Federal financial assistance;
- 45 CFR Part 92: Uniform administrative requirements for grants and cooperative agreements to State and local governments; and
- 45 CFR Part 100: Intergovernmental Review of Department of Health and Human Services Programs and Activities.

In addition, the following statutory and regulatory provisions may be applicable to grants under Title X:

- The Patient Protection and Affordable Care Act (Public Law 111-148);
- The Trafficking Victims Protection Act of 2000, as amended (Public Law 106-386);
- Sex Trafficking of Children or by Force, Fraud, or Coercion (18 USC 1591);
- The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191); and
- Appropriations language that applies to the Title X program for the relevant fiscal year.

Additional Title X Guidance

B.2

In addition to the Title X Program Requirements and the QFP, the OPA has established a set of national priorities, some of which they may elect to emphasize during a given Title X grant cycle. These may change over time. The current program priorities and other key issues are listed below.

OPA Program Priorities

The following priorities, derived from Healthy People 2020 Objectives and HHS priorities, represent the overarching goals for the Title X program:

1. “Assuring the delivery of quality family planning and related preventive health services, where evidence exists that those services should lead to improvement in the overall health of individuals, with priority for services to individuals from low-income families. This includes ensuring that grantees have the capacity to support implementation (e.g., through staff training and related systems changes) of the Title X Program Requirements throughout their Title X services sub-recipients, and that sub-recipient staff have received training on Title X Program Requirements;
2. Providing access to a broad range of acceptable and effective family planning methods and related preventive health services in accordance with the Title X program requirements and QFP. These services include, but are not limited to, natural family planning methods, infertility services, services for adolescents, breast and cervical cancer screening, and sexually transmitted disease (STD) and HIV prevention education, testing, and referral. The broad range of services does not include abortion as a method of family planning;
3. Assessing clients’ reproductive life plan as part of determining the need for family planning services, and providing preconception services as stipulated in QFP;
4. Addressing the comprehensive family planning and other health needs of individuals, families, and communities through outreach to hard-to-reach and/or vulnerable populations, and partnering with other community-based health and social service providers that provide needed services; and
5. Demonstrating that the project infrastructure will ensure sustainability of family planning and reproductive health services throughout the proposed service area including:

- Incorporation of certified Electronic Health Record (EHR) systems and other HIT systems that are interoperable;
- Evidence of contracts with insurance and systems for third party billing as well as the ability to facilitate the enrollment of clients into insurance and Medicaid optimally onsite; and to report on numbers assisted and enrolled;
- Evidence of the ability to provide comprehensive primary care services onsite or demonstration of formal robust linkages with comprehensive primary care providers.”

Other Key Federal Issues

“In addition to the Program Priorities, the following key issues have implications for Title X services sub-recipients, and should be considered in developing the project plan:

1. Incorporation of the 2014 Title X Program Requirements throughout the proposed service area as demonstrated by written clinical protocols that are in accordance with Title X Requirements and QFP.
2. Efficiency and effectiveness in program management and operations;
3. Patient access to a broad range of contraceptive options, including long acting reversible contraceptives (LARC), other pharmaceuticals, and laboratory tests;
4. Establishment and use of performance measures to regularly perform quality assurance and quality improvement activities;
5. Establishment of linkages and partnerships with comprehensive primary care providers, HIV care and treatment providers, and mental health, drug and alcohol treatment providers;
6. Incorporation of the National HIV/AIDS Strategy (NHAS) and CDC’s “Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings;”
7. Efficient and streamlined electronic data collection (such as for the Family Planning Annual Report (FPAR)), reporting and analysis for internal use in monitoring performance, program efficiency, and staff productivity in order to improve the quality and delivery of family planning services; and
8. Incorporation of research outcomes and evidence-based approaches that focus on family planning service delivery.”

Program Policy Notices

The Office of Population Affairs periodically sends out Program Policy Notices that update or clarify the Program Requirements. [Exhibit B-9](#) contains all Program Policy Notices released since April, 2014.

Program Policy Notices are also available at:
http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program_policy_notice/

Title X Clinical Services

B.3

Protocols

Evidence based, high quality clinical services are a priority of the program. The RH program developed a set of protocols that incorporate the Title X Program Requirements, US MEC, SPR, QFP, and other national standards of care to ensure that high quality RH services are provided. Sub-recipients are expected to use these protocols, adapting them to address their unique service delivery needs. Protocols must be approved by the RH program to be considered compliant.

Abortion Restrictions

Section 1008 of the Title X Public Health Service Act (the law that established federally funded family planning programs) states that *“none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.”*

Every family planning program must provide non-directive pregnancy diagnosis and counseling to all clients in need of this service, even though activities related to abortion are restricted. See **Options Counseling** below.

A number of federal documents have been published to clarify and interpret the Section 1008 abortion regulations. For additional information on this issue, please contact the Reproductive Health Program.

Options Counseling

Section 9.11 of the federal Program Requirements for Title X Funded Family Planning Projects states:

“Projects must offer pregnant women the opportunity to be provided with information and counseling regarding each of the following options:

- *Prenatal care and delivery;*
- *Infant care, foster care, or adoption; and,*
- *Pregnancy termination.*

If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.”

This nondirective counseling is also referred to as client-centered options counseling.

Due to the sensitive nature of this issue for staff and local communities, we require that clients with unintended pregnancies be given a single handout that provides referral information to local resources for all three options. If there are no local resources for a given option, indicate where a client can go to receive the services. This will help fulfill the requirement for nondirective counseling, as well as serve clients who may change their minds, or who want to consider a different alternative after leaving the clinic.

Infertility Services

Clinics must make basic infertility services available to women and men desiring such services. At a minimum, Level I services must be provided at all Title X funded sites. Level II infertility services may be provided, but Level III and IV infertility services are prohibited.

- Level I includes initial infertility interview, education, physical examination, counseling, and appropriate referral.
- Level II includes such testing as semen analysis, assessment of ovulatory function, and post-coital testing.
- Level III and IV are more complex than Level I and II services in that they include complex medication administration and management, including in vitro fertilization, and are considered to be beyond the scope of a Title X program.

See the [QFP \(Exhibit B-1\)](#), for additional information.

Application & Funding

B.4

LPHA Contracts

Each year, every local public health authority (LPHA) in Oregon receives a Financial Assistance Contract with programmatic and service deliverable. Several areas of the contract specifically address family planning.

Program elements: The contract contains general and specific program elements (formerly called assurances). A copy of the current program element for reproductive health services follows at the end of this section in [Exhibit B-2](#).

Funding: Family planning grant funding is based on a formula agreed upon by the Oregon Health Authority (OHA) and the Conference of Local Health Officials (CLHO). The current formula provides a small base amount and distributes the remaining funds on a per client basis. It is described in more detail below.

All Title X sub-recipients also receive a Notice of Grant Award (NGA) and an extensive interagency agreement/contract from the OHA Contracts Office in Salem. The contract and NGA must be signed and returned to OHA prior to July 1 so that funding for the next fiscal year can begin.

The Title X funding period is July 1 through June 30. Any changes in funding throughout the year are initiated through the contract amendment process.

Expenditure Reports

Title X funds are awarded to sub-recipients yearly. The amount is divided by 12 months and grant payments are made to Title X sub-recipients monthly. Sub-recipients are required to submit quarterly expenditure reports to the Office of Financial Services. A sample of the current Revenue and Expenditure Report is included as [Exhibit B-3](#).

Accuracy is important. It is important to ensure that expenditure reports are accurate by line item. Personal service expenditures must be based on time activity reports where appropriate.

Final expenditure reports. Family Planning Service Grant funds may not be carried forward to the next year. Therefore, it is in sub-recipients' best interest to spend up to the limit of their grant. We

recommend spending Title X funds before local funds so that there is no danger of funds being lost.

Family Planning Funding Formula

The OHA and the Conference of Local Health Officials have approved the current version of the family planning funding formula, which went into effect beginning July 1, 2006. The formula is used to distribute Title X grant funds to serve low-income clients who do not have public or private medical insurance.

After exploring a variety of funding models, an ad hoc funding formula workgroup recommended the following formula:

- 1. Distribute a base amount of \$5,000 to each sub-recipient.**
- 2. Distribute the remaining funds on a per-client basis, using the total number of non-Medicaid (non-CCare and non-OHP) or uninsured clients served by each agency in the prior year.**

Fee Collection

B.5

Establishing Fee Collection Policies

Every family planning sub-recipient must set fees for all family planning services and supplies. Fees should be designed to recover the reasonable costs of providing services and may include clinical, support, and administrative costs. (Requirements are listed in Program Requirements for Title X Funded Family Planning Projects, Section 8.4.)

Each sub-recipient is responsible for maintaining fee collection policies that meet Title X billing and collections requirements and reflect their individual business model. The information in this sub-section is intended to help. Please note, however, that it does not cover every situation that may arise.

Important Basic Guidelines

1. The goal is to **charge fees based on the client's ability to pay**. Fee collection policies and practices should never be a barrier to a client receiving services.
2. **Clients may not be subjected to any variation in quality of services** because of inability to pay.
3. Employees within the same agency must **deliver consistent messages** to clients about fee collection.

Clients Who Are Unable to Pay

Federal regulations clearly state that clients must never be denied services because of an inability to pay. This fact should be reflected in the clinic's fee policy, in any clinic signage addressing fees, and in any discussions with clients about fees.

Who Qualifies As "Unable to Pay"

Clients with incomes at or below 100% of the federal poverty level are assumed to be unable to pay and cannot be charged.

A client whose income is above the federal poverty level but is unable to pay for good cause (as determined by the project director) may have the fee waived, in full or in part. The sub-recipient must determine, as accurately as possible, the client's ability to pay based upon family income.

Note: In the case of minors seeking confidential services, just the minor's income may be used in fee assessments.

Family Planning Fees Must Be Kept Separate

In accordance with federal rules, fees collected in all family planning clinics funded through Oregon's RH Program must be kept separate from other funds and shall be used only to support the Family Planning Program. Program income collected must be fully used within the period of the LPHA contract agreement and not carried over into subsequent years. See [Exhibit B-2](#) for details.

Donations Must Be Voluntary

Voluntary donations from clients are permissible, under the following conditions:

- Clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies.
- Client donations do not waive billing/charging requirements.
- Any donation policy, including information offered about the agency's ability to accept donations, must be applied consistently across all clients, regardless of fee or payment status.
- Donation solicitation is optional and is encouraged to help support the program, but is not required.

Sliding Fee Scale

Sub-recipients must base fees on an authorized sliding fee scale that incorporates federal poverty guideline figures. The Title X Service and Supply Discount Schedule and Reproductive Health Program Sliding Fee Scale are in [Exhibit B-3](#) and [Exhibit B-4](#), respectively.

In order to apply the sliding fee scale, determine the client's family size and income. Instructions for making those calculations are explained in the CVR Manual for Title X and CCare in [Section D](#) of this manual.

Important Considerations about Fees

- Clients whose incomes are at or above 250% of the federal poverty level must be charged the full fee for services and supplies.
- Clients whose incomes are between 101% and 250% of the federal poverty level shall be charged according to an approved sliding fee scale.
- Clients whose incomes are at or below 100% of the federal poverty level must not be charged.

- No flat or minimum fees of any sort (no-show fees, dispensing fees, family planning lab handling fees, etc.) may be charged. As noted previously, voluntary donations may be discussed with all clients.
- No one may be denied services based on an inability to pay.
- Proof of income is not required to receive Title X services.

Reporting Requirements & Agency Reviews

B.6

Clinic Visit Record

The Clinic Visit Record (CVR) serves as the data collection tool for the Family Planning Information System and as the billing mechanism for services provided to CCare clients.

All agencies (Title X and CCare) must fill out a CVR for every reproductive health visit by a client of Oregon's Reproductive Health Program. For complete information on filling out a CVR, see [Section D](#).

Other Important Reports and Dates

Reporting deadlines and other important dates that apply specifically to recipients of federal grant funds (Title X or Title V) are:

Annual Plan Request

Each sub-recipient must submit an annual plan for family planning services covering the period July 1 through June 30 of the succeeding year. The Reproductive Health Program will supply the required format, deadline and current service data for use in completing the plan.

Annual Request for Information

Known as "the January mailing," this packet requests information required for the State of Oregon's federal Title X grant application. It also provides the opportunity to update contact information and assess training needs. The request is usually sent to local sub-recipients in early January and is due back to the state in approximately three weeks.

Budget Projection

A projected budget for Family Planning Services covering the period of July 1 through June 30 of the succeeding year is submitted to the Reproductive Health Program annually. The due date is supplied by the Program, generally as part of the local agency contract process.

Local Agency Contracts

A contract outlining all requirements for funding must be signed annually between the State of Oregon and each local public health authority. The contract contains a specific program element for the Reproductive Health Program. This signing process takes place in May and June.

Expenditure Reports

Quarterly expenditure reports are due to the Office of Financial Services on October 25, January 25, April 25, and July 25.

Pap Testing Results

All agencies are required to provide data about abnormal cervical cancer screening test results for the previous calendar year for purposes of the Federal Family Planning Annual Report. This information will be requested in the Annual Request for Information packet described above.

Agency Reviews

Agency reviews are part of an ongoing effort to evaluate and provide technical assistance to Title X-funded sub-recipients. They are conducted on-site by OHA Public Health every third year, on a rotating basis. The Reproductive Health Program staff provides follow-up during the other two years.

The following information can be found in this section's Exhibits:

- [Exhibit B-6](#): Review Schedule through 2019;
- Exhibit B-7: Reproductive Health Program Review Tool; and
- Exhibit B-8: Reproductive Health Chart Audit Tool.

Section B: Exhibits

[Exhibit B-1: Providing Quality Family Planning Services \(QFP\)](#)

[Exhibit B-2: Program Element #41](#)

[Exhibit B-3: OHA Revenue & Expenditure Report](#)

[Exhibit B-4: Title X Service and Supply Discount Schedule](#)

[Exhibit B-5: Reproductive Health Program Sliding Fee Scale](#)

[Exhibit B-6: Reproductive Health Program Review Schedule](#)

[Exhibit B-7: RH Program Review Tool](#) (Word download)

[Exhibit B-8: Chart Audit Tool](#) (Excel download)

[Exhibit B-9: OPA Program Policy Notices](#)



Oregon
Health
Authority

Reproductive Health Program Manual
January 2016

Section C

Oregon
Contraceptive Care
(CCare)

Center for Prevention and Health Promotion
Oregon Health Authority – Public Health

Overview

The Oregon ContraceptiveCare (CCare) Program is a Medicaid waiver program that serves Oregonians with incomes at or below 250% of the federal poverty level (FPL) who are not enrolled in the Oregon Health Plan (OHP). CCare services are limited to those related to preventing unintended pregnancy and may include: annual visits; follow-up visits to evaluate or manage problems associated with contraceptive methods; medical procedures, lab tests, and counseling services associated with contraceptive management; and contraceptive methods.

Goals and Objectives

CCare aligns with national and state reproductive health and maternal and child health objectives. The goal of CCare is to improve the well-being of Oregonians by reducing unintended pregnancies and improving access to primary health care services. Short term and long term objectives are:

1. Increase the proportion of clients who use a highly effective or moderately effective contraceptive method.
2. Increase the proportion of clients who receive help to access primary care services and comprehensive health coverage.
3. Increase the proportion of reproductive-age Oregonians use a highly effective or moderately effective contraceptive method.
4. Increase the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.
5. Decrease the proportion of Oregon births classified as unintended.
6. Decrease the unintended pregnancy rate in Oregon.
7. Decrease the teen pregnancy rate in Oregon.

Overview

CCare requires that enrolled providers/agencies:

- Offer in-depth visits for clinical and preventive contraceptive management services.
- Meet all the requirements listed in the CCare Standards of Care (below). The Standards can also be found in the Oregon Administrative Rules at [OAR 333-004-0060](#).
- Make referrals for free or low-cost psychosocial services when necessary. Clients must also be offered information about where to access free or low-cost primary care services. Clients in need of full-benefit health insurance coverage, private or public, must be offered written information about how to obtain health insurance enrollment assistance. An example brochure is provided in [Exhibit C-12](#).
- Maintain an on-site contraceptive dispensary consisting of a full range of family planning drugs and supplies, and directly dispense to clients at the time of their appointment.
- Participate in a CCare-specific billing and data collection system. A [CVR](#) (Clinic Visit Record) must be completed for each visit. Proprietary software for data entry and submission is available for purchase. Alternative software may be used if the provider can ensure the correct file formats for data submission.
- Screen and document client eligibility using the [CCare Enrollment Form](#).
- Designate a staff member as the Reproductive Health Coordinator (RHC). This person is the primary point of contact between state Reproductive Health Program staff and the provider agency, including all clinic sites and subcontractors. Please see [Exhibit A-7](#) for a description of the RHC roles and responsibilities.

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

SECTION	DESCRIPTION
<p>(1) Informed Consent</p> <p>The client's decision to participate in and consent to receive family planning services must be voluntary and without bias or coercion.</p>	<p>(a) The informed consent process, provided verbally and supplemented with written materials, must be presented in a language and style the client understands.</p> <p>(b) A signed consent must be obtained from the client before receiving family planning services.</p>
<p>(2) Confidentiality</p> <p>Services must be provided in a manner that respects the client's privacy and dignity in accordance with OAR 333-004-0060(7)(b)(B).</p>	<p>(a) Clients must be assured of the confidentiality of services and of their medical and legal records.</p> <p>(b) Records cannot be released without written client consent, except as may be required by law, or otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).</p>
<p>(3) Availability of Contraceptive Services</p> <p>A broad range of Federal Drug Administration (FDA)-approved contraceptive methods and their applications, consistent with recognized medical practice standards, as well as fertility awareness methods must be available on-site at the clinic for dispensing to the client at the time of the visit.</p>	<p>(a) Clients shall be able to get their first choice of contraceptive method during their visits unless there are specific contraindications.</p> <p>(b) Contraceptive methods, including emergency contraception, must be available at the clinic site and available to the client at the time of service, except as provided in OAR 333-004-0060(8)(a).</p> <p>(c) If the agency's clinical staff lack the specialized skills to provide vasectomies, intrauterine devices or intrauterine contraceptive systems (IUDs/IUSs) or subdermal implants, or if there is insufficient volume to ensure and maintain high skill level for these procedures, clients must be referred to another qualified provider for these procedures.</p>

SECTION	DESCRIPTION
<p data-bbox="183 310 591 384">(4) Linguistic and Cultural Competence</p> <p data-bbox="183 426 607 926">All services, support and other assistance must be provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, languages and behaviors of the client receiving services, and in a manner that has the greatest likelihood of ensuring maximum program participation.</p>	<p data-bbox="634 306 1435 611">(a) 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 and sections 1557, 1331 and 1001 of the Affordable Care Act (ACA).</p> <ul style="list-style-type: none"> <li data-bbox="704 632 1398 741">(A) All persons providing interpretation services must adhere to confidentiality guidelines. <li data-bbox="704 762 1398 871">(B) Family and friends shall not be used to provide interpretation services, unless requested by the client. <li data-bbox="704 892 1435 1081">(C) Individuals under age 18 shall never be used as interpreters for clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance. <li data-bbox="704 1102 1414 1407">(D) The agency should employ bilingual staff, personnel or volunteers skilled or certified in the provision of medical and clinical interpretation that meets the needs of the client during all clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance. <p data-bbox="634 1428 1425 1654">(b) 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.</p> <p data-bbox="634 1675 1435 1938">(c) 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.</p>

SECTION	DESCRIPTION
Linguistic and Cultural Competence (cont.)	<p>(d) The agency shall make easily understandable print materials available to clients and post signage in the languages of groups represented or commonly encountered in the service area.</p> <p>(e) 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.</p>
<p>(5) Access to Care</p> <p>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.</p>	<p>(a) 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 given the option to be referred to other qualified provider agencies in the area.</p> <p>(b) Clinics may offer established clients the option of receiving their contraceptive methods by mail.</p> <p>(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.</p> <p>(B) Contraceptive methods that require a written prescription may only be mailed to established clients who have been using the method(s) with no problems or contraindications.</p> <p>(C) Non-prescription methods may be mailed to any established client, regardless of the client's previous use of the method(s).</p> <p>(D) Clients must not incur any cost for the option of receiving contraceptive methods through the mail.</p> <p>(E) Clinics must package and mail supplies in a manner that ensures the integrity of the contraceptive packaging and</p>

SECTION	DESCRIPTION
Access to Care (cont.)	<p>effectiveness of the method upon delivery.</p> <ul style="list-style-type: none"> <li data-bbox="639 365 1432 516">(c) Although not covered by CCare, treatment and supplies for sexually transmitted infections must be available at the clinic site, or by referral. <li data-bbox="639 537 1409 764">(d) 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. <li data-bbox="639 785 1383 894">(e) Clients must be offered information about where to access free or low cost primary care services. <li data-bbox="639 915 1409 1066">(f) Clients in need of full-benefit health insurance coverage, private or public, must be given information about how to obtain health insurance enrollment assistance. <li data-bbox="639 1087 1442 1465">(g) All services must be provided to eligible clients without regard to race, color, national origin, religion, sex, sexual orientation, gender identity, marital status, age, parity or disability in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A. <li data-bbox="639 1486 1432 1751">(h) All counseling and referral-to-care options appropriate to a pregnancy test result during an authorized CCare visit must be provided in a client-centered, unbiased manner, allowing the client full freedom of choice between prenatal care, adoption counseling or pregnancy termination services.

SECTION	DESCRIPTION
(6) Clinical and Preventive Services	<p>(a) The scope of services available to clients at each CCare clinic site must include:</p> <ul style="list-style-type: none"> (A) A comprehensive health history, including health risk behaviors and a complete contraceptive, personal, sexual health, and family medical history; and reproductive health assessment in conjunction with contraceptive counseling; (B) Routine laboratory tests, which may include a Pap test, blood count, and pregnancy test, and health screenings related to the decision-making process for contraceptive choices; (C) Provision of a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception; (D) Vasectomy counseling, including a comprehensive health history that includes health risk behaviors, a complete contraceptive, personal and family medical history, and a sexual health history; (E) Vasectomy or referral for vasectomy; (F) Follow-up care for maintenance of a client's current contraceptive method or to change their method, including removal of a method; (G) Information about providers available for meeting primary care needs and direct referral for medical services not covered by CCare, including management of high-risk conditions and specialty consultation if needed; and (H) Preventive services for communicable diseases, provided within the context of a CCare visit, including:

SECTION	DESCRIPTION
Clinical and Preventive Services (cont.)	<ul style="list-style-type: none"> (i) Screening tests 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. <p>(b) All services must be documented in the client's medical record.</p>
(7) Education and Counseling Services	<ul style="list-style-type: none"> (a) All education and counseling services must be provided using a client-centered approach to help the client clarify their needs and wants, promote personal choice and risk reduction. (b) The following elements comprise the required client-centered education and counseling services that must be provided to all family planning clients: <ul style="list-style-type: none"> (A) Initial clinical assessment and re-assessment as needed, of the client's educational needs and knowledge about reproductive health, including: <ul style="list-style-type: none"> (i) Relevant reproductive anatomy and physiology; (ii) Counseling and education about a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception; (iii) A description of services and clinic procedures; (iv) Preventive health care, nutrition, preconception health, pregnancy intention, and STI and HIV prevention; (v) Psychosocial issues, such as partner relationship and communication,

SECTION	DESCRIPTION
Education and Counseling Services (cont.)	<p>risk-taking, and decision-making; and</p> <p>(vi) An explanation of how to locate and access primary care services not covered by CCare.</p> <p>(B) 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:</p> <p>(i) An explanation of the results of the physical examination and the laboratory tests;</p> <p>(ii) Information on where to obtain 24-hour emergency care services;</p> <p>(iii) The option of including a client's partner in an education and counseling session, and other services at the client's discretion; and</p> <p>(iv) Effective educational information that takes into account diverse cultural and socioeconomic factors of the client and the psychosocial aspects of reproductive health.</p> <p>(C) Using a client-centered approach, each client must be provided with adequate information to make an informed choice about contraceptive methods, including:</p> <p>(i) A general verbal or written review of all FDA-approved contraceptive methods, including sterilizations and emergency contraception, along with the opportunity for the client to ask questions. Documentation of this method</p>

SECTION	DESCRIPTION
Education and Counseling Services (cont.)	<p>education must be maintained in the client record;</p> <ul style="list-style-type: none"> (ii) A description of the implications and consequences of sterilization procedures, if provided; (iii) The opportunity for questions concerning procedures or methods; and (iv) Written information about how to obtain services for contraceptive-related complications or emergencies. <p>(D) Specific instructions for care, use, and possible danger signs for the selected method each time the method is dispensed.</p> <p>(E) 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.</p>
(8) Exceptions	<p>(a) School-Based Health Centers are exempt from the requirement to make contraceptive methods available for on-site dispensing described in section (3) and subsection (5)(b) of this rule. 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. RH 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.</p>

SECTION	DESCRIPTION
<p>Exceptions (cont.)</p>	<p>When referral clinics do not participate in CCare, payment arrangements must be made between the referring and receiving clinics. Dispensing by any provider must not result in a charge to the client.</p> <p>(b) Non-School-Based Health Center sites:</p> <p>(A) Agencies may bill CCare for family planning services conducted and contraceptive supplies dispensed at a school site, grade 12 and under, if the site meets the following criteria:</p> <ul style="list-style-type: none"> (i) The school site must be within a RH-approved distance from the enrolled CCare agency to ensure adequate access to client contraceptive method of choice; and (ii) The school site must have a dedicated, private room for services to be conducted. <p>(B) Agencies that wish to bill CCare for client counseling and education services conducted at school sites must adhere to the following standards:</p> <ul style="list-style-type: none"> (i) The agency must notify RH of the school site to be enrolled and must request from RH 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 described in OAR 333-004-0020 and are enrolled according to OAR 333-004-0030 at the school site; (iv) For clients already enrolled in CCare, the agency must ensure that clients have active eligibility;

SECTION	DESCRIPTION
Exceptions (cont.)	<ul style="list-style-type: none"> <li data-bbox="781 289 1435 594">(v) The agency must follow all standards of care for family planning services described in OAR 333-004-0060 with the exception of OAR 333-004-0060(3) (supplies dispensed on-site) and OAR 333-004-0060(6) (clinical and preventive services); <li data-bbox="781 615 1435 804">(vi) The agency must offer clients a written referral to an enrolled CCare clinic for supply pick-up, if not dispensed on-site, and full array of clinical services; and <li data-bbox="781 825 1435 972">(vii) The agency must submit claims for services conducted at the school site using the assigned project and site number of the school site.

Definitions

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

Client – An individual of reproductive capacity who receives medical or counseling services for the purposes of preventing unintended pregnancy and for whom a medical record is established.

CCare Visit – A visit in which the primary purpose is for family planning services and is coded with a primary diagnosis within the Z30 Contraceptive Management series of the International Classification of Diseases (ICD).

Family Planning 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 services intended to prevent unintended pregnancies for eligible CCare clients.

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

Family Planning Services – The scope of family planning services is outlined in sections (6) Clinical and Preventive Services, and (7) Education and Counseling Services 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. A link to the full set of those rules can be found on the [CCare-Specific Resources](#) page of our website.

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 Centers for Medicare and Medicaid Services (CMS) requires all family planning Medicaid waiver programs (including CCare) to have a primary care referral component that directs clients to primary care services in their state.

CCare providers who do not offer primary care in their clinics must provide clients with written information about how to access primary care services at least once a year, preferably at enrollment and re-enrollment. Those who do offer primary care should inform all CCare clients about the availability of such services. In both cases, the fact that this information was provided must be noted on the CCare Enrollment Form in each client’s file.

[Exhibit C-12](#) is a brochure created to meet this requirement (in English and Spanish). It briefly details what services CCare does 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.

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.

To meet this requirement, the CCare Enrollment Form includes a question asking if the client would like to register to vote (see Sub-Section C.3 for instructions on how to complete the Enrollment Form). If the client answers “No”, that serves as an official declination. If the client answers “Yes”, 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 must follow the procedures described on the [CCare-Specific Resources](#) page of our website for reporting and mailing the completed registration form to the correct agency.

The form necessary for complying with NVRA requirements can be found online:

<http://sos.oregon.gov/elections/Pages/voter-registration-reporting.aspx>.

Notice of Privacy Practices (NOPP) Requirement

As part of HIPAA privacy implementation efforts, the Oregon DHS/OHA Information Security and Privacy Office developed a Notice of Privacy Practices (NOPP) document that must be offered 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>.

To meet this requirement:

- Keep a stack of printed NOPP documents at the check-in desk.
- Offer the NOPP document to every CCare client at each visit.
- 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. The document must just be offered.
- Staff 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 clinic flow. However, CCare clients are the only ones who must be offered the Notice.

Client Eligibility and Enrollment

C.3

CCare Eligibility

Oregonians are eligible for CCare if they meet the following criteria:

- Resident of Oregon
- Reproductive capacity
- Of reproductive capacity (i.e., not sterilized)
- Can provide proof of ID
- Can provide Social Security Number (unless age 19 or younger)
- Can prove U.S. citizenship or eligible immigrant status*
 - *Clients 19 or older who are lawful permanent residents (LPRs) must have held LPR status for 5 or more years
- At or below 250% of the federal poverty level (FPL) based on income and household size. All clients are determined eligible based on individual income.

Eligibility and enrollment must be documented on the CCare Enrollment Form, as part of the client's medical record, and in the CCare Eligibility Database.

Once eligibility criteria have been verified, 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;
- As necessary, offer clients assistance with documenting their U.S. citizenship or eligible immigration status; and
- Enter the Enrollment Form information into the CCare Eligibility Database for final determination by the system.

CCare Enrollment Form

The CCare Enrollment Form ensures accurate documentation, eases review processes, and provides the Centers for Medicare and Medicaid Services (CMS) assurance that appropriate program eligibility screening is being performed.

The form must be completed by every client requesting CCare-covered services prior to receiving CCare services, and a new form must be completed each year thereafter. All boxes must be completed, even if the answer is “0” or “N/A”. No eligibility card will be issued to the client.

During an audit, the clinic must be able to produce this form (either the original paper version or a scanned electronic version) as documentation of eligibility screening and requests for special confidentiality.

The Enrollment Form data must be entered into the online CCare Eligibility Database. For instructions on using the database, see [Exhibit C-1](#).

The CCare Enrollment Form is located in Exhibit C-2 in both [English](#) and [Spanish](#). Below are instructions for completing the Enrollment Form. Note that the standardized form may not be altered by individual agencies. However, the back of the form may be printed 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: Legal Last Name(s)/Surnames, First Name, Middle Initial

This client information is vital for clinic records and must be complete, accurate, and legible.

2: Oregon Address, City, Zip

Clients must provide a residential address located in Oregon. If the client is a college student, they may provide their college address. If the client is homeless, enter the clinic address where they are seeking services.

3: Date of Birth, and U.S. Citizen or Eligible Immigrant Status?

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

Citizenship or Eligible Immigration Status: The federal Deficit Reduction Act (DRA) of 2005 requires all CCare applicants to provide proof of U.S. citizenship or eligible immigration status prior to enrolling in CCare. Please see [Exhibit C-3](#) for examples of acceptable documents, [Exhibit C-4](#) for an overview of various eligible immigration status types, and page C4-1 for state and local resources to assist clients in verifying citizenship status or eligible immigration status.

Clients must check only one box indicating their status.

Note: Clients who are eligible for Citizen/Alien-Waived Emergency Medical (CAWEM) coverage through OHP do **not** qualify for CCare. Title X clinics should use grant resources for clients who do not meet the citizenship/eligible immigration requirement of CCare.

4: Social Security Number (SSN)

Valid social security numbers are required for all CCare clients. 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, leave this field blank when entering information into the CCare eligibility database and check the box *Teen client (≤ 19) cannot provide SSN*. This will allow the teen to enroll while state staff and/or the applicant work to determine their SSN.

Be sure to give every client (new and renewing) a copy of the SSN statement. English and Spanish versions of this statement can be found in [Exhibit C-11](#).

5: 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.

6: Do you have OHP?

Those with the Oregon Health Plan coverage **do not** qualify for CCare.

7: Do you have private health insurance?

Clients who have private insurance may still qualify for CCare. CCare is a Medicaid program and should be the payer of last resort. If a client has private health insurance, bill their insurance first (unless they have confidentiality concerns, see below). CCare will pay the difference not covered by insurance up to the maximum amount CCare would have paid in the absence of insurance.

8: If you have private health insurance, are you worried your partner, spouse or parent will find out about the services you get today? (Special Confidentiality)

If a client is concerned that they may suffer physical or emotional harm if information about their visit is inadvertently disclosed to parents, partners, or the primary insurance policy holder, they should check yes. Then, CCare should be billed INSTEAD OF private health insurance.

Note: When a client with private health insurance requests special confidentiality, be sure to enter the third party resource (TPR) code **NC** in CVR box 17A for every visit.

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 in the CCare Eligibility Database indicating if the client requests special confidentiality or not.

9: Household Size based on Tax Filings

This information is used to assess whether the applicant meets the financial eligibility requirements for CCare. An accurate answer requires that both the applicant and staff understand precisely what constitutes a household for the purposes of CCare.

The household size is based on the client's tax filing status. To help the client determine their household size use the flowchart in [Exhibit C-9](#).

Determining Household Size

For the purposes of CCare eligibility, household size is based on tax filings. Anyone included in the same tax filing as the client is counted. If the client filed their own taxes, all persons included in their tax filing are counted in the household size. If the client did not file their own taxes and someone else claimed them, all persons included in the same tax filing as the client are counted. If the client did not file taxes and was not included on anyone else's, their household size is one.

- Client filed their own taxes:
Household Size = the client + anyone they included in their taxes
- Client did not file their own taxes, but was claimed on another person's taxes:
Household Size = the client + anyone else included on the same tax filings.
- Client did not file their own taxes and was not claimed on anyone else's:
Household size = the client

Foster children or other unrelated children included in the tax filing are not counted in the household size; and payments received for caring or foster children are not considered income.

10: GROSS Income

This information is also used to assess whether the applicant meets the financial eligibility requirements for CCare. An accurate answer requires that both the applicant and staff understand what is included and not included in income. Only the client's income is counted.

Make every attempt to get an actual or estimated figure. Note, however, that clients are not required to provide proof of income for CCare eligibility.

Income from Jobs

- 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 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 knows only the amount of net income (take-home pay), calculate gross income by multiplying net income by 1.15.
- If the applicant is self-employed, include their net income.

Other Income

- If the applicant is currently unemployed, count any unemployment benefits currently received. Do not count employment income from previous months.
- Count any tips, worker’s compensation, or alimony.

These sources of income should be included	These sources of income should NOT be included
<ul style="list-style-type: none"> • Salaries, wages, tips • Net earnings from self-employment • Public assistance* • Unemployment compensation • Alimony • Net investment income (rent, interest, dividends) • Pensions, annuities • Royalties and commissions • Business profits • Deductions commonly taken out of income before the client receive it. These include: <ul style="list-style-type: none"> ○ Federal, state and local taxes ○ Social Security payments ○ Deductions for savings bonds, other savings plans, or union dues 	<ul style="list-style-type: none"> • Grants • Loans • Withdrawal from savings • Food stamps • Tax refunds • Receipts from sale of possessions • Inheritances • Lump sum compensation for injury or legal damages • Maturity payments on insurance policies • Payments for foster parenting <p><i>*Note: A client who is receiving cash assistance through TANF is likely to have OHP coverage and would not qualify for CCare. Before enrolling into CCare, verify OHP coverage. See page A5-4 for OHP contact information.</i></p>

See [Exhibit B-4](#) or [Appendix F](#) for the Federal Poverty Level Guidelines to determine CCare income eligibility.

Income Verification

State CCare staff verify clients’ income using a secure electronic process with the Oregon Employment Department (OED). Wage information from the OED is available on a quarterly basis and is pulled from the quarter the client enrolled in CCare. The quarterly wage is then calculated into a monthly average.

Clients whose average monthly income is above the eligibility guidelines for their stated household size are suspended for 45 days, at which point their eligibility is terminated unless the discrepancy has been resolved.

- **Suspension:** When a client’s eligibility has been suspended, state CCare staff can reinstate their eligibility, at which point the client can receive CCare services again.
- **Termination:** When a client’s eligibility has been terminated, the client must complete a new CCare enrollment form (including updated self-declared income) to receive CCare services. Clients whose eligibility has been terminated will remain in the CCare Eligibility Database so they can re-enroll.

If a client’s eligibility has been suspended or terminated the CCare Eligibility Database display a message. Additionally, clients whose eligibility is suspended (according to the schedule below) will be listed in the CCare Eligibility Status Update spreadsheet that is sent to designated CCare Eligibility Database users via email.

CCare Client Income Verification Schedule	
Client Enrolled During:	Income Will be Checked In:
Jan. 1 – Mar. 31 (Q1)	May
Apr. 1 – Jun. 30 (Q2)	August
Jul. 1 – Sep. 30 (Q3)	November
Oct. 1 – Dec. 31 (Q4)	February

Claims with dates of service before the date of suspension will reimburse. However, claims with dates of service after the suspension date (and before reinstatement, if applicable) or termination date will be denied.

Option to request form in alternate format

Language I speak: _____
Let us know if you need: <input type="checkbox"/> An interpreter <input type="checkbox"/> A sign language interpreter
<input type="checkbox"/> Written materials translated (<i>what language</i>):
<input type="checkbox"/> Materials in: <input type="checkbox"/> Braille <input type="checkbox"/> Large print <input type="checkbox"/> Audio tape <input type="checkbox"/> Computer disk <input type="checkbox"/> Oral presentation

To ensure clients of all abilities are able to enroll in CCare and receive same-day services, try to accommodate clients’ needs using systems already in place at the clinic.

The enrollment form can be provided in alternate formats, however, alternate formats are not immediately available.

11: Do you want to register to vote today?

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 section of the CCare-Specific Resources](#) page of our website.
- 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.

Client 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.

CLINIC STAFF USE ONLY

12: Agency number and Clinic number

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.

13: Offered OHA Notice of Privacy Practices

Clients must be offered a copy of the OHA Notice of Privacy Practices.

14: If requested, provided voter registration card and assistance completing and submitting the form.

If an applicant indicates that they want to register to vote, they must be provided a voter registration card and offered assistance in completing and mailing the card.

15: Explained what services are covered by CCare and discussed payment options for services not covered by CCare.

Clients should be informed of what services CCare does and does not cover. If the client needs services that are not covered by CCare, payment options for these services should be discussed.

16: Provided health insurance enrollment information.

Clinic staff must indicate whether health insurance enrollment information, including Oregon Health Plan (OHP) enrollment, was given to the client. Providing this information is a program requirement.

17: Provided information on where to access primary care services.

Clinic staff must indicate whether information on where to access primary care services was offered to the client. Remember, offering this information once a year is a program requirement. Clinics may customize the primary care information brochure in [Exhibit C-12](#) in order to meet this requirement.

18: U.S. Citizenship

If the client provided proof of their U.S. citizenship, make a copy of the document for their medical record and check the box "Client provided proof of U.S. citizenship."

If the state needs to perform electronic verification, check the box "Electronic verification by the state is required." Make sure to check the box in the CCare Eligibility Database to indicate that the client is using the Reasonable Opportunity Period.

If the applicant is already listed in the CCare Eligibility Database with their U.S. citizenship already verified, check the box "Client provided proof of U.S. citizenship."

19: Eligible Immigration Status

If the client provided proof of their eligible immigration status, make a copy of the document for their medical record and check the box “Client provided proof of eligible immigration status.”

If the state needs to perform electronic verification, check the box “Electronic verification by the state is required.” Then provide the immigration document information when the client provides it. This information is needed to perform electronic verification. Additionally, make sure to check the box in the CCare Eligibility Database to indicate that the client is using the Reasonable Opportunity Period.

If the applicant is already listed in the CCare Eligibility Database with their eligible immigration status already verified, check the box “Client provided proof of eligible immigration status.”

20: Identity

Applicants must provide proof of identity to qualify for CCare services. If they provided proof of their identity (including some documents that also provide proof of citizenship or immigration status), make a copy of the documentation for their medical record and check the box “Client provided proof of identity.”

If the applicant did not provide proof, they must return with proof during their initial 45-day Reasonable Opportunity Period. If the applicant provides proof of identity after the ROP has expired, the applicant must complete a new enrollment form.

21: Client’s income

Document where the client’s income falls according to the federal poverty guidelines. The client may need services that are not covered by CCare, in which case sliding fee scale guidelines may be applied.

22: Staff Name, Date, and Client’s CCare number

Staff name: The name of the staff person who helped the client complete the enrollment form or handled their intake. This helps in case there are questions about the client’s information.

Date: The date the client completed the Enrollment form.

Client’s CCare number: The CCare number is required for reimbursement. This number is automatically generated by the

CCare Eligibility Database when the client's information is first entered into the database.

More Information about Enrollment

- 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 meet one of the following two criteria:
 1. The client has had at least one face-to-face reproductive health visit with an agency clinician in the last two years, or
 2. The client was enrolled in CCare and established on a birth control method at another agency within the last year.

If the client meets the above criteria, click the button *Supply-only Encounter: Established family planning patient within your agency OR Established CCare client at another agency* in the CCare Eligibility Database in order to submit a claim for a supply-only pick-up encounter before submitting a claim for an actual visit.

CCare Eligibility Assistance

C.4

Reasonable Opportunity Period (ROP)

The reasonable opportunity period (ROP) allows clients to receive 45 days of CCare eligibility while they gather the required citizenship or immigration documentation. It may be used in certain circumstances to provide services to individuals who cannot provide full documentation of their U.S. citizenship or eligible immigration status. It may only be used once per client. All other CCare eligibility criteria must still be met.

It does not exempt clients from the SSN requirement.

Clients who use the ROP will not be granted regular, full-year CCare eligibility until their U.S. citizenship or eligible immigration status is fully documented.

For clients with a valid SSN, state staff will attempt to find a citizenship match through the Social Security Administration (SSA) using the client's SSN, name and DOB. Teen clients who cannot provide their SSN will need to complete either the Oregon Birth Information form or an out-of-state birth certificate request form since SSA cannot match without a valid SSN. Clinic staff should assist all clients who cannot provide their SSN and who are using the ROP for citizenship verification in completing the appropriate form. More information about requesting birth certificates on behalf of clients can be found below.

Birth Certificate Requests and SSA Electronic Match

There are four ways in which the state Reproductive Health Program can offer assistance to clients to obtain proof of U.S. citizenship or eligible immigration status:

1. **Oregon Birth Record Request** – The state Reproductive Health Program is able to access the Oregon Vital Records Electronic Birth Record Database for clients born in Oregon. There are two methods for submitting a birth record request for Oregon-born applicants, depending on needs. For detailed instructions, please refer to the CCare Eligibility Database Instructions in [Exhibit C-1](#) and see the CCare Oregon Birth Information Form in [Exhibit C-5](#).
1. **SSA Electronic Citizenship Match** – Every month, state RH staff retrieve the SSNs for all newly enrolled clients and send them to SSA for a match. For teens who don't know their SSN, state staff search state databases in an attempt to find their SSN and, if

found, send them to SSA for a match. However, teens who don't know their SSN should always complete an Oregon birth record form or an out-of-state birth certificate request form.

For clients whose information is sent to SSA and for whom a match is found, the client's citizenship verification will be automatically updated in the CCare Eligibility Database and the client's eligibility will be extended for a full year of coverage.

Clients who are not matched through the SSA electronic match will be listed in an eligibility report spreadsheet that state RH staff send to designated CCare Eligibility Database users each month. Reasons for non-matches include name changes, DOB mismatches, incorrect or invalid SSNs, and clients who indicate on the CCare enrollment form that they are U.S. Citizens but the SSA electronic match indicates are not U.S. Citizens.

Clients who fail the SSA electronic match will need to be contacted by clinic staff to verify their SSN or any possible name changes. Any alternate information should be provided to state RH staff who will resubmit the information to SSA for a match. If no alternate information is available, the client will need to complete an Oregon or 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. Once the ROP period ends, an extension is not possible. If the SSA match indicated the client is not a U.S. Citizen, the client will need to provide a Certificate of Naturalization to verify their citizenship.

- 2. 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 the [CCare-Specific Resources](#) page of our website.
- 3. Electronic Verification of Eligible Immigration Status** – For clients who have eligible immigration status but do not have their documentation at the time of CCare enrollment, the clients may be enrolled using the ROP. During the 45-day ROP, the client must call the clinic to provide the required information from their immigration document (see [Exhibit C-3](#) for a list of immigration document types and what information is required). Clinic staff should enter this information into the client's record in the CCare Eligibility Database and state RH Program staff will search an electronic database to verify the client's status.

To order an out-of-state birth certificate follow the steps below:

- If the client is not yet in the CCare Eligibility Database and will not be using the reasonable opportunity period for a visit that day, screen him/her for eligibility to ensure that they are CCare eligible.
- Determine in which state (or California county) the client was born and go to the state/county's vital records website (links are available on the [CCare-Specific Resources](#) page of our website).
- Check the state/county's requirements for requesting a birth certificate (e.g., copy of ID, age requirements, notarized signature, etc.) and ask the client to complete the state/county-specific birth certificate request form.
- Ask the client to complete the Authorization to Release Birth Certificate form. 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 copy of photo ID. Mail requests to the Reproductive Health Program as needed.
- The Reproductive Health Program will mail all of the requested 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 U.S. Citizenship Status 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 a clinic-specific release of medical information form and place a photocopy of the birth certificate in the client's medical records before releasing the original to the client.

For more detailed instructions on ordering out-of-state birth certificates on behalf of clients, refer to [Exhibit C-6](#).

Billing and Data Collection

C.5

This section contains information on CCare reimbursement; and using the CVR to bill for CCare services.

Data & Billing System History

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.

The Reproductive Health Program has long used the Clinic Visit Record (CVR) to collect client and visit information, and to bill CCare claims. 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. 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 analysis functions available through Ahlers.

CCare Reimbursement

Please see [Exhibit C-14](#) for current CCare reimbursement rates.

Services

CCare services are reimbursed using a single bundled encounter rate. The bundled rate covers services as recommended by national standards of care for a typical reproductive health visit focused on preventing unintended pregnancy and includes a supply-dispensing fee. Therefore, no matter what services are performed within a CCare visit, the reimbursement rate is the same.

The only service not included in the bundled rate is a combined Chlamydia/gonorrhea test, performed within a contraceptive management visit. This is reimbursed separately. Reimbursement is triggered by checking box #29 in the Medical Services section (13A) on the CVR.

The Ahlers Connection

The terms “Ahlers system” and “Ahlers data” 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.

Supplies

Contraceptive supplies dispensed are reimbursed at the clinic's acquisition cost for the supply/method.

Billing Guidelines

The only visits that may be billed to CCare are medically necessary visits with eligible clients for the purposes of preventing unintended pregnancy. In order for a visit to be billable to CCare, two primary requirements must be met:

- (1) The client must be at risk of an unintended pregnancy (i.e., of reproductive capacity, not currently pregnant, and not seeking pregnancy), and
- (2) The visit's primary diagnosis code must be in the Z30 series for contraceptive initiation or management.

Services covered under CCare include: annual exams; 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. See the CCare Standards of Care in Sub-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, or repeat Pap tests. See [Exhibit A-1](#) for what is billable to CCare.

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 and rescreening for STIs are not covered under CCare.

There are no absolute limits on the number of 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 are typically seen less frequently). Agencies are subject to review if providers bill for visits substantially in excess of this average.

Established 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 encounters, and only the cost of supplies may be billed to CCare. Requests for emergency contraception (EC) often fall into this category, especially for returning clients who have already received a 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 and/or the client to obtain the insurance information and document the attempt(s).

Section 17A of the CVR includes information about third party resources. Either Item 1 or Item 2 must be completed if the client has private health insurance. 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](#) 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 payer 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 in Box 39: Clinic use (optional) on the CCare 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 having 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 Z30 family planning diagnosis code. Therefore, if a client has Medicare, make sure to document this in Box 39: Clinic use (optional) on the CCare Enrollment Form and bill CCare for the visit.

Supplies

CCare providers are reimbursed for contraceptive supplies at acquisition cost, up to a maximum allowable amount. See [Exhibit C-14](#) 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 visits with a clinician before billing CCare for a supply-only encounter. There are two exceptions to this rule, the first claim submitted to CCare may be a supply-only encounter when:

- The client has had at least one face-to-face family planning visit with an agency clinician in the last two years, or
- The client was enrolled in CCare and established on a birth control method at another agency within the last year.

In order to bill CCare for a supply-only encounter for a newly enrolled CCare client, 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 C-1](#) for more guidance about the eligibility database.

Using the CVR to bill for CCare services

The CVR is the required (and only) 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. Refer to [Section D](#) for item-by-item instructions on how to complete a CVR and for a blank CVR see Exhibit D-5. Refer to [Exhibit D-6](#) 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 [Exhibit D-7](#) for list of monthly submission deadlines.

Timely Submission

CCare claims are only payable within 12 months of the date of service. 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, 2015 that was sent to Ahlers on May 24, 2016 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 reproductive health services under regular Medicaid (OHP). If a match is found, the CCare claim is rejected and the service should be billed to the client's CCO or FFS 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, [Exhibit D-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 to be corrected, not the entire batch.

Remittances

Following each month's processing, Ahlers & Associates creates two reports: 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 C-15](#) and [Exhibit D-9](#) respectively. Electronic remittance advices, in HIPAA-compliant 835 format, are also available. Please contact Ahlers directly to receive electronic remittances.

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.

CCare Program Integrity Plan

C.6

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 and 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 - Many edits are built into the Ahlers data collection/billing system. A list of edits to the data and billing system is attached. 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" that 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, and/or
- Revenue received by billing third party resources.

Each month the billing register is reviewed to identify any unusual circumstances or findings. 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 is referenced in subsequent billing registers to determine if the identified problem has been resolved.

Additionally, supply billing is monitored against purchasing data and 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 data showing client 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 a regular basis, or the need may be identified through the monthly desk audit.

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 chart audit may be identified by any of the other audit functions described above and is also done a regular rotating monthly 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 30 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

reviewer(s) come to the agency site a dedicated room/office must be available for the process and entrance and exit discussions are required.

Charts are reviewed by the RH Program reviewer(s) and a matrix of findings is developed identifying the results of each chart reviewed. This matrix is provided to the agency for review. (See Appendix F for sample matrix). 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 the visit was appropriately billed to CCare; however, other findings may also be identified. For a visit to qualify as billable to CCare, contraceptive counseling or services must be the primary purpose of the visit and it must be accurately supported/ documented in the chart notes. If a client is of reproductive age (at risk of unintended pregnancy) and is seeking contraception, it doesn't matter what the stated purpose of the method is or if the client identifies as lesbian. See Appendix J for Administrative Rules that define covered and excluded services.

Chart notes which determine that claims were billed in error to be corrected in the Ahlers system using the void/resubmit process in the next claims submission cycle.

Eligibility and Enrollment Form Audit

The CCare Enrollment Form and its citizenship verification components are also reviewed as part of the chart audit. (See CCare Audit Tool) Examples of what reviewers look for include:

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

Enrollment forms are regularly requested and reviewed for completeness and accuracy. Proof of identify and citizenship are included in this review and monitored against the CCare database.

CCare Audits during Regular Title X Review

Agencies receiving Title X funds are reviewed for compliance with Title X program requirements on a triennial basis. Chart reviews are performed as part of the process using the CCare Audit Tool. Reviewers will request a list of ten CCare client charts for review when

reviewing charts for Title X compliance. This review tool is also available for providers to encourage regular self-audit.

Other Request for Information

The state RH program may request specific information on an as-needed basis. For example, contraceptive supply invoices may be requested to verify supply prices being billed to CCare.

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
- Items omitted on the CCare Enrollment Form

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 the chart audit process and documented in the matrix of findings or the CCare review tool.
- A cover letter and notice of overpayment (invoice) is sent.
- Agency has a 10-day period to review the matrix/chart audit findings and to discuss or refute the findings with the auditor.
- Claims that are determined to be billed in error should be corrected using the void and resubmit process in the Ahlers system during the next monthly billing cycle.
- A repayment agreement may be arranged at the discretion of OHA, using a repayment contract signed by both parties.
- If the audited agency is in disagreement with the findings, the contested case hearing procedure is followed (OAR 333-004-0230).

CCare Eligibility Verifications

Income Verification

Individuals enrolling in CCare must have an income at or below 250% of the federal poverty level at the time of enrollment. Clients enrolling in CCare self-declare their income and household size on the enrollment form. Once per quarter, clients' wage information is obtained via a secure electronic process with the Oregon Employment Department, and a monthly average is calculated. Clients whose average monthly income is above the eligibility guidelines for their stated household size will have their eligibility suspended. Clients whose eligibility is suspended will be listed in the CCare Eligibility Status Update spreadsheet that is sent via email to RH Coordinators, billers, and CCare eligibility database users.

Clients whose eligibility has been suspended will have their eligibility terminated after 45 days of suspension unless the discrepancy has been resolved. When a client's eligibility has been suspended following the income check, clinic staff contact the client and have a verbal conversation to confirm their income information. If the client has a reasonable explanation for the discrepancy, clinic staff contact state CCare staff to have the client's eligibility reinstated. It is not necessary to ask the client for pay stubs or other paper documentation.

SSN Verification

On the first day of each month, state CCare staff generate a list of clients enrolled or re-enrolled in CCare during the prior month. State staff will send this file to the Social Security Administration (SSA) for SSN verification. SSA returns a results file and every client's SSN is matched, unmatched or corrected. For unmatched clients, CCare staff will attempt to manually verify or correct SSNs using State databases.

Based on the results of the SSA match and the manual verification, two files will be uploaded to the CCare Eligibility Database:

1. A list of clients for whom corrected SSNs were identified, and
2. A list of clients for whom SSNs could not be verified, and for whom CCare eligibility is being suspended.

These lists will then be emailed to all clinics in an Excel spreadsheet once per month. The lists will be sorted by project and clinic number for easier identification. No client names or SSNs will be included on the spreadsheet. Clients whose eligibility has been suspended will have their eligibility terminated after 45 days of suspension unless the SSN

has been corrected or an alternate explanation (such as a name change) has been provided.

Citizenship Verification

State CCare staff use two processes to verify citizenship electronically for clients who do not have their own citizenship documentation. These processes include the electronic citizenship match with SSA and the Oregon birth records match.

The electronic citizenship match with SSA occurs with the SSN verification process described above. For clients whose SSN is verified, the file from SSA will indicate the client's citizenship status (US citizen or non-citizen). For clients whose SSN is not verified, state staff will attempt to manually verify or correct SSNs using the process described above, and any corrected information will be resubmitted to SSA in order to obtain the citizenship status information.

Based on the results of the SSA match and the manual verification, a list of clients whose citizenship has been confirmed by SSA will be uploaded to the CCare eligibility database. Any clients who declared US citizenship on their CCare enrollment form and whose citizenship has not been confirmed and who do not have their own citizenship documentation will be listed in the CCare Eligibility Status Update spreadsheet that is sent via email once per month. For these clients, their eligibility will not continue past the initial 45-day Reasonable Opportunity Period unless they provide their own documentation and/or other information that state CCare staff can use to verify citizenship electronically.

The second method of verifying citizenship is applicable to CCare enrollees born in Oregon. State CCare staff have access to an Oregon vital records database and clients may request an electronic vital records search by completing the Oregon Birth Information Form. Clinic staff enter the information provided by the client into the CCare eligibility database and twice a month, state CCare staff download all requested matches and conduct a search. All matches will be uploaded to the CCare eligibility database. State CCare staff will notify clinic staff of the results of these matches in a bimonthly CCare Oregon birth records update email.

Eligible Immigration Status Verification

Clients who have eligible immigration status can have their status verified by providing appropriate documentation (see Exhibit XXX for immigration status types and corresponding documents) at the time of

CCare enrollment. Clients who do not have documentation with them at the time of enrollment may use the Reasonable Opportunity Period (ROP) and may call the clinic during the 45-day ROP period to provide immigration document information (see Exhibit XXX for which information is required for each document type). Clinic staff will enter this information in the client's record in the CCare Eligibility Database. If the 45-day ROP has expired, clinic staff can request an extension from RH Program staff if the client is providing additional information. State RH Program staff will check the provided information against a federal immigration database to verify the client's status. Clients whose immigration status is confirmed will have their records updated in the CCare Eligibility Database. All clients who have requested electronic verification of immigration status will be listed in the monthly CCare Eligibility Status Update spreadsheet along with the results of that verification check.

Section C: Exhibits

[Exhibit C-1: CCare Eligibility Database Instructions](#)

Exhibit C-2: CCare Enrollment Form ([English](#) and [Spanish](#))

[Exhibit C-3: U.S. Citizenship, Eligible Immigration Status, and Identity Documentation for CCare Enrollment](#)

[Exhibit C-4: Overview of Immigration Categories & Documents](#)

[Exhibit C-5: CCare Oregon Birth Information Form](#)

[Exhibit C-6: Requesting Out-of-State Birth Certificate Instructions and Flowchart](#)

[Exhibit C-7: Authorization to Release Form](#)

[Exhibit C-8: Affidavit/Statement of Identity](#)

[Exhibit C-9: Household Size Flowchart](#)

[Exhibit C-10: CCare Income Verification FAQs](#)

[Exhibit C-11: Social Security Statement \(English and Spanish\)](#)

[Exhibit C-12: CCare Primary Care Referral Brochure \(English and Spanish\)](#)
(Word download)

[Exhibit C-13: Clinical Reimbursements for CCare Billable Visits](#)

[Exhibit C-14: CCare Reimbursement Rates for Visits and Supplies](#)

[Exhibit C-15: Sample Billing Register/Remittance Advice](#)

[Exhibit C-16: CCare Chart Review Tool](#) (Word download)



Oregon
Health
Authority

Reproductive Health Program Manual
January 2016

Section D

CVR Manual for
Title X and CCare

Center for Prevention and Health Promotion
Oregon Health Authority – Public Health

Overview

D.1

This manual is designed to help inform and assist those who use the Client Visit Record (CVR) to collect data for the state of Oregon and/or bill Oregon's reproductive health Medicaid waiver, Oregon ContraceptiveCare (CCare).

The Purpose of the CVR: Data Collection & Billing

The Oregon Clinic Visit Record (CVR) serves to both collect data required by federal funders and to bill CCare.

The data collected by the CVR serves to prove the importance of both Title X and CCare to federal and state officials. Oregon's CVR is an important source of data for:

- Describing reproductive health clients who receive services in Oregon;
- Constructing financial and internal reports;
- Planning the allocation of resources;
- Measuring outcomes;
- Analyzing clinic effectiveness and efficiency; and
- Providing data to the Region X Office of Family Planning, the Centers for Medicare and Medicaid Services (CMS), the Oregon Health Authority Public Health Division, and delegate agencies.

The current CVR is located in [Exhibit D-5](#).

CVR Revisions

Occasionally, changes need to be made to the Oregon CVR. Updates relating to Title X are based on changing data requirements by OPA. All changes are vetted by members of the Reproductive Health Program Advisory Committee. Oregon Reproductive Health Program staff make final decisions about the CVR in consultation with the contractor for CVR data processing and billing, Ahlers and Associates (Ahlers).

When changes are made, a software patch is provided to agencies using the Ahlers billing software system. Revised paper CVRs are also provided by Ahlers to those agencies that use them.

Terminology

Ahlers uses the terminology *project* and *service site*, or *site*, to mean *agency* and *clinic* respectively. To use a CVR, each agency must be assigned a project number and each clinic a service site number. Please note that these terms are used interchangeably throughout this manual. To request a service site number see [Exhibit D-1](#).

CVR FAQs

D.2

Q. What exactly is the CVR? And how is CVR data collected?

The Oregon CVR (Clinic Visit Record) is a specialized data collection tool for reporting required reproductive health visit information and for billing CCare.

A variety of methods and software can be used to collect CVR data. In most clinics, the CVR is incorporated as a section of a computerized billing/client information system. Agencies may use the software developed by the data processor, Ahlers and Associates (Ahlers), or any number of other billing and/or client information software packages. A few clinics continue to use a paper CVR.

No matter what format is used, all data fields are identical, and the same definitions and guidelines apply. Sub-Section D.3 describes how to complete a CVR.

Q. When and for whom do I submit a CVR?

Clinics that receive Title X funding are expected to submit a CVR for every reproductive health client visit (except a **non-CCare** supply-only pick-up encounter), regardless of the source of pay. CCare providers must submit a CVR to receive reimbursement.

A CVR is required for the following types of visits and services:

- All initial, annual, and other medical visits for clients who are receiving reproductive health medical and/or counseling services and for whom a client record is established and updated for each visit.
 - This applies to both female and male clients, and to clients who are using abstinence or sterilization as their contraceptive method.
- Pregnancy test visits where testing and professional counseling services related to pregnancy test results are provided and recorded on the client record (applicable to Title X only).
- Vasectomy visits that include professional counseling services and the establishment of a client record.
- Vasectomy medical services provided by a provider or a contracted referral provider.
- Counseling-only visits where the information is placed in the client record.

- Emergency contraceptive visits that include the establishment or update of a client record.
- Supply-only pick-up encounters in which an established client receives refills of their contraceptive method without needing other services (applicable to CCare only).

Q. What happens to the CVR data?

CVR data are collected at each registered clinic site in the agency and then transmitted via mail (paper CVRs) or electronically through a HIPAA-compliant website to Ahlers. The information is scanned for errors, tallied, and parsed into usable form in tabular reports. CVR data are reported by project/agency (all clinic sites at the agency included) and by each individual clinic site.

Q. How does information from the CVR help me?

Ahlers provides a wealth of statistical data broken down by date of service: quarterly, calendar year (January – December), fiscal year (July – June), FPAR (December 1 – November 30 of the following year), and special request. These reports are provided at no additional charge.

Q. How can I obtain reports from Ahlers?

We strongly encourage using the on-line reports section of the Ahlers website at www.ahlerssoftware.com. A user ID and password are required. Staff at agencies with fewer than 10 clinics should use [Exhibit D-2a](#) for a login and password application for the Ahlers system, while staff at agencies with more than 10 clinics should use [Exhibit D-2b](#).

Once in the secure portion of the website, clinics/agencies may access and print data for the last three years as standard reports (under the View Reports option) or as custom tables (using the Build a Report function). Sample reports are also included as [Exhibit D-3](#). Raw, visit-level data can be downloaded and manipulated. [Exhibit D-4](#) describes the steps to access data.

Agencies and clinics that need access to paper versions of reports should contact Ahlers.

Q. We use Ahlers' WINCVR software. Is it the same as the paper CVR?

Yes. Ahlers built their WINCVR system around a modular client information system geared specifically toward public health,

particularly reproductive health. The Title X and CCare CVR components are integrated into this system.

Q. We use third-party billing software. How will it capture CVR information?

Most CVR components are common to client registration systems (super bills) and most standard billing software. Oregon may collect a few items that are not included in the third-party system, such as data on referrals or counseling. To capture the required CVR data correctly, add these elements to the software. To transmit the data, use the standard file format included as [Exhibit D-6](#).

Q. What are the deadlines for transmitting data to Ahlers?

Because the CVR is used for both billing and data collection, there are two data submission deadlines:

1. **Claims Payment:** CCare reimbursements are generated monthly. In order to receive a timely payment, CVR data must be submitted no later than the **Thursday before the 15th of the month** (see [Exhibit D-7](#) for current deadlines). These data typically consist of CVRs from the previous month, but may include CVRs with dates of service up to the deadline date or as old as one year.
2. **Report Generation:** CVR data should be submitted by the processing deadline for each month to ensure that Ahlers reports are accurate and comprehensive.

Month	Report
February:	Annual Report
April:	Quarter 1 Report
July:	Quarter 2 Report
August:	Fiscal Year Report
October:	Quarter 3 Report
December:	FPAR Report
January:	Quarter 4 Report

Q. How do we know our data are really reaching Ahlers? Can we run a test batch?

Yes. In fact, any time the CVR is upgraded or revised, or an agency changes their EHR or data system, it's advisable to transmit a

monitored test batch of data. This should be done prior to the cutoff for monthly data to resolve any problems. Ahlers should also be provided with an email address for a contact in the agency. Upon request, Ahlers will send tallies of the number of records received after an electronic transmission. An Ahlers employee can help with the process and help look for data anomalies and incomplete files. See the contact information for Ahlers on the last page of the CCare Eligibility Database Instructions ([Exhibit C-1](#)).

Q. How do we resubmit a CVR that has been rejected?

Data errors and billing errors can cause CVRs to be rejected. Along with the monthly billing register, agencies receive a CVR Error Report (See [Exhibit D-9](#) for a sample report) that shows CVR rejections and an explanation for each rejection.

Rejected CVRs can be corrected and resubmitted with the next month's batch of CVRs. In some cases, missing information will need to be provided and in others, billing errors will need to be corrected. See [Exhibit D-8](#) for more information on CVR error messages.

Q. How does HIPAA affect the Family Planning Information System?

HIPAA, the Health Insurance Portability and Accountability Act of 1996, requires that all information transferred via the Internet be encrypted to protect client privacy.

HIPAA information is available on many websites. One of the more comprehensive is:

<http://www.hipaa.com> - covers many aspects of the law and its implementation.

For more information, visit www.ahlerssoftware.com and click on HIPAA.

submit a clinic/site number request form ([Exhibit D-1](#)) to the RH Program.

Section 2: Client Number

2. CLIENT NUMBER									
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The client number is an agency-specific identifier used in conjunction with the date of birth field to ensure that the correct data are matched to the client. It can be found in the client's medical records or other client information files.

Like the Service Site Number, all nine boxes must be filled in. If the client number is fewer than nine digits, use leading zeroes. For example, client number **1122** should be entered as **000001122**. (Ahlers WINCVR automatically fills in leading zeroes.)

Assigning Client Numbers

The client number is an agency-specific identifier used in conjunction with the date of birth field to ensure that the correct data are matched to the client. Each agency may follow its own procedures for assigning numbers, as long as the numbers meet the following requirements:

- There are no duplicate numbers:
 - No two clients within a service site (clinic) may have the same number.
 - No two clients within a project (agency) may have the same number.
- The client number must not contain alphabetic or non-numeric characters.
- The client number cannot be longer than nine digits.
- Projects with multiple clinic sites may want to use prefixes to better identify clients from each site. This will also help to avoid duplicates.

Example:

- Site A assigns numbers with a 1 prefix: 100000789.
- Site B assigns numbers with a 2 prefix: 200000789.

If a client has been inactive in the system for 36 months or more, Ahlers will discontinue that client number. If the client returns to the system, that old number can be reactivated, or a new one assigned. Do not assign a previously used number to a different client.

Section 3: Date of Visit

3. DATE OF VISIT	MO.	DAY	YR.		
			2	0	

Enter the actual **date on which the client received medical and/or counseling services**, not the date the information is entered. Be sure to use the actual visit date, even if the CVR is completed at a later time.

Enter the date in month/day/year format (mm/dd/yyyy). Convert month and day to two-digit numbers:

January	01	July	07
February	02	August	08
March	03	September	09
April	04	October	10
May	05	November	11
June	06	December	12

For example: if the visit happened on July 9, 2012, enter the date as 07/09/2012.

Only one CVR can be submitted for a client per day. If a client makes more than one visit on the same day, code all services provided on that day on a single CVR. Under Purpose of Visit (Section 12), enter the code number for the most inclusive exam.

Section 4: Date of Birth

4. DATE OF BIRTH	MO.	DAY	YR.		

The date of birth is the month, day, and year the client was born. Record as much of this information as the client is able to give. If the birth year is unknown, ask the client, "How old are you?" and calculate the year. If the birth month is unknown, use July 15, a default date used by the processor for unknown data.

Enter the date in month/day/year format (mm/dd/yyyy), using the same two-digit code as in date of visit.

For example: If the client's date of birth is June 3, 1988, enter the date as 06/03/1988.

A **control field** is a piece of information that the computer uses to detect errors. **Date of birth** is a control field on all CVR submissions.

A client can have only one date of birth.

For Ahlers' WINCVR software, always record the same birth date as on the CVR for the client's first visit. Otherwise, the CVR will be rejected.

Clients sometime give different dates at different times, so check the actual records.

Section 5: Sex

5. SEX 1 - Female 2 - Male

This section refers to the client's **biological sex** assigned at birth. If sex is not indicated on the client's medical record, try asking a clarifying question, such as "What sex were you at birth?" **Do not make assumptions or rely on observations.**

Section 6: Ethnicity

6. ETHNICITY 6 - Hispanic or Latino 9 - Not Hispanic or Latino

One box **must** be checked, but only one box: Hispanic or Latino; OR Not-Hispanic or Latino.

If ethnicity is not included on the client's medical record, try asking a clarifying question, such as "Do you consider yourself Hispanic or Non-Hispanic?" **Do not make assumptions or rely on observation to complete this box;** neither are reliable means of ascertaining ethnicity.

Hispanic origin or descent include:

1. Mexican-American = Mexicana(o)-Americana(o)
2. Puerto Rican = Puerto Riqueña(o)
3. Cuban = Cubana(o)
4. Central or South American = Centro o Sudamericana(o)
5. Other Spanish Speaking = Otra Categoria Español

Section 6a: Race

6a. RACE (Mark All That Apply) 5 - Asian 6 - Other
 1 - White 3 - American Indian 7 - Unknown/Not Reported
 2 - Black/Afr. Amer. 4 - Alaska Native 8 - Native Hawaiian/Pac. Isl.

Check all that apply.

Many people assume that Hispanic or Latino is a racial category; however, our funders categorize Hispanic or Latino as ethnicity and consider race to be a separate category. Funders need to know if Hispanic/Latino clients also identify as White, African American, etc. This data is important to collect because it allows us to provide the most effective and appropriate healthcare services and to better understand the health behaviors/practices of our clients. Please work with clients, particularly those of Hispanic ethnicity, to explain why we need information about ethnicity and race and to help clients identify a racial category that best describes them.

If race is not indicated on the client’s medical record, try asking a clarifying question, such as “What race or races do you identify with?” Again, **do not rely on assumptions or observation**; neither are reliable means of ascertaining race. If the client doesn’t know or chooses not to answer, check box **7 – Unknown/Not reported**.

Section 7: Additional Demographic

7. ADDITIONAL DEMOGRAPHIC (Check if Applicable) <input type="checkbox"/> 5 - Limited English Proficiency

Limited English Proficiency describes a client who has a limited ability to read, speak, or understand English and may need assistance to optimize her or his use of reproductive health services. Check this box if the staff must speak in the client’s native language or if a third person or interpreter service is used to communicate with staff/client.

Section 7A: Client’s Previous Test Dates

7a. CLIENT’S PREVIOUS TEST DATES - Females Only				MO.	YR.
1 - Chlamydia (age ≤ 24)	<input type="checkbox"/> 1 Never	<input type="checkbox"/> 2 Unk	3 Date		
2 - Pap (age ≥ 21)	<input type="checkbox"/> 1 Never	<input type="checkbox"/> 2 Unk	3 Date	MO.	YR.

This section is intended to capture female clients’ most recent test dates (month and year) **prior to today’s visit**, as used in clinical decision-making. Test dates may be self-reported by the client or populated from client medical records, when available.

- Check **1 Never** if the client has never had one of these tests
- Check **2 Unknown** if test dates are unknown or unavailable
- For **3 Date**, only enter Chlamydia test dates for female clients age 24 years and younger, and Pap test (cervical cytology) dates for female clients age 21 years and older. If test dates are entered for clients outside these age ranges, Ahlers will clear out the dates upon receipt of the CVR data.

Section 8: Zip Code

8. ZIP CODE						
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Enter the zip code provided by the client. This item is important for documenting the location of the client’s residence. If the client is homeless, use the zip code of the clinic providing service, or that of the address where the client receives mail.

Section 9: Assigned Source of Payment

9. ASSIGNED SOURCE OF PAYMENT (Check one)		
<input type="checkbox"/> 01 - No Charge	<input type="checkbox"/> 04 - Private Insurance	<input type="checkbox"/> 07 - Other
<input type="checkbox"/> 02 - Title XIX (OHP)	<input type="checkbox"/> 05 - Full Fee	<input type="checkbox"/> 10 - Non-CCare Visit/ CCare Supply*
<input type="checkbox"/> 08 - CCare*	<input type="checkbox"/> 06 - Partial Fee	<input type="checkbox"/> 11 - OVP
<input type="checkbox"/> 03 - WA Take Charge	*Complete top section and 17 for CCare	

Document how the agency expects to be paid for the services provided during the visit. This number-by-number guide will help determine which **single box** to check.

01 - No Charge: Client does not qualify for third-party billing (Medicaid or insurance) and is below 100% of the Federal Poverty Level (FPL) based on income/family size assessment.

02 - Title XIX (OHP): Client is currently enrolled in the Oregon Health Plan and the visit is billable to OHP.

03 – WA Take Charge: Client has Take Charge coverage (Washington State’s family planning Medicaid waiver program) and the clinic is a Take Charge provider. Take Charge will be billed for the visit.

04 - Private Insurance: Client has private insurance and today’s visit will be billed to that company. Check this box even when the billing outcome is unknown.

05 - Full Fee: Client does not have insurance or Medicaid coverage that will pay for the visit, is over 250% of the poverty level based on income/family size assessment, and will be charged the full fee for the visit. The client may not pay for all/any of the fee on the date of visit.

06 - Partial Fee: Client does not have Medicaid or private insurance for the visit and is between 100% and 250% of poverty level based on income/family size assessment. The client will be charged a partial fee and may not pay all or any of the fee on the date of visit.

07 - Other: Check this box when other, non-specified third-party payers are charged. These may include special federal or state funds for American Indians or male services.

08 - CCare: Client is eligible for CCare, visit is to prevent unintended

Section 9 records how the agency **expects** to be paid. It may not be the method that eventually covers the invoice. If **any** payment from CCare is expected, be sure to check either 08 or 10. If payment is expected from a combination of resources (e.g., partial fee and private insurance), check the resource that is expected to cover the largest portion of the invoice.

Donations are not a source of payment.

They are not to be reported on the CVR.

pregnancies and CCare is being billed.

10 - Non-CCare Billable Visit/CCare Supply: Client is CCare eligible, has a visit that is not for contraceptive management, but also receives contraceptive supplies. Although, the visit is not billable to CCare, the contraceptive supplies may be.

For example, a CCare eligible client comes in for an STI check and requests a refill of her oral contraceptives at the same visit. This is not considered a contraceptive management visit and therefore does not qualify for CCare reimbursement. However, this box **can** be checked to bill CCare only for the contraceptive supplies dispensed at the visit.

11 - OVP: Client is being seen for a vasectomy counseling or procedure visit under the Oregon Vasectomy Project (OVP). To receive payment for these visits, the appropriate medical services (box 20 - Sterilization Procedure in Section 13A) and/or counseling service (box 03 - Sterilization in Section 14A) must be checked. This box should also be marked with box 8 - Vasectomy Referral in Section 12 AND box 18 - Vasectomy Referral Fee in Section 13A when billing OVP for administrative and/or referral work for a client receiving vasectomy services from a sub- or state-contracted vasectomy provider. See Exhibits [D-10](#) and [D-11](#) for instructions on billing OVP and sample CVRs.

Section 9A: Diagnosis Code

9A. DIAGNOSIS CODE (Complete if billing CCare)	Z30.
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This section should be completed only for visits and supplies billed to CCare. Complete it if box 08 – CCare, or 10-Non CCare Visit/CCare Supply in Section 9 is checked. Otherwise, leave it blank.

Enter the ICD-10 diagnosis code that represents the **contraceptive** service provided during the client’s visit. To be reimbursed by CCare, list a Z30 (ICD-10) code. CCare-reimbursable codes are listed in [Exhibit A-1](#).

Use the highest level of specificity within the Z30 series. That means always using five-digit codes where they are available. Assign four-digit codes if there are no five-digit codes; assign three-digit codes if there are no four-digit codes.

Section 9B: Will Insurance Be Billed for This Visit?

9B. WILL INSURANCE BE BILLED FOR THIS VISIT?
(Complete if Question 9 is 8 or 10). 1- No 2- Yes (Complete 17A.)

This section is only for visits billable to CCare. Clients with insurance coverage for contraceptive management services are also eligible for CCare. Per federal Medicaid regulations, insurance should always be billed first, so that Medicaid (CCare) is the payer of last resort.

- Check **1-No**, if:
 - The client has insurance but it will not be billed due to a need for special confidentiality.
 - Remember to enter the TPR code NC in Section 17A, item 1 (also see instructions for Section 9C.)
 - The client does not have insurance.
- Check **2-Yes**, if the client's insurance will be billed for any portion of the visit, and enter the insurance amount in Section 17A, item 2. If the insurance company denies payment, remember to enter the appropriate TPR code in Section 17A, item 1.

Section 9C: Special Confidentiality Needs

9C. SPECIAL CONFIDENTIALITY NEEDS 1-Yes

The special confidentiality option is available to any CCare client who believes she or he would be at risk of physical or emotional harm if a parent/partner or other household member learned the client was seeking reproductive health services. This section is not limited to teens, nor should it be used for every teen client.

Check **1 - Yes** if the client has CCare as a source of pay and indicates that special confidentiality is needed; otherwise, leave blank. If the client requires special confidentiality, be sure to:

- Enter the TPR code NC in Section 17A. This is required and provides documentation of why insurance was not billed, which is necessary for audit purposes.
- Notify outside labs of the client's special confidentiality request (if applicable).
- Ensure the client has also indicated her or his request for special confidentiality on the CCare Enrollment Form (if applicable).

Section 18: Client Insurance Status (Principal Health Insurance Covering Primary Care)

18. CLIENT INSURANCE STATUS (check one) (Principal Health Insurance covering primary care)	
<input type="checkbox"/> 1 - Public Health Insurance	<input type="checkbox"/> 3 - Uninsured
<input type="checkbox"/> 2 - Private Health Insurance	<input type="checkbox"/> 4 - Unknown

Assess whether reproductive health clients have health insurance for “a broad set of primary medical care benefits” (not just reproductive health services). Clients may have more than one kind of coverage so ask them directly about their primary car insurance. Note that the information in Section 9: Assigned Source of Payment is not a reliable indicator of what should go in Section 18.

Complete this section for all clients.

Here are guidelines on which category to check:

1. Check **Public Health Insurance** if the client is currently enrolled in the Oregon Health Plan (OHP) or has Medicare coverage for primary care. CCare should not be counted as public health insurance for this box because it does not cover primary care.
2. Check **Private Health Insurance** if the client has personal or employer-sponsored primary health care insurance, whether or not the insurance pays for reproductive health, contraceptive services, or supplies.
3. Check **Uninsured** if the client has no coverage for primary health care services. This includes clients who may receive primary care services from the Indian Health Service, as that is not considered “insurance.”
4. Check **Unknown** only if no other option is applicable.

Section 10: Income and Household Size

10. INCOME AND HOUSEHOLD SIZE	AMOUNT
a. Monthly Income?	
	NUMBER
b. Household Size?	

Note: Instructions for calculating household size and income for CCare eligibility differ from the instructions below. **If your agency does NOT receive Title X funding, enter the household size and income given by the client on their CCare enrollment form.** (Instructions for calculating household size and income for CCare eligibility purposes can be found in [Section C.](#))

If your agency DOES receive Title X funding, follow the instructions

below for calculating and reporting household size and income.

Ask the client for this information. See below for an explanation of what constitutes a household and how to determine income for the purposes of the CVR.

Start with box 10b - Household Size. Using the definition for *household* (see sidebar), determine how many people are supported by this income. The answer must be at least one. Then compute the monthly income of each person and enter the total amount in whole dollars in **box 10a**. For example, if the income is \$431.41 enter \$431. See page D3-12 for the kinds of income that should be included.

Make every attempt to get an actual or estimated figure from the client. Please note that **clients are not required to provide proof of income for Title X or CCare eligibility.**

What Is Household?

Household is a social unit of one or more persons living together and sharing a source of income. Household members do not need to be married to be counted in income; dependents away at school also are included. The income of all these persons should be counted to calculate the total income of the household. 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

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

Roommates are each considered a family of one.

Helpful Guidelines for Determining Income

If the client works:

- Full-time - base the average gross monthly income on the client's most recent month's income.
- Part-time, on a commission basis, or otherwise has an unsteady income - use the average gross monthly income for the previous 12 months.

Some clients may only know their take-home pay, or net income. To calculate gross income, multiply the net income (take-home pay) by 1.15. Do this for all contributing members of the family.

Teens living at home and college students aged 19 and under who are dependent on family income pose special challenges. CCare defines a teen as someone aged 10–19. Title X defines a teen as a minor, which in Oregon is someone aged 10–18.

- Reporting for teen clients at Title X agencies
 - **Teens are considered as a household-of-one only when confidential services are necessary.** In **box 10b**, enter the number 1; in **box 10a**, enter any personal income derived from allowances or employment.
 - Include the parents' income and the total number of people supported by the parents for teens who consider themselves to be supported by their parents (and do not require confidential services).

What Is *Income*?

The gross average monthly income is all money coming in that contributes to the support of the family. Sources of income that should be included are listed on the following page.

Types of Income

These sources of income should be included	These sources of income should NOT be included
<ul style="list-style-type: none"> • Salaries • Wages • Tips • Help from relatives and non-relatives • Public assistance • Unemployment compensation • Worker’s compensation • Veterans benefits • Sick pay • Social Security cash benefits (such as widow’s benefits and children’s allowances) • Alimony/child support • Net investment income (rent, interest, dividends) • Net earnings from self-employment • Pensions • Annuities • Royalties and commissions • Business profits <p>Include deductions commonly taken out of income before the client receives it. These include:</p> <ul style="list-style-type: none"> • Federal, state and local taxes • Social Security payments • Deductions for savings bonds, other savings plans, or union dues 	<ul style="list-style-type: none"> • Grants • Loans • Withdrawal from savings • Tax refunds • Receipts from sale of possessions • Inheritances • Lump sum compensation for injury or legal damages • Maturity payments on insurance policies • Payments for foster parenting • Dollar amount of Food Stamps

Section 11: Health Insurance Enrollment Assistance

11. HEALTH INS. ENROLLMENT ASSISTANCE <input type="checkbox"/> 1 - Onsite <input type="checkbox"/> 2 - Referral
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Record if health insurance enrollment assistance (not including CCare) was provided to the client.

- Check **1-Onsite** if enrollment assistance was provided by a trained enrollment assister at the agency, regardless of when the assistance is provided (e.g., sent to another program of same agency later that day or soon after the original visit).
- Check **2-Referral** if the client was referred for assistance outside of the agency (even if they are located within the same building as the agency).

Section 12: Purpose of Visit

12. PURPOSE OF VISIT (Check One)	
<input type="checkbox"/> 1 - First Annual Exam	<input type="checkbox"/> 5 - Pregnancy Test Visit
<input type="checkbox"/> 2 - Return Annual Exam	<input type="checkbox"/> 6 - Supply Only-Mailed (CCare Only)
<input type="checkbox"/> 3 - Other Medical	<input type="checkbox"/> 9 - Supply Only Visit (CCare Only)
<input type="checkbox"/> 4 - Counseling Only	<input type="checkbox"/> 8 - Vasectomy Referral (w/OVP SOP)

Record the **primary** reason for the client visit. Check one box only.

1 - First Annual Exam: First comprehensive examination at the agency during which physical exam and lab services are provided as clinically indicated (see Section 13A: Medical Services Provided) and contraceptive counseling and education are given. This examination does not necessarily take place during the client's first visit to the agency.

2 - Return Annual Exam: Subsequent visit (often provided annually) during which the client receives a comprehensive medical examination. Physical exam and lab services should only be provided as clinically indicated during this visit. Other services may also be provided. Return annual exams must occur no sooner than 11 months plus one day after the previous annual exam date. For example, if the first annual exam is 05-10-14, then the return annual exam must be on 04-11-15 or later.

3 - Other Medical: A visit during which one or more medical services are provided for routine contraceptive, sterilization, infertility, or related care. Counseling may be provided along with the services. These services include:

- Contraceptive follow-up, such as hormonal method supply, IUD, contraceptive injection, and diaphragm check.
- Method prescription without complete physical exam and lab services: pill prescription, diaphragm fit, IUD insertion, etc.
- Follow-up to initial or annual medical exam visit because all services were not provided at that time.
- Vasectomy or tubal ligation.
- Infertility consultation only if medical or lab services are provided. If not, check box **4 - Counseling Only**.
- Male physical examination.
- Contraceptive method change related to method complaints: IUD removal, poor diaphragm fit, pill change, etc.
- Exam or service related to contraceptive method complaints: pelvic exam because of abdominal pain, excessive bleeding, fatigue, etc.

- Positive or borderline lab test follow-up: repeat Pap smear, monitoring of blood pressure, repeat gonorrhea culture, etc.
- Post-pregnancy check.
- Sickle cell, blood sugar, or other screening because of high-risk status.
- Gestation check. (Note: Prenatal exams are not included because they are not included in the Title X definition of family planning services).
- Emergency contraception provided, including history and counseling.

4 - Counseling Only: A visit during which the client receives consultation specific to reproductive health, but no medical services are provided. This consultation is recorded in the medical record. For examples of counseling services, see Section 14A: Counseling Education Provided.

5 - Pregnancy Test Visit: The primary purpose for the visit is a pregnancy test and counseling. The visit may consist solely of a urine pregnancy test or the urine test plus a pelvic examination. Counseling may be provided at another visit if preferred.

6 - Supply Only-Mailed (CCare Only): This box should be used only for returning CCare clients who choose to have their refill of their contraceptive method mailed to their address. Use of this option is at the discretion of the client; it cannot be offered as the only way in which to receive supplies. 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.

8 - Vasectomy Referral (w/OVP SOP): This box should be used to indicate administrative and/or referral work for clients receiving vasectomy services through a sub-contracted vasectomy provider. See example CVR in [Exhibit D-11](#).

CCare and Pregnancy Tests

A pregnancy test visit is not billable to CCare. If a pregnancy test was performed as a routine part of providing contraceptive management services, check box 1, 2, or 3 instead of box 5 in Section 12.

To receive reimbursement (for detailed instructions see [Exhibit D-10](#)):

- A new CVR, separate from the CVRs completed for the vasectomy counseling visit or vasectomy procedure, must be completed with a unique date,
- Box 11 – OVP in Section 9: Assigned Source of Payment, must be marked, even if the vasectomy counseling visit or vasectomy procedure are being covered under a different source of payment, and
- Box 18 – Vasectomy Referral Fee in Section 13A: Medical Services must be checked.

9 - Supply Only Visit (CCare Only): This box should be used only for established CCare clients who present for a refill of their contraceptive method (more packs of pills, additional Rings and packs of EC, etc.) and receive no or very brief medical (e.g., vital stats check) or counseling services.

If this is the first visit being billed to CCare, the client must:

- Be an established client at the clinic, having had a face-to-face reproductive health visit with a clinician within the last two years, OR
- Have been enrolled in CCare and established on a birth control method at another CCare agency within the last year. Make sure that this has been indicated in the CCare eligibility database at the time of the visit.

Note that provision of Depo-Provera can be classified under box **3 - Other Medical**, since the Depo injection requires medically trained staff.

Section 13A: Medical Services

13A. **MEDICAL SERVICES** (Check all Applicable)

Exam & Lab Services

<input type="checkbox"/> 02 - Blood Pressure	<input type="checkbox"/> 24 - Urine Dip Strip/Urinalysis
<input type="checkbox"/> 03 - Height/Weight	<input type="checkbox"/> 25 - Pap Test Conventional
<input type="checkbox"/> 04 - Thyroid Exam	<input type="checkbox"/> 26 - Pap Test Liquid-Based
<input type="checkbox"/> 05 - Heart/Lung Auscultation	<input type="checkbox"/> 27 - Colposcopy
<input type="checkbox"/> 06 - Breast Exam	<input type="checkbox"/> 34 - Immunization
<input type="checkbox"/> 07 - Abdominal Exam	<input type="checkbox"/> 42 - Male Genitalia Exam
<input type="checkbox"/> 08 - Extremities	<input type="checkbox"/> 49 - Colo-Rectal Cancer Screening
<input type="checkbox"/> 09 - Bimanual/Speculum Pelvic Exam	<input type="checkbox"/> 36 - Other Lab or Exam
<input type="checkbox"/> 23 - Hgb / Hct	<input type="checkbox"/> 37 - No Lab or Exam

Contraceptive Related Services

<input type="checkbox"/> 17 - Diaphragm / Cap Fit	<input type="checkbox"/> 40 - Hormonal Injection
<input type="checkbox"/> 19 - IUD/IUS Insert	<input type="checkbox"/> 48 - EC-Immediate Need
<input type="checkbox"/> 20 - Sterilization Procedure	<input type="checkbox"/> 46 - EC-Future Need
<input type="checkbox"/> 38 - Hormone Implant In	<input type="checkbox"/> 22 - IUD/IUS Removal
<input type="checkbox"/> 39 - Hormone Implant Out	<input type="checkbox"/> 18 - Vasectomy Referral Fee

Pregnancy Related Services

<input type="checkbox"/> 21 - Post Pregnancy Exam	<input type="checkbox"/> 33 - Positive Pregnancy Test
<input type="checkbox"/> 31 - Serum Pregnancy Test	<input type="checkbox"/> 35 - Infertility Screening
<input type="checkbox"/> 32 - Negative Pregnancy Test	

13A. **CONT. MEDICAL SERVICES** (Check all Applicable)

STD Related Services

<input type="checkbox"/> 11 - Vaginitis/Urethritis/Eval/Dx	<input type="checkbox"/> 16 - Herpes Test
<input type="checkbox"/> 12 - Vaginitis/Urethritis/Eval/Rx	<input type="checkbox"/> 28 - Gonorrhea Test
<input type="checkbox"/> 29 - Chlamydia Test	<input type="checkbox"/> 30 - Wet Mount
<input type="checkbox"/> 13 - Chlamydia Treatment	<input type="checkbox"/> 43 - HIV Test
<input type="checkbox"/> 14 - Chlamydia Presumptive Rx	<input type="checkbox"/> 47 - Syphilis Test
<input type="checkbox"/> 15 - Wart Treatment	<input type="checkbox"/> 50 - HPV Test

Record the examination, laboratory, diagnostic, and treatment procedures provided to a client during the visit. The medical provider should complete this section at the time of service. Alternatively, the information can be transcribed from the client's medical record at the end of the visit.

Medical services should only be performed as clinically indicated by national standards of care.

Check all the boxes that apply.

The list below describes medical services in numerical order. On the CVR, the services are divided into four categories and not listed in numerical order. The categories are: Exam & Lab Services, Contraceptive Related Services, Pregnancy Related Services, and STD Services.

02 -Blood Pressure: Use of a stethoscope and blood pressure cuff to measure the force exerted on the walls of arteries as blood is pumped through them.

03 -Height/Weight: Measurement of client's height and/or weight are recorded.

04 -Thyroid Palpation: Manual and physical examination of the thyroid to evaluate size, shape, symmetry, or tenderness.

05 -Heart Lung Auscultation: Evaluation of heart and lung sounds using a stethoscope.

06 -Breast Exam: Visual inspection and palpation of the female/male breasts to evaluate the symmetry of shape, color, size, surface characteristics, and for masses.

- 07 - Abdominal Palpation:** Visual inspection and palpation of the abdomen to evaluate for abnormalities.
- 08 -Extremities:** Inspection and/or palpation of the arms and legs to evaluate for abnormalities.
- 09 -Bimanual/Speculum Pelvic Exam:** Visual and/or manual examination of the vulva, vagina, cervix, and pelvic organs to detect any abnormalities and collect specimens/samples for laboratory analysis when indicated.
- 11 -Vaginitis/Urethritis/Eval/DX:** Evaluation of the vagina, urethra, and male/female or genital area via palpation, visual inspection, and/or laboratory tests to detect infection.
- 12 -Vaginitis/Urethritis/Eval/Rx:** Treatment of any vaginal/genital or STD infection not specifically identified elsewhere under 13A - Medical Services Provided.
- 13 -Chlamydia Treatment:** Providing treatment for a laboratory diagnosed case of *Chlamydia trachomatis* (CT).
- 14 -Chlamydia Presumptive Treatment:** Prescribing medication to treat CT based on history, e.g., contact with a confirmed case, and/or clinical findings. This may be done without performing a CT test or prior to receiving the results of the test.
- 15 -Wart Treatment:** Treatment of external genital HPV infection with medication or cryotherapy. This may also include giving the client a prescription for self-administered medication.
- 16 -Herpes Test:** Blood tests or cultures of lesions taken to diagnose Herpes Simplex Virus (HSV).
- 17 -Diaphragm/Cervical Cap Fit:** Assessment for proper fit and client instruction on use of diaphragm or cervical cap.
- 18 - Vasectomy Referral Fee:** Administrative and/or referral work for clients receiving vasectomy services through a sub-contracted or state-contracted vasectomy provider. Box 11 – OVP in Section 9: Assigned Source of Payment AND box 8 – Vasectomy Referral (w/OVP SOP) in Section 12: Purpose of Visit must also be checked. The vasectomy referral fee must be indicated on a unique CVR with its own date of service, separate from those of the vasectomy counseling visit and vasectomy procedure, in order to receive reimbursement. See example CVR in [Exhibit D-11](#).
- 19 -IUD/IUS Insert:** Insertion of an intrauterine contraceptive device, or system into the uterus.

- 20 -Sterilization Procedure:** Any procedure on a man or woman intended to provide permanent contraception; e.g., tubal ligation or vasectomy.
- 21 -Post Pregnancy Exam:** Physical assessment of a woman's health status with emphasis on uterine involution, presence or absence of infection, and reproductive health status, following a pregnancy of any gestational age.
- 22 -IUD/IUS Removal:** The intrauterine contraceptive device or system is removed from the uterus.
- 23 -Hgb/Hct:** A measurement of the hemoglobin (Hgb) content or the solids/serum ratio (Hct) of capillary blood as an indirect assessment for anemia.
- 24 -Urine Dip Strip/Urinalysis:** A narrow plastic strip containing chemical reagents that is dipped in a small amount of urine as to provide a quick, point-of-service check for sugar (diabetes), protein (kidney problems and dehydration), and white cells (infection). A urinalysis is a sample of urine submitted to a laboratory for a thorough evaluation with special equipment.
- 25 -Pap Test Conventional:** A sample of cervical cells taken during a speculum exam of the vagina and cervix to detect cervical dysplasia or cancer. The sample is submitted to a clinical laboratory on a dry glass slide.
- 26 -Pap Test Liquid-Based:** A sample of cervical cells taken during a speculum exam of the vagina and cervix to detect cervical dysplasia or cancer. The sample is submitted to a clinical laboratory in a small vial of liquid preservative.
- 27 -Colposcopy:** An examination of the cervix, vagina, or vulva with a special microscope called a colposcope, to detect for abnormal cell changes.
- 28 -Gonorrhea Test:** A laboratory test performed to detect the bacterium *Neisseria gonorrhoeae* (also called GC). Test specimens may be collected from the urethra, vagina, cervix, rectum, and throat. Tests are also commonly performed on urine samples.
- 29 -Chlamydia Test:** A laboratory test performed to diagnose *Chlamydia trachomatis* (also called CT). Endocervical and urethral samples are taken during a pelvic exam. Clients may self-collect samples using vaginal swabs. Tests are commonly performed on urine samples. If checked, and the source of pay is CCare, Ahlers will generate an additional reimbursement rate for a combined GC/CT test.

- 30 -Wet Mount:** A microscopy procedure to detect vaginitis by visually scanning a sample of vaginal discharge on a slide prepared with saline and/or KOH.
- 31 -Serum Pregnancy Test:** A blood test to detect pregnancy soon after conception and before a missed period; useful for assessing suspected ectopic or molar pregnancy when performed in a series. Also called a quantitative pregnancy test.
- 32 -Negative Pregnancy Test:** A negative test either by serum or urine HCG as part of the pregnancy diagnosis.
- 33 -Positive Pregnancy Test:** A positive test either by serum or urine HCG testing as part of a pregnancy diagnosis.
- 34 -Immunization:** Providing vaccinations for a variety of diseases including, but not limited to, hepatitis B, HPV, and rubella.
- 35 -Infertility Screening:** A basic Level 1 screening that includes an initial infertility interview, education, physical exam, counseling, and appropriate referral.
- 36 -Other Lab or Exam:** Medical services provided in conjunction with other reproductive services, and other related services.
- 37 -No Lab or Exam:** No medical or laboratory services were provided. This is a “counseling only” visit.
- 38 -Hormone Implant In:** A surgical procedure to insert a flexible, matchstick-sized rod containing small amounts of a contraceptive hormone.
- 39 -Hormone Implant Out:** A surgical procedure to remove implanted contraceptive hormone rod.
- 40 -Hormonal Injection:** An intramuscular or subcutaneous injection of the contraceptive hormone progestin.
- 42 -Male Genitalia Exam:** Examination of the male external genitalia via visual inspection and palpation to detect any abnormalities.
- 43 -HIV Test:** This may include a point-of-care or “rapid test” or a laboratory test performed by a reference laboratory (“outside” lab) by any means (blood, saliva) to detect the presence of human immunodeficiency virus (HIV) antibodies.
- 46 -EC-Future Need:** Prescription or product given for future use, with instructions to use in the event of unprotected intercourse or birth control failure, e.g., broken condom.
- 47 - Syphilis Test:** Includes any type of point-of-care (“rapid test”) or laboratory test for syphilis, a sexually transmitted infection.

48 -EC-Immediate Need: Emergency contraception (EC) prescribed or provided to be used as soon as possible after unprotected intercourse to prevent pregnancy.

49 -Colo-Rectal Cancer: A fecal sample placed on a card with chemical reagent to screen for blood in the stool.

50 -HPV Test: A laboratory test using genetic viral typing to detect human papilloma virus (HPV) infection.

Section 14A: Assessment/Education/Counseling

14A. ASSESSMENT/EDUCATION/COUNSELING (Check all Applicable)		
<input type="checkbox"/> 01 - Contraceptive	<input type="checkbox"/> 09 - STD/HIV Prevention	<input type="checkbox"/> 18 - Relationship Safety
<input type="checkbox"/> 02 - Fertility Aware Mthd	<input type="checkbox"/> 16 - Abnormal Pap	<input type="checkbox"/> 12 - Phys. Act./ Nutrition
<input type="checkbox"/> 03 - Sterilization	<input type="checkbox"/> 19 - BSE	<input type="checkbox"/> 05 - Tobacco
<input type="checkbox"/> 04 - Infertility	<input type="checkbox"/> 15 - Behavioral Health	<input type="checkbox"/> 06 - Substance Abuse
<input type="checkbox"/> 08 - Preconception	<input type="checkbox"/> 17 - Encourage Parental/ Family Involvement	
<input type="checkbox"/> 13 - Abstinence		
<input type="checkbox"/> 07 - Pregnancy Options		

Record any client-centered counseling that occurred. Check all boxes that apply. Client-centered counseling is a dialogue in which the client and provider make health care decisions **together**, taking into account:

Record All Counseling Sessions

Make sure that all counseling segments provided to a client are recorded on a CVR. All counseling logged on a CVR must also be recorded in the client's medical record.

- (1) The client's preferences, experiences, and values;
- (2) The client's current health related behaviors; and
- (3) The best scientific evidence available.

Client-centered counseling assists the client in clarifying her or his needs and wants, and examines options available. It also reinforces positive behavior. Questions should be open-ended and non-judgmental.

01 - Contraceptive Counseling: Conversation with the client to determine the best contraceptive method for her or his life style. Obstacles (*e.g., varying daily schedule, does not want partner to know, religious beliefs, etc.*), life goals (*e.g., education, work/career, family, etc.*), and preferences/behaviors (*e.g., freedom to be spontaneous, ability to remember a daily pill, visibility of method, etc.*) are identified and taken into account. This could also indicate a brief discussion of all available contraceptive options, or the client's current method.

- 02 -Natural Family Planning/Fertility Awareness Method:** In-depth conversation with the client concerning non-medical or “natural” family planning techniques including using a calendar, mucous ovulation, basal body temperature, CycleBeads, and other related methods of fertility awareness.
- 03 -Sterilization Counseling:** In-depth conversation with the client regarding a permanent birth control method, i.e., tubal ligation or vasectomy.
- 04 -Infertility Counseling:** Conversation with the client or couple concerning their inability to conceive and how to promote fertility.
- 05 -Tobacco Counseling:** Conversation with the client regarding tobacco use, its relationship to birth control and general health, and providing smoking cessation resources.
- 06 -Substance Abuse Counseling:** Conversation with the client concerning substance use, its relationship to birth control and general health, and providing resources to promote cessation.
- 07 -Pregnancy Options Counseling:** Conversation with the client discussing all pregnancy options. Client may decline to discuss any option she does not want to explore.
- 08 -Preconception Counseling:** Conversation with a client who is seeking pregnancy regarding planning a healthy pregnancy and optimizing health.
- 09 -STD/HIV Prevention Counseling:** Conversation with the client concerning sexually transmitted diseases (including HIV) and individualized risk reduction techniques.
- 12 -Phys. Act/Nutr. Counseling:** Conversation with the client regarding habits/behaviors that promote a healthy weight/BMI and may also include a discussion about physical activity and diet.
- 13 -Abstinence Counseling:** Conversation with an adolescent client at their initial visit, and at least annually thereafter, acknowledging that abstinence is the most effective way to prevent pregnancy and reduce risks of STIs. More detailed information may be provided based on client need.
- Abstinence may also be discussed with clients of any age, as indicated.
- 15 -Behavioral Health:** Conversation with the client regarding behavioral/mental health issues..
- 16 -Abnormal Pap:** Conversation with the client regarding an abnormal pap result. Test results, symptoms, possible

implications, need for follow-up and referrals for further testing are discussed.

17 -Encourage Parental/Family Involvement: Conversation with an adolescent client at their initial visit, and at least annually thereafter, assessing the current level of parental/family involvement in the client’s reproductive health decisions, identifying obstacles, providing information on how to communicate with their parents/guardians, and encouraging the client to maintain or improve parental/family involvement.

Conversation with a client of any age assessing the current level of partner/family involvement in the client’s reproductive health decisions and encouraging the client to maintain or improve partner/family involvement.

18 -Relationship Safety: Conversation with an adolescent client at their initial visit, and at least annually thereafter, assessing for intimate partner violence (IPV), sexual coercion, and contraceptive coercion; and, when indicated, providing support and tools on how to resist coercion and promote healthy relationships.

Conversation with a client of any age assessing for IPV, sexual coercion, and contraceptive coercion, and promoting/encouraging healthy relationships.

19 -BSE: Conversation with the client regarding Breast Self- Exam, when clinically indicated.

Section 19A: Pregnancy Intention Screening

19. PREGNANCY INTENTION SCREENING

- 1 - Yes, Near Future 3 - Unsure
 2 - No, Maybe Later 4 - Never

Indicate the client's intentions regarding pregnancy in the near future (e.g. next 6-12 months), regardless of which pregnancy intention screening tool was used.

If pregnancy intention screening was not conducted, this section should be left blank.

Client pregnancy intentions are expected to align with medical and counseling services provided at that visit, for example, if 1-Yes, Near Future is checked, preconception counseling should occur at the visit and be checked in Section 14A. For clients whose stated intentions change during the visit, the final stated intention should be indicated.

Section 13B.14B: Provider of Medical Services/Counseling/Education Services

13B.14B. PROVIDER OF MEDICAL SERVICES/COUNSELING/EDUCATION SERVICES (Mark all that Apply)

- 1 - Physicians
 2 - Physician Assistants, Nurse Practitioners, Certified Nurse Midwives
 3 - RNs, LPNs
 4 - Other service providers, health educators, social workers, clinic aides and lab technicians.

Identify who provided the services recorded in Section 13A and Section 14A.

Check all that apply, based on the following provider categories:

1. Physician: a licensed doctor of medicine (M.D.) or osteopathy (D.O.).
2. Physician Assistants (PA), Nurse Practitioner (NP), or Certified Nurse Midwife (CNM).
3. Registered Nurse (RN) or licensed practical nurse (LPN).
4. Other service providers, health educators, social workers, clinic aides, and lab technicians.

A provider is a trained individual whose primary responsibility is to assess the client's health status and exercise independent judgment regarding which services the client needs.

Section 15A: Primary Contraceptive Method & Section 15B: If None at the End of This Visit, Give Reason

15A. PRIMARY CONTRACEPTIVE METHOD (Complete before and after blocks)		
HIGHLY EFFECTIVE	02 - Oral Contraceptives	08 - NFP/FAM
14 - Male Sterilization	17 - Hormonal Patch	07 - Spermicide
01 - Female Sterilization	18 - Vaginal Ring	OTHER
11 - Hormone Implant	04 - Diaphragm	09 - Other Method
15 - IUS	LESS EFFECTIVE	13 - Abstinence
03 - IUD	06 - Male Condom	10 - None
22 - LAM	19 - Female Condom	
MODERATELY EFFECTIVE	21 - Contraceptive Sponge	
16 - Hormonal Injection	20 - Withdrawal	
BEFORE VISIT <input type="text"/> <input type="text"/> AFTER VISIT <input type="text"/> <input type="text"/>		
15B. IF NONE AT THE END OF THIS VISIT, GIVE REASON.		
Pregnant:	<input type="checkbox"/> 1 - Planned	<input type="checkbox"/> 8 - Unplanned
	<input type="checkbox"/> 3 - Seeking Pregnancy	<input type="checkbox"/> 7 - Other

Use Section 15A to record the contraceptive method the client used before the visit and the method the client will use as a result of the visit. It should be noted that agencies' electronic data collection systems may not reflect the order of methods by effectiveness as shown on the paper CVR.

Use Section 15B to record the reason that the client will not use a contraceptive method after the visit.

Here are instructions that apply to the coding for both sections:

- In the Section 15A **Before Visit** space, enter the two-digit code of the primary or most effective method even if more than one method is used.
- In the Section 15A **After Visit** space, enter the code of the primary or most effective method to be used after the visit even if more than one method will be used. If the client receives two methods, code the primary method only.
- **Clients relying on their partners' methods should be marked as users of those methods.** For example, if a male client relies on his female partner's Depo-Provera for contraception, use code 16. Similarly, if a female client relies on her male partner's vasectomy, use code 14.
- Mark box 13 - Abstinence for clients reporting they are not sexually active.
- If no contraceptive method is continued or initiated at the end of this visit, enter code 10 (None) in Section 15A and the most important reason for this decision in Section 15B. **Please note**

that code 3-Seeking Pregnancy in Section 15B is will cause CVRs with a CCare source of pay to reject.

- In order to bill CCare for a client requesting an IUD removal for the purposes of seeking pregnancy, mark box 10 - None in Section 15A and box 7 - Other in Section 15B.
- For infertility clients, enter code 10 (None) in Section 15A. (Even if a method is being used as treatment, its purpose is not to prevent pregnancy, but to enhance fertility.)
- If any code except 10 is entered in the **After Visit** space in Section 15A, skip Section 15B.

Section 16: Referral Information

16. REFERRAL INFORMATION (Check all Applicable)		
<input type="checkbox"/> 02 - High Risk Pregnancy	<input type="checkbox"/> 05 - Sterilization	<input type="checkbox"/> 10 - Social Sevicees
<input type="checkbox"/> 15 - Adoption	<input type="checkbox"/> 06 - Infertility	<input type="checkbox"/> 09 - Nutrition
<input type="checkbox"/> 03 - Abortion	<input type="checkbox"/> 04 - STD	<input type="checkbox"/> 13 - Substance Abuse
<input type="checkbox"/> 01 - Prenatal	<input type="checkbox"/> 17 - Colposcopy	<input type="checkbox"/> 14 - Abuse/Violence
<input type="checkbox"/> 16 - Breast Evaluation	<input type="checkbox"/> 08 - Other Medical	<input type="checkbox"/> 11 - None
<input type="checkbox"/> 12 - Mammography or U.S.		

Indicate whether the client was referred to another agency or clinician, or to another program in a multi-service agency. Check all that apply for the current visit. All referral information must be documented in the client medical record.

Section 17: Medicaid Billing

17. MEDICAID BILLING (Complete top section for CCare)					
Supplies Billed	Qty.	Unit Price	Supplies Billed	Qty.	Unit Price
01-Orals			07-Condoms, Male		
16-EC			08-Condoms, Fem.		
14-Patch			17-Ring		
15-Mirena IUS			18-Sponge		
03-Copper IUD			19-Subdermal Implants		
04-Depo Provera			20-Cycle Beads		
05-Diaphragm			21-Skyla IUS		
06-Spermicide			22-Liletta IUS		

Use this section to bill for contraceptive supplies provided to clients enrolled in CCare. If the client is not enrolled in CCare or is receiving services not covered by CCare, this section can be ignored. Note that contraceptives are the only supply/medication that can be billed to CCare.

Please see [Exhibit C-14](#) for the contraceptive supply codes list, with maximum allowable quantities and reimbursement rates per unit that may be billed on each date of service. Enter the appropriate quantity and CVR code for each method dispensed to the client.

Pay particular attention to the following special instructions for the billing of these methods:

- The patch and the ring are both billed per patch or ring (*per each*). Even though the patch comes in a box of three (one cycle), they are billed as 1/3 of the total price times the quantity of three. When billing for one box of patches, use the quantity 3.
- For Depo, the unit price is the total acquisition cost. For OHP use quantity 150 and the total unit cost, for CCare use quantity 1 or 150 and the total unit cost. The Ahlers system will convert quantity 150 to quantity 1 for CCare.

Contraceptives are reimbursed at their **acquisition cost**, not at the CCare maximum allowable amount. Each agency must document the calculations used to determine the acquisition cost of each supply. That information must be available for audit purposes. See [Section C](#) for guidance on how to calculate acquisition costs.

Section 17A: Third Party Resource (TPR) Codes

17A. THIRD PARTY RESOURCE CODES	
(Complete if client has other insurance coverage.)	
1 - Explanation Code	<input type="text"/>
2 - Other Insurance Paid	<input type="text"/>

Complete if the CCare client indicated having any insurance coverage on the CCare Enrollment Form.

- Mark **1 - Explanation Code** to indicate why no payment was made by the private insurance company. (See the next page for the list of seven TPR codes to use.) Do not include an Explanation Code for those claims billed to CCare in which partial payment was made by the private insurance company. If preferred, an alternate list of standard claim reason/remark codes may be used, rather than the list of TPR codes listed below. These standard codes will then be converted into one of the seven TPR codes during claims processing. Contact the RH Program and request the CCare TPR and Reason/Remark Code Crosswalk for the full list. If insurance is not billed due to confidentiality needs, mark NC.

TPR Codes: Single Insurance Coverage	
Code	Description
UD	Service Under Deductible
NC	Service not Covered by Insurance Policy (Use also when special confidentiality is requested)
PP	Insurance Payment Went to Patient/Policyholder
NA	Service Not Authorized or Prior Authorized by Insurance
NP	Service Not Provided by Preferred Facility
MB	Maximum Benefits Used for Diagnosis/Condition
OT	Other (Use also when insurance information is unavailable)

- Use item **2 - Other Insurance Paid** to record the amount paid by the private insurance for the reproductive health service. CCare will reimburse the balance up to the maximum reimbursement rate.

Clients should be asked about current insurance status at each visit. 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 or Title X is the payer of last resort.

If a client with insurance requests special confidentiality at the time of enrollment, insurance should not be billed and the Explanation/TPR Code NC should be entered in Section 17A of the CVR.

If a client reports having insurance on the CCare Enrollment Form but does not bring the card or policy information to the visit, clinic staff are expected to try to contact the insurance company and/or the client to obtain the information necessary for billing and document the attempt(s). If this follow-up does not yield the necessary information, CCare can be billed using the TPR code OT.

CCare claims will be rejected from the Ahlers system when a client has indicated having private insurance on the CCare Enrollment Form, but no dollar amount paid or explanation code is provided with the claim.

- The error message on the CVR Error Report will read as follows:

REJECT: PVT INS FROM WEB IS YES BUT 17A IS BLANK

Section D: Exhibits

[Exhibit D-1: Project/Site Number Request Form](#)

Exhibit D-2: Ahlers User ID/Password Request Form

[Exhibit D-2a](#) (for agencies with fewer than 10 clinics)

[Exhibit D-2b](#) (for agencies with 10+ clinics)

[Exhibit D-3: Reports Generated from CVR Data](#)

[Exhibit D-4: Accessing Ahlers & Associates Data Online](#)

[Exhibit D-5: Oregon CVR ICD-10](#)

[Exhibit D-6: File Format for Data Submission from non-WINCVR Systems](#)

[Exhibit D-7: CVR Submission Deadlines & Ahlers Report Creation Dates](#)

[Exhibit D-8: CVR Error Messages](#)

[Exhibit D-9: Sample CVR Error Report](#)

[Exhibit D-10: Instructions for Billing OVP](#)

[Exhibit D-11: Sample OVP CVRs](#)



Oregon
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Section E

Appendices

Center for Prevention and Health Promotion
Oregon Health Authority – Public Health

Section E: Appendices

[**Appendix A:** Directory of Oregon Family Planning Clinics](#)

[**Appendix B:** Oregon Reproductive Health Program Contacts](#)

[**Appendix C:** Oregon Health Authority Organizational Chart](#)

[**Appendix D:** Center for Prevention and Health Promotion Organizational Chart](#)

[**Appendix E:** Adolescent, Genetics, and Reproductive Health Section Organizational Chart](#)

[**Appendix F:** Medicaid Income Guidelines](#)