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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-13](#).
- 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>(4) Linguistic and Cultural Competence</p> <p>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>(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> <p>(A) All persons providing interpretation services must adhere to confidentiality guidelines.</p> <p>(B) Family and friends shall not be used to provide interpretation services, unless requested by the client.</p> <p>(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.</p> <p>(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> <p>(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>(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 1442 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="639 533 1442 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="639 781 1442 890">(e) Clients must be offered information about where to access free or low cost primary care services. <li data-bbox="639 907 1442 1058">(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 1075 1442 1457">(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 1474 1442 1747">(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
<p>(6) Clinical and Preventive Services</p>	<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-13](#) 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-12](#).

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-13](#) 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-15](#) 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-15](#) 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-16](#) 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.