MERCER

State of Missouri Department of Social Services

Evaluation of the Women's Health Services Program

Section 1115 Waiver Demonstration Project

EVALUATION YEAR 6: OCTOBER 1, 2012 – SEPTEMBER 30, 2013

Prepared by:
Mercer Government Human Services Consulting
1255 23rd Street NW, Suite 500
Washington, DC 20037

Submitted: January 28, 2014

MARSH & McLENNAN COMPANIES

EXECUTIVE SUMMARY

This is the sixth evaluation of the Missouri Women's Health Services Program 1115 Waiver Demonstration (the Program). The waiver was originally approved as a part of Missouri's Section 1115 Managed Care Plus (MC+) waiver in 1998. The current waiver started on October 1, 2007 and was recently extended until December 31, 2014. The evaluation has covered every year since Year 1 of the waiver in 2007-2008.

Missouri's objectives in implementing the Program are:

- Providing access to contraceptive supplies and information on reproductive health care and women's health services to the demonstration population;
- Reducing the number of unintended pregnancies in Missouri;
- Reducing Medicaid expenditures by preventing unintended births; and
- Assisting women in preventing sexually transmitted infections (STIs).

This evaluation tested five hypotheses related to the state's objectives. The hypotheses, the measures used to test those hypotheses, and the findings are summarized below for federal fiscal year (FFY) 2013, covering the period from October 1, 2012 through September 30, 2013 (referred to in this report as "the Program year").

During the previous reporting period, the state changed its claims adjudication system to more closely align with the objectives of the waiver, and the 3 year trends seen in this report still reflect the effect. The change took place in December of 2011, and consisted of tightening the claims requirements to enforce the restriction that covered family planning services must be provided in a setting that is primarily a family planning visit. This change resulted in a decline in some payable services which affected the overall utilization figures, with a high impact on utilization of STI services. Contraceptive services were largely unaffected by the change. If an individual presents for service for anything other than a family planning service as defined in the waiver it is not claimable as a family planning waiver service. This change is discussed further in hypothesis 5.

Objective: Reduce the number of unintended pregnancies among the demonstration population.

Hypothesis 1: The Program will result in a reduction in the number of unintended pregnancies among the demonstration population.

Measure: The share of women in the Program for whom unintended pregnancy has been averted during the Program year.

Finding: Out of the 114,610 women enrolled during the Program year (referred to in this report as the "Program population"), rates of pregnancy were lower than the birth rates in the base year of FFY 2000 that we used for comparison. The reduction in pregnancy rates means that a total of 5,394 births were averted among the program population.

Objective: Reducing Missouri's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services.

Hypothesis 2: The Program will reduce MO HealthNet expenditures for unintended births.

Measure: The Program year MO HealthNet savings from averted births for Program enrollees.

Finding: By averting 5,394 births among Program enrollees, the Program resulted in total state and federal savings of $32,445,352. The savings are derived from the avoided costs of pregnancy, labor, and delivery. Savings are even greater ($64,380,587) when accounting for the cost savings related to the first year of life.

Objective: Providing access to contraceptive supplies and information on reproductive health care and women's health services to the Demonstration population.

Hypothesis 3: The Program will provide information on reproductive health and women's health services to the demonstration population.

Measure: The share of women in the Program who have accessed family planning services during the Program year.

Finding: A total of 37,172 women, or 32.6% of the Program population, had at least one claim for a women's health, family planning, or other waiver-covered service.

Hypothesis 4: The Program will provide access to contraceptive supplies for the demonstration population.

Measure: The share of women who have accessed contraceptive supplies or services during the Program year.

Finding: In total, 16,794 Program enrollees, or 14.7% of the Program population, had at least one claim for contraceptive supplies or services ranging from oral contraceptives to sterilization procedures.

Objective: Assisting women in preventing sexually transmitted infections

Hypothesis 5: The Program will assist women in preventing STIs.

Measure: The share of women in the Program who are tested for STIs during the Program year.

Finding: In total, 4,529 Program enrollees, or 4% of the Program population, had at least one claim for sexually transmitted infection treatment or testing.

PROGRAM OVERVIEW

Unintended pregnancies account for almost half (49%) of all pregnancies in the United States[1], and are associated with risks such as low birth weight, maternal depression and delays in receiving prenatal care.[2] [3] Unintended pregnancies are defined as those that, at the time of conception, are either unwanted (mother did not want pregnancy) or mistimed (mother wanted the pregnancy to occur at a later time).[4] Mothers who have unintended pregnancies are less likely to breastfeed and have lower levels of psychological well-being during pregnancy and after the birth.[5] [6] For teen mothers and their children, the consequences of an unintended pregnancy can be even more profound. For mothers between the ages of 15 to 19, 82% of pregnancies are unintended.[7] Studies have shown that teen mothers are less likely to graduate from high school or get their GED, earn lower incomes, and have to rely on public assistance for twice as long as those who postpone having children until their twenties.[8] [9]

In addition to the health impact that an unintended pregnancy can have for mother and child, there are significant social and economic consequences. A study published in 2013, using 2008 data, found that unintended pregnancies resulted in 1.7 million births nationally. Of those, 65% were paid for by Medicaid/CHIP programs. Using Pregnancy Risk Assessment Monitoring

[1] Finer L, Henshaw S. Unintended pregnancy in the United States, 2006. Contraception, 2011 Nov; 84 (5): 478-85.
[2] Cheng D, Schwarz E, Douglas E, et al. Unintended pregnancy and associated maternal preconception, prenatal and postpartum behaviors. Contraception. 2009 Mar; 79(3):194-8.
[3] Kost K, Landry D, Darroch J. Predicting maternal behaviors during pregnancy: Does intention status matter? Family Planning Perspectives 1998 Mar–Apr; 30(2):79-88.
[4] Santelli, J. S., Rochat, R., Hatfield-Timajchy, K., Gilbert, B., Curtis, K., Cabral, R., et al. (2003). The measurement and meaning of unintended pregnancy. *Perspectives on Sexual and Reproductive Health, 35*(2), 94-101.
[5] D'Angelo, D. V., Gilbert, B. C., Rochat, R. W., Santelli, J. S., & Herold, J. M. (2002). Differences between mistimed and unwanted pregnancies among women who have live births. Perspectives on Sexual and Reproductive Health, 36(5), 192-197.
[6] Grussu, P., Quatraro, R. M., & Nasta, M. T. (2005). Profile of mood states and parental attitudes in motherhood: Comparing women with unplanned and planned pregnancies. Birth, 32(2), 107-114.
[7] Finer L, Henshaw S. Disparities in rates of unintended pregnancy in the United States, 1994 – 2001. Perspectives on Sexual and Reproductive Health, 2006 Jun; 38 (2): 90-6.
[8] Hoffman S, Maynard R, eds. Kids having Kids; Economic Costs and Social Consequences of Teen Pregnancy, 2nd ed. Washington: Urban Institute Press; 2008.
[9] Hoffman S, By the Numbers: The Public Costs of Teen Childbearing. Washington: National Campaign to Prevent Teen Pregnancy; 2006. http://www.thenationalcampaign.org/costs/

System (PRAMS) data, state surveys, and other methodology, the study found that 53% of the 2 million births, funded in 2008 by public dollars, were due to unintended pregnancies and accounted for $12.5 billion of public expenditures.[10] While these costs may be high, the authors estimate that costs of unintended births would be as high as $25 billion a year without family planning services to help curtail the number of unintended pregnancies.[11] The Guttmacher Institute, a nonprofit organization advancing sexual and reproductive health through research, policy analysis and public education, reported that publicly funded family planning services, such as Missouri's Family Planning Waiver, help avert 1.94 million unintended pregnancies each year among enrollees, and help to prevent the incidence of unintended pregnancies from being almost two-thirds higher than what it is currently.[12] Moreover, they note that almost $4 in Medicaid costs for pregnancy-related care is saved for every $1 on family planning services, which is similar to what the results are in Missouri in Hypothesis 2 when looking at total state and federal costs.[13] [14] Similar estimates of cost savings from family planning services were noted by author James Trussell in his 2007 article comparing the $5 billion spent on direct medical costs of unintended pregnancies in 2002 to the cost savings of $19 billion resulting from use of contraceptives.[15]

Missouri is one of 37 states participating in PRAMS, a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS, a population-based survey that began in 1987, collects information from mothers regarding their experiences and attitudes before, during and after pregnancy. The following information comes directly from the Missouri PRAMS 2009-2010-2011 data report, which is the most recent report available[16]:

- Nearly half (45.2 percent) of live births in Missouri during 2009-2010-2011 were from unintended pregnancy, including 72% of births of those on Medicaid.
- The percentages of unintended pregnancies were higher among women who were under 20 years old, had less than a high school education, Non-Hispanic Black or Hispanic, rural, unmarried and covered by Medicaid before pregnancy.

[10] Sonfield A and Kost K, Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008, New York: Guttmacher Institute, 2013, http://www.guttmacher.org/pubs/public-costs-of-UP.pdf
[11] Ibid.
[12] Guttmacher Institute. In Brief: Facts on Publicly Funded Contraceptive Services in the United States. New York, NY: 2011. http://www.guttmacher.org/pubs/fb_contraceptive_serv.pdf
[13] Gold RB, Sonfield A, Richards CL, et al. Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System. New York, NY: Guttmacher Institute; 2009. http://www.guttmacher.org/pubs/NextSteps.pdf
[14] Frost J, Finer L, Tapales A. The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings. J Health Care Poor Underserved. 2008; 19(3):778-796.
[15] Trussel J, Contraception. 2007 March; 75(3):168-70.
[16] Missouri Pregnancy Risk Assessment Monitoring System (PRAMS) 2009-2010-2011 report obtained from state officials

- Among women reporting an unintended pregnancy, 48.2 percent were not using any type of contraception.
- Women who were unmarried, had less than a high school education and those with Medicaid or no insurance before pregnancy were less likely to use contraception than their counterparts. In total, 51.3% of women with no insurance with an unintended pregnancy were not using birth control at the time of conception.
- Of the 48.2% of women who did not use birth control and had unintended pregnancies, 11.2% of women reported having problems getting birth control when they needed it.

To reduce the number of unintended pregnancies, the Women's Health Service Program Section 1115(a) Waiver Demonstration (Program) covers uninsured women who are 18 through 55 years of age losing their MO HealthNet eligibility 60 days after the birth of their child. This population is eligible for women's health services for a maximum of one year after their MO HealthNet eligibility expires. Uninsured women age 18 through 55 years of age with family net incomes of 185% FPL or below, and with assets totaling less than $250,000, are also eligible for program services as long as they continue to meet eligibility requirements.

The waiver was originally approved as part of Missouri's Managed Care Plus (MC+) waiver which was in place from May 1, 1998 through March 1, 2007. Beginning October 1, 2007, the waiver was approved as a stand-alone women's health services Section 1115 waiver. Effective January 1, 2009, eligibility was expanded to uninsured women between 18 and 55 whose income was below 185% of the federal poverty level. The Centers for Medicare and Medicaid Services (CMS) have approved extensions of the waiver, with the Program currently being authorized until December 31, 2014.

Under this Program, women are eligible only for women's health services, which are defined as:

Family planning services and supplies are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting.

Family planning services and supplies include:

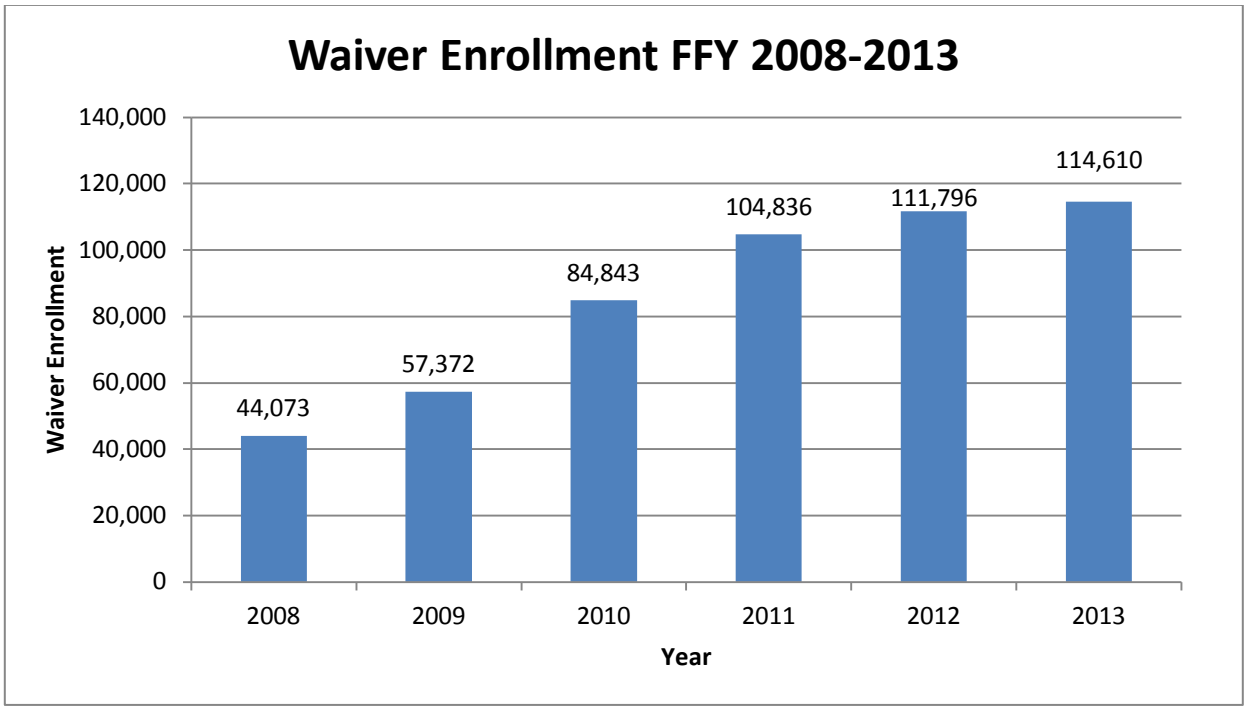
- Approved methods of contraception;
- Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
  - Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
- Drugs, supplies, or devices related to women's health services described above that are

prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and
- Contraceptive management, patient education, and counseling.

Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit.

Examples of family planning-related services and supplies include:
- Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
- Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
- Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.
- Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
- Treatment of major complications arising from a family planning procedure such as:
  - Treatment of a perforated uterus due to an intrauterine device insertion;
  - Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
  - Treatment of surgical or anesthesia-related complications during a sterilization procedure.

The Program has seen significant growth since its inception. The chart below illustrates program population for each year since 2008.



Women's Health Services are obtained through state-approved MO HealthNet fee-for-service providers. The following is a list of Title X clinics that participate in MO HealthNet and have billed for women's health services. These clinics, which are located throughout the State, ensure access statewide, are longstanding providers of women's health services, and will continue to provide services to the Program population.

Butler County Health Department

- Butler County Health Department – Poplar Bluff
- Carter County Health Center

Children's Mercy Hospital (The)

- CMH Teen Clinic
- CMH Northland Teen Clinic
- Synergy Youth Resiliency Center

East Missouri Action Agency

- EMAA Women's Wellness Center – Park Hills
- EMAA Women's Wellness Center – Cape Girardeau
- Madison County Health Department
- Howell County Health Department

Economic Security Corporation of the Southwest Area
- Economic Security Corporation of the Southwest Area – Joplin
- Economic Security Corporation of the Southwest Area – Neosho
- McDonald County Health Department

Family Care Health Centers
- Family Care Health Centers – St Louis (Holly Hills Ave)
- Family Care Health Centers – St Louis (Manchester Ave)

Family Planning Clinic of Franklin County, Inc.
- FPCFC – St Clair

Family Planning of St. Joseph, Inc.
- Family Planning – St Joseph
- Family Planning – Maryville

Green Hills Community Action Agency
- Hamilton Methodist Church
- GHCAA/Women's Health Services
- Harrison County Health Department
- Linn County Health Department
- GHCAA/Women's Health Services
- Putnam County Health Department
- Carroll County Health Department
- Ray County Health Department
- Chariton County Health Department

Jefferson County Health Department
- Jefferson County Health Department - Hillsboro
- Jefferson County Health Department – Arnold

Lincoln County Health Department
- Lincoln County Health Department – Troy

North East Community Action Corporation
- NECAC Family Planning Center – Hannibal
- NECAC Family Planning Center – Bowling Green
- Shelby County Health Department
- Audrain County Health Unit
- NECAC Family Planning Center – Warrenton
- NECAC Family Planning Center – O'Fallon
- Monroe County Health Department
- Adair County Health Department

Ozarks Area Community Action Corporation
- OACAC Family Planning - Springfield
- Barry County Health Department – Cassville
- Barry County Health Department – Monett
- Dade County Health Department
- Lawrence County Health Unit
- OACAC Family Planning – Lebanon
- Polk County Health Department
- Stone County Health – South
- Stone County Health Department – Galena
- Taney County Health Department – Forsyth
- Taney County Health Department – Branson
- Wright County Health Department – Hartville
- Wright County Health Department – Mountain Grove

Planned Parenthood of Kansas and Mid-Missouri
- Brous Center
- North Kansas City Center
- Warrensburg Center
- Columbia Center
- Independence Center
- Randolph County Health Department
- Boone County Health Department

Planned Parenthood of the St. Louis Region and Southwest Missouri
- Central West End Health Center
- South Grand Health Center

St Louis County Department of Health
- John C Murphy (JCM) Health Center
- North Central Community Health Center
- South County Health Center

Stoddard County Public Health Center
- Mississippi County Health Department
- New Madrid County Health Department
- Pemiscot County Health Department
- Scott County Health department
- Stoddard County Public Health Center

Swope Health Services
- Swope Health Central – Kansas City

Tri-Rivers Family Planning, Inc.

- Rolla Center
- Lake Center
- Lewis County Health Department
- Phelps-Maries County Health Department
- Scotland County Health Department
- Clark County Health Department
- Crawford County Health Department

West Central Missouri Community Action Agency

- WCMCAA – Butler
- WCMCAA – Warsaw
- WCMCAA – Clinton
- WCMCAA – Appleton City
- WCMCAA – Vernon County Health
- WCMCAA – Belton

Women who access services under the Program receive referrals for primary care services through the extensive network of Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) in Missouri. The Missouri Primary Care Association (MPCA) is a partner with the State of Missouri in this effort.

Note: As with evaluations from the last several years, this evaluation does not provide a comparison to the first Program year evaluation, for FFY 2008, because the State expanded Program eligibility criteria after the first year. The Program now includes Uninsured Women's Health Services which means that the mean age of Program participants for FFY 2013 is older than those enrolled in the program during FFY 2008, making comparisons with FFY 2008 less meaningful.

FINDINGS

Hypothesis 1: The Program will result in a reduction in the number of unintended pregnancies among the demonstration population.

Women enrolled in the Program had overall lower rates of pregnancy, 37.97 per 1,000 Program enrollees, than women in the base year of FFY 2000, when the rate was 78.53. Overall, when adjusted for the change in age groups among program participants since the base year, Program enrollees combined for a net reduction of 5,394 pregnancies in FFY 2013.

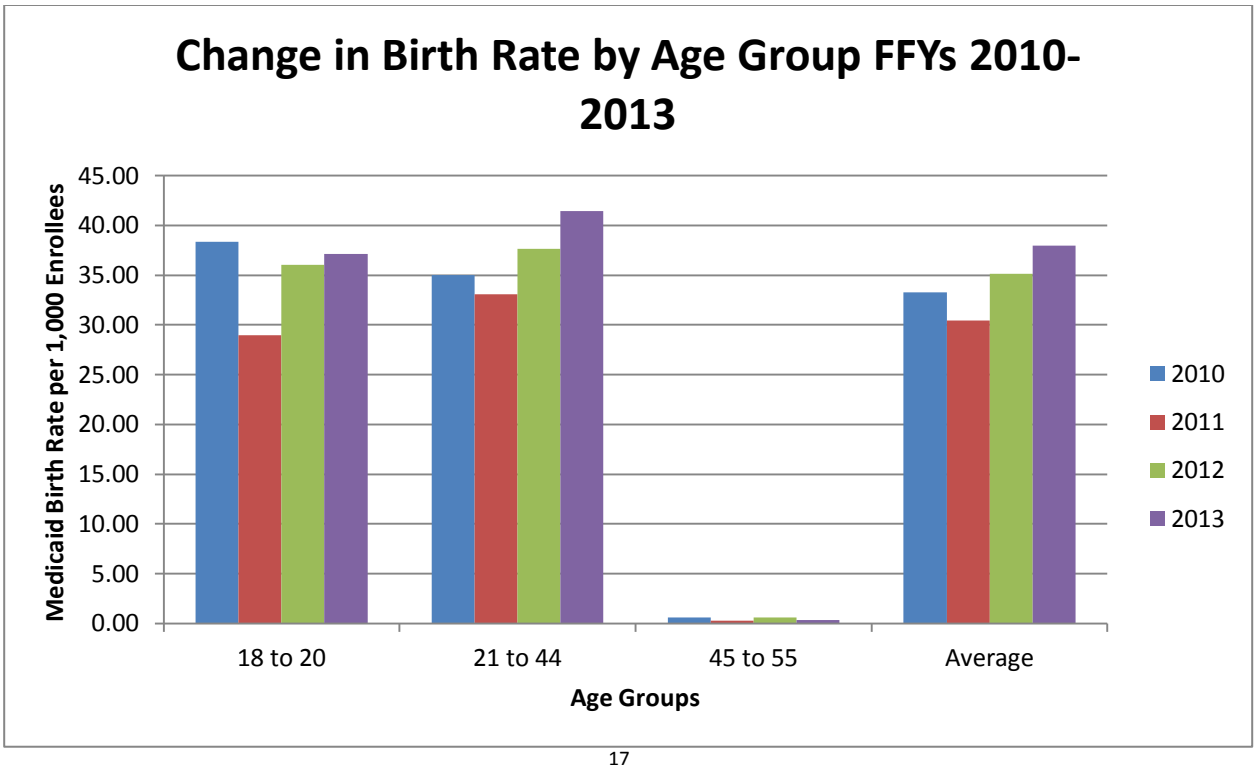
Table 1: Estimated Averted Pregnancies by Age Group, FFY 2013

Age Group	Medicaid Birthrate in FFY 2000	Count of Program Pregnancies	Program Population	Program Birthrate per 1,000	Estimated Expected Pregnancies	Estimated Averted Pregnancies
18 to 20	89.16	529	14,237	37.16	1,269	740
21 to 44	91.98	3,820	92,108	41.47	8,472	4,652
45 to 55	0.53	3	8,265	0.36	4	1
Total	**78.53**	**4,352**	**114,610**	**37.97**	**9,746**	**5,394**

Source: Missouri Department of Social Services 1115 Waiver Budget Neutrality
Note**:** The 18 - 20 age group baseline MO HealthNet birthrate in 2000 includes women aged 13 - 17 as the 1115 Waiver at that time included both CHIP and Women's Health Services. The Program population birthrate does not include these women because women under 18 are not eligible for the Program as of October 1, 2007. This change in age requirement for the Program occurred with the implementation of a separate 1115 Waiver for Women's Health Services. Birthrates are per 1,000 enrollees. "Estimated expected pregnancies" is the base year birthrate applied to FFY 2013 population. Age group cohorts are those used in the budget neutrality calculations. Numbers in the Estimated Averted Pregnancies column do not necessarily add up due to rounding

The pregnancy rates among Program enrollees varied by age group as shown in Table 1, with women in the 18 - 20 age group at 37.16 births per 1,000 enrollees. This represents an improvement from the base year birth rate of 89.16 births per 1,000 enrollees. This improvement is notable because the program in FFY 2000 included women aged 13 – 17 who have lower birth rates than women aged 18 – 20. Therefore the measured improvement in birth rate in comparison to the baseline probably understates the significant impact of the Program because that age group in the program today only includes women from 18 – 20.

A comparison of fiscal years 2012 and 2013 shows an increase in birth rates among the main program population aged 18 to 44. The overall program birth rate increased from 35.16 births per 1,000 in FFY 2012 to 37.97 births per 1,000 in FFY 2013. The increase is not isolated to one age group and represents a total of 421 additional births among the program population, though the increase is largest in the 21-44 age group. This measure should be monitored in the future to see if it is a fluctuation or a trend.



[17]

Hypothesis 2: The Program will reduce MO HealthNet expenditures for unintended births.

Averting pregnancies for women who are enrolled in the Program results in avoidance of the costs related to pre-natal care, pregnancy, labor, delivery, and first year of life for the infant. By averting 5,394 pregnancies among Program enrollees, the Program achieved savings of $32.4 million. This amount is calculated by multiplying the number of averted births by the actual cost of pregnancy, labor, and delivery for a MO HealthNet enrollee in FFY 2013 and subtracting the program spending. The total savings are even greater at $64.4 million, when actual FFY 2013 Medicaid costs in the first year of life are included.[18]

The reported costs of pregnancy, labor, and delivery increased by 4.1 % from FFY 2012. Some of this may be due to the addition of a new managed care organization (MCO) who experienced a lag in payment reporting in FFY 2012. As a result, the cost of birth payments

[17] Note: The graph from the FY 2012 report did not use the final data in showing pregnancy rates for FY 2012. The issue has been corrected for this year's report.

[18] Savings from averted births related to costs of pregnancy, labor, delivery and the cost of the first year of life were calculated by multiplying the number of averted births (5,394) by the average Medicaid cost of a birth in FFY 2013 ($7,408) and the average Medicaid cost of the first year of life in FFY 2013 ($5,920), and subtracting Program spending ($7,514,188). Costs were as reported on the CMS 64 report for FFY 2012. This calculation of savings differs from the method used on the family planning waiver budget neutrality report because that report does not use actual cost figures, per CMS instructions. Rather, costs per birth in the budget neutrality report are base year costs inflated to the program year. Actual costs are used in this evaluation to show the calculation of savings based on actual costs for the contemporaneous fiscal year.

that showed up in FY 2012 may have been artificially depressed and likely reflect reality more in FFY 2013.

The costs associated with the first year of life fell by 7.4% and the total cost of the family planning program fell by 4.1%. (See Table 2) The program saved $64,380,587, which was less than in FFY 2012 because of the decrease in averted births and the decrease in costs for the first year of life.

Table 2: Program Costs and Savings, FFY 2012 and FFY 2013[19]

	FY 2012	FY 2013
Births Averted	5,677	5,394
Costs Per Birth	$7,119	$7,408
Costs Per First Year	$6,393	$5,920
FP Waiver Costs	$7,831,424	$7,514,188
Total Savings for Births	$32,583,588	$32,445,352
Total Savings for Births and First Years	$68,880,911	$64,380,587

[19] Note: Births Averted, Costs per Birth, and Costs per First Year are rounded in Table 2, but are not rounded in the calculations for total savings. The result is that the final numbers do not multiply exactly to the numbers in the table.

Hypothesis 3: The Program will provide information on reproductive health and women's health services to the demonstration population.

The Program makes women's health services, including routine exams, contraceptive supplies, and STI screening and treatment, available to women who would not otherwise have health coverage for these services because they have no other source of credible coverage. As a measure of whether information on reproductive health and women's health services is provided to the Program population, this evaluation examined the number of Program enrollees who used at least one women's health service.

As shown in Table 3, a total of 37,172 women, or 32.6% of the Program population, had at least one claim for a Program-covered service in FFY 2013. In general, the rate of service use declined with increasing age. The youngest cohorts, those ages 18 - 24 and 25 - 29 years old, had the highest rate of service use at 37.2% and 36.1% respectively.

Table 3: Program Service use, FFY 2013

Age group	Service Users	Program Population	Share (in percent)
18 to 24	14,440	38,839	**37.2%**
25 to 29	9,835	27,249	**36.1%**
30 to 34	6,678	20,048	**33.3%**
35 to 39	3,218	11,817	**27.2%**
40 to 44	1,709	7,702	**22.2%**
45 to 56	1,292	8,307	**15.6%**
Total	**37,172**	**113,962**	**32.6%**

Source: Mercer analysis of claims data and enrollment data from Missouri DSS MMIS
Notes: The slight discrepancy in enrollment numbers between the analysis performed for Hypothesis 3 and the analysis in Hypothesis 1 (see Table 1) is due to the counting methodology: The budget neutrality population data is based on the period of remittance dates for claims paid during FFY 2013, while the program population for the service usage sections is based on the period of enrollment during FFY 2013, a shift of about 2 weeks. Age of service users is as of the end date of the evaluation period (September 30, 2013), and thus includes women who were 56 at the end of the period but would have had a period of eligibility during FY 2013 while they were still 55. "Service users" is an unduplicated count of unique departmental control numbers (DCN) in the claims data file. For a complete description of data and methods see page 22. Age categories 45 - 50 and 51 - 56 were combined due to small population ranges.

While total program population grew, the percentage and number of Program enrollees who used at least one women's health service in FFY 2013 increased from 32.3% in FFY 2011 to 32.6% as shown in the charts below:

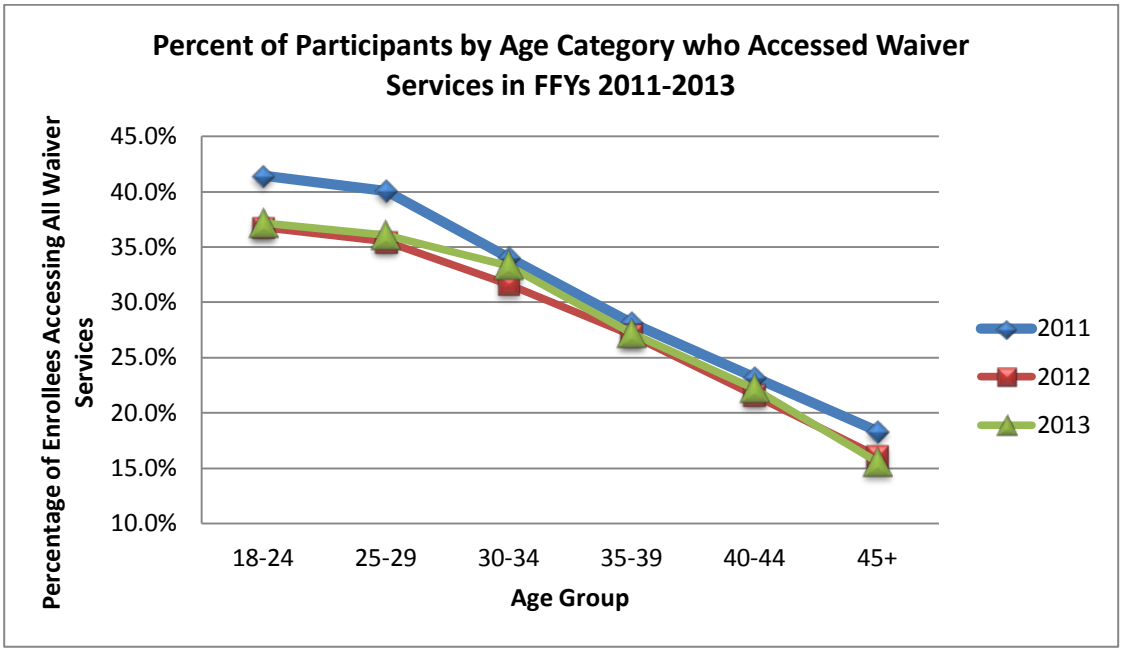
Table 4: Number of Enrollees Using Program Services, FFY 2011-2013

Year	Service Users	Percent Share
2011	37,941	35.9%
2012	35,701	32.3%
2013	37,172	32.6%

Table 5: Percentage of Enrollees by Age Groups Accessing Program Services, FFY 2011-2013

Age Group	2011	2012	2013
18-24	41.4%	36.7%	37.2%
25-29	40.1%	35.5%	36.1%
30-34	34.1%	31.6%	33.3%
35-39	28.1%	27.0%	27.2%
40-44	23.2%	21.6%	22.2%
45+	18.3%	16.1%	15.6%
Total	**35.9%**	**32.3%**	**32.6%**

The slight drop in overall access from 2011 to 2012 was largely accounted for by a change in requirements discussed in last year's report for family services claims made in December of 2011, to align the program with the intention of the waiver. The overall use increased slightly from 2012 to 2013 and increased slightly across almost every age group.



Hypothesis 4: The Program will provide access to contraceptive supplies for the demonstration population.

Providing access to contraceptive supplies is one of the Program's objectives and is integral to reducing unintended pregnancies. This evaluation assessed the number of unique users of contraceptive services and supplies, such as oral contraceptives, diaphragms, and tubal ligation. In total, 14.7% of the women enrolled during the Program year had at least one claim for contraceptive supplies or services (see Table 6). Women in the 18 to 24 age group had the highest rates of contraceptive use, with 19.4% of women using contraceptive services or supplies for which there was a claim paid by the Program. It is important to note that this measure of contraceptive use counts provider encounters for contraceptive procedures, e.g., insertion, implantable contraceptive capsules, and modes of contraception for which a claim would have been submitted by a physician or pharmacy. It does not include non-prescription methods of contraception such as condoms, nor does it include an office visit during which guidance on natural family planning methods or abstinence may have been provided.

Table 6: Contraceptive supplies and service use by age group, FFY 2013

Age group	Service Users	Program Population	Share (in percent)
18 to 24	7,524	38,839	**19.4%**
25 to 29	4,658	27,249	**17.1%**
30 to 34	2,842	20,048	**14.2%**
35 to 39	1,121	11,817	**9.5%**
40 to 44	453	7,702	**5.9%**
45 to 56	196	8,307	**2.4%**
Total	**16,794**	**113,962**	**14.7%**

Source: Mercer analysis of claims data and enrollment data from Missouri DSS MMIS
Notes: The slight discrepancy in enrollment numbers between the analysis performed for Hypothesis 4 and the analysis in Hypothesis 1 (see Table 1) is due to the counting methodology: The budget neutrality population data is based on the period of remittance dates for claims paid during FFY 2013, while the program population for the service usage sections is based on the period of enrollment during FFY 2013, a shift of about 2 weeks. Age of service users is as of the end date of the evaluation period (September 30, 2013). "Service users" is an unduplicated count of unique departmental control numbers (DCN) in the claims data file. For a complete description of data and methods see page 22. Age categories 45 - 50 and 51 - 56 were combined due to small population ranges.

As shown in the figure below, users of contraceptive supplies and services as a percentage of the Program population declined slightly between FFY 2012 and FFY 2013 in every age group. 14.7% of Program enrollees had a claim for contraceptive supplies or services, as opposed to 16.9% in FFY 2012.

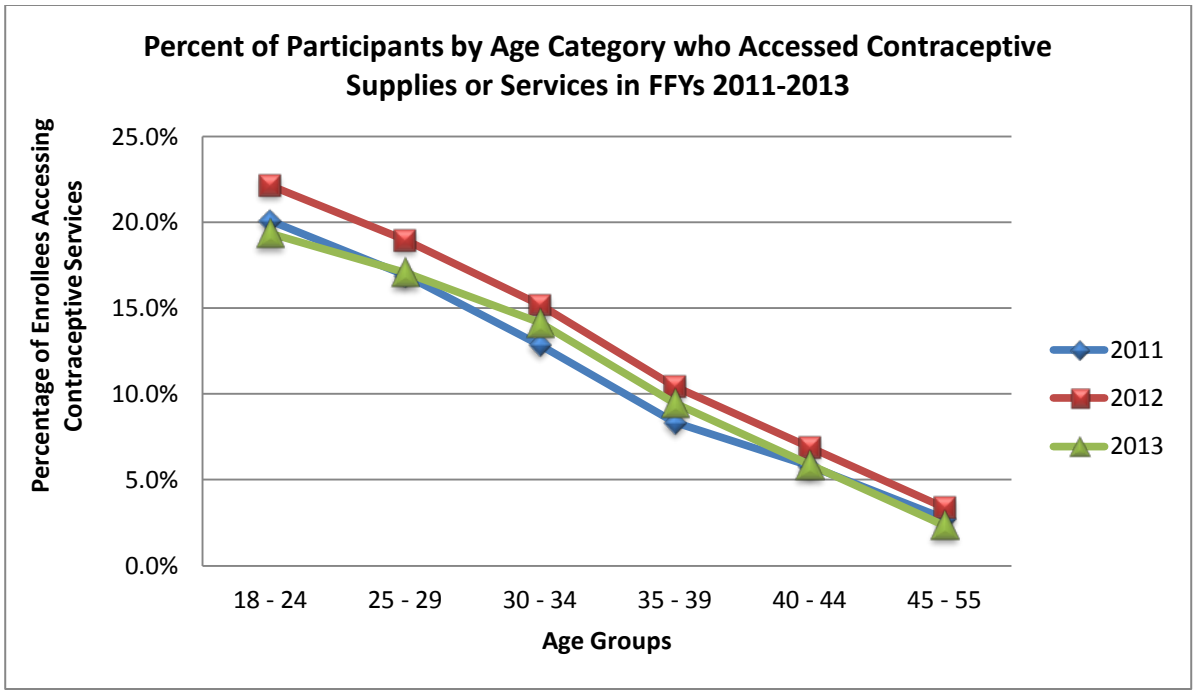


Table 7 below shows that the contraceptive service use share has declined in 2013 below both the 2012 and 2011 rates.

Table 7: Contraceptive Services Usage, FFY 2011 – 2013

Age Group	2011	2012	2013
18 - 24	20.1%	22.2%	19.4%
25 - 29	16.9%	19.0%	17.1%
30 - 34	12.9%	15.2%	14.2%
35 - 39	8.3%	10.4%	9.5%
40 - 44	5.8%	6.9%	5.9%
45 - 55	2.7%	3.4%	2.4%
Total	**15.0%**	**16.9%**	**14.7%**

Hypothesis 5: The Program will assist women in preventing STIs.

Detecting and preventing STIs such as chlamydia, gonorrhea, and syphilis for women in family planning settings is another goal of the Missouri Women's Health Services Program. Untreated STIs can have a long-lasting negative impact on a woman's life. Untreated gonorrhea and chlamydia can cause infertility, with estimates of at least 24,000 women in the United States becoming infertile each year due to untreated STIs.[20] Undetected STIs can increase the risk of HIV and cause other serious health problems. The CDC estimates that every year there are 19 million new STI infections, incurring $17 billion in costs annually to the health care system.[21]

In December of 2011, MO HealthNet made a claims system change to enforce the policy that payable family planning claims under this waiver must be provided during a family planning visit. The state imposed stricter edits on diagnosis/procedure matches on claims, meaning that claims would not be paid if they were not provided during a visit that had the primary purpose of family planning, as indicated by the primary diagnosis code. Specifically, the state now requires that the primary diagnosis be in the range from V25 to V259, which are all in the category of Contraceptive Management.

This change reflects the intention of the state and CMS that the family planning waiver be used to pay for visits that are primarily for the purpose of family planning, and that STI or other treatments or testing that are performed during an episode with any other primary diagnosis are not intended to be covered by this waiver.

The diagnosis code restriction resulted in an increase in denied claims for services that would have been allowable before the change. Analysis of those denials shows that as expected, a high percentage of the denied claims are for STI services that were no longer payable because the diagnosis code did not fall within the allowable range. This appears to account not only for the significant drop in STI service use from 10.2% of enrollees in FFY 2011 to 4.6% in FFY 2012, but also in the slight overall drop in service use seen in hypothesis 3. While this makes comparison of service use less meaningful between years, it is an indication that the policy change was effective in limiting the services paid for under this waiver to services and settings intended by the waiver, since the denied claims are for services which were provided in a setting with a primary diagnosis that was not family planning.

Based on analysis of claims data, this evaluation found that 4,529 women or 4.0% of the FFY 2013 Program population received services for an STI. The rate of those tested or treated was highest among the 25 - 29 age group, with the rates generally declining with age. When comparing Program STI testing rates to other populations it should be noted that many of the Program enrollees, by virtue of having been pregnant and given birth in the past year, were likely to have had previous access to testing and treatment of STIs during their pregnancies.

[20] 2010 Sexually Transmitted Disease Surveillance, Centers for Disease Control and Prevention at http://www.cdc.gov/std/stats10/trends.htm
[21] Ibid.

Table 8. Sexually Transmitted Infections testing, FFY 2013

Age group	Service Users	Program Population	Share (in percent)
18 to 24	1,617	38,839	**4.2%**
25 to 29	1,209	27,249	**4.4%**
30 to 34	859	20,048	**4.3%**
35 to 39	442	11,817	**3.7%**
40 to 44	223	7,702	**2.9%**
45 to 56	179	8,307	**2.2%**
Total	**4,529**	**113,962**	**4.0%**

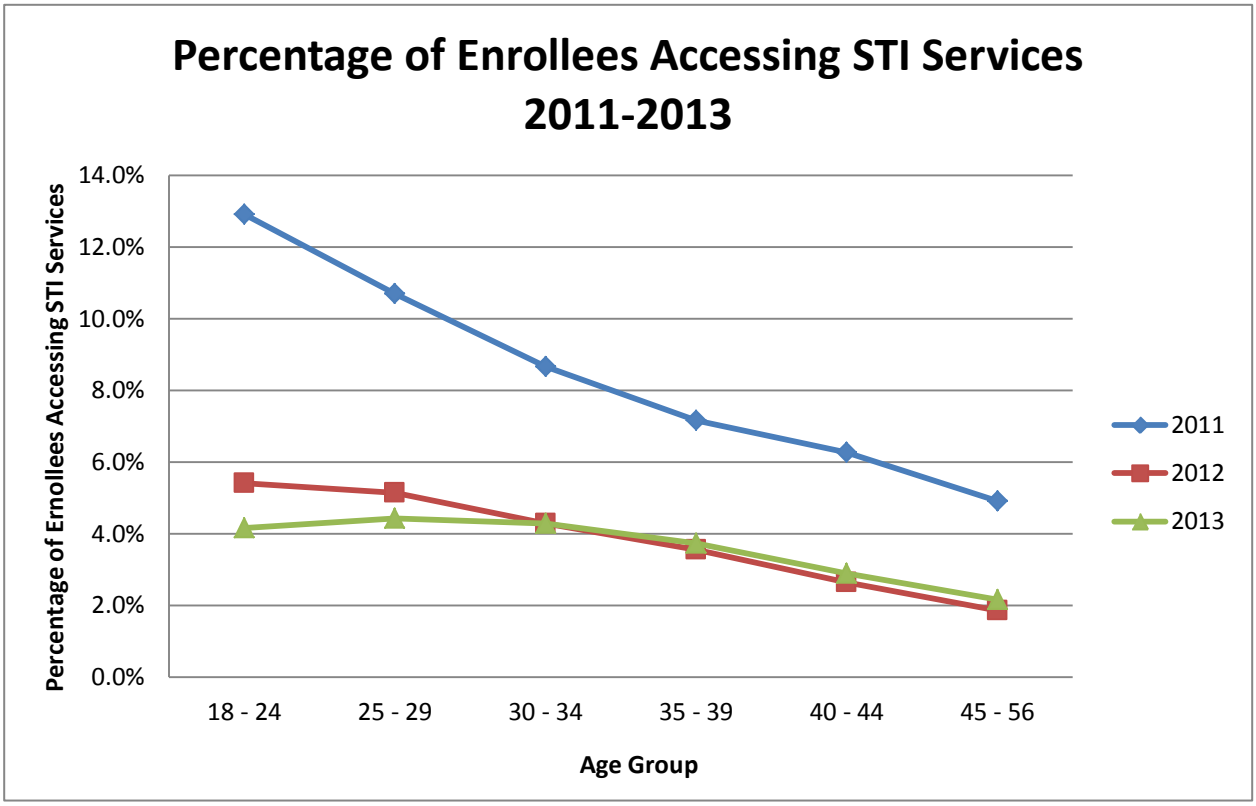
FFY 2013 shows a very slight decline in overall use from FFY 2012, shown in table 9 below. The decrease was in the younger age groups, women aged 18 to 29, while women aged 35 to 56 actually increased use rates slightly.

Table 9: Sexually Transmitted Infections testing, FFY 2011 – 2013

Age Group	2011	2012	2013
18 - 24	12.9%	5.4%	4.2%
25 - 29	10.7%	5.1%	4.4%
30 - 34	8.7%	4.3%	4.3%
35 - 39	7.2%	3.5%	3.7%
40 - 44	6.3%	2.6%	2.9%
45 - 56	4.9%	1.9%	2.2%
Total	**10.2%**	**4.6%**	**4.0%**

Source: Mercer analysis of claims data and enrollment data from Missouri DSS MMIS

Notes: The slight discrepancy in enrollment numbers between the analysis performed for Hypothesis 4 and the analysis in Hypothesis 1 (see Table 1) is due to the counting methodology: The budget neutrality population data is based on the period of remittance dates for claims paid during FFY 2013, while the program population for the service usage sections is based on the period of enrollment during FFY 2013, a shift of about 2 weeks. Age of service users is as of the end date of the evaluation period (September 30, 2013). "Service users" is an unduplicated count of unique departmental control numbers (DCN) in the claims data file. For a complete description of data and methods see page 22. Age categories 45 - 50 and 51 - 56 were combined due to small population ranges.



SUMMARY AND CONCLUSIONS

Data from this evaluation period shows that the birthrate for women in the Program continues to be significantly lower than the baseline year of FFY 2000. Consequently, the program avoided the potential costs associated with the averted births. The Program saved a total of $32,445,352 in birth costs, and a total of $64,380,587 including first year costs, in FFY 2013. Because these savings figures are based on the actual average cost of Medicaid prenatal, labor, delivery, and infant costs, this could be an underestimate of program savings. Waiver savings could be greater to the extent that births occurring within the first year after a preceding birth are more likely to result in adverse perinatal outcomes.

Service data continues to show that women in the Program are accessing waiver services, contraceptive services and STI services. Women aged 18-29 accessed contraceptive and STI testing services at a rate higher than any other age group. This relatively higher rate of contraceptive use among younger women is encouraging given their higher fertility than older women. Generally, rates of service usage declined with age and were lowest for the oldest age cohort. This is likely because younger populations are more likely to be sexually active and are more likely to have a greater need for contraceptive services or STI testing.

Service use for contraceptives shows a slight drop in FFY 2013 that may indicate that the increase seen between FFY 2011 and FFY 2012 was merely fluctuation rather than a trend. The drop in the rate of women accessing STI services from 10.2% in FFY 2011 to 4.6% in FFY 2012 was the expected result of the policy change made in December, 2011 to prevent services from being inappropriately billed and paid, and there is very little change in the STI usage rate between FFY 2012 and FFY 2013.

Program enrollment continues to increase since the expansion of coverage to uninsured women ages 18 through 55 years of age with net family incomes at or below 185% FPL and assets of less than $250,000. This expansion of coverage, coupled with the impact of the recession on Medicaid enrollment, resulted in a significant increase in enrollment from 57,372 in FFY 2009 to 114,610 in FFY 2013.

Providing contraceptive services is a core mission of this Program, and ensuring that every interested enrolled woman receives access to contraceptive services should be a priority for the state. As suggested in previous years' reports, efforts to encourage further increases in the rate of access to contraceptive services should be made. The state should consider conducting informational interviews with women who sign up for the program to determine what kind of barriers are preventing contraceptive use, and examine strategies for helping to remove those barriers. It should be noted that claims for users who seek services at an FQHC and who discover other medical complications during the visit are not billed as a family planning visit, which may account for a slightly lower number of contraceptive visits, as many enrollees receive their care from FQHCs in the state.

DATA SOURCES AND METHODS

Data to address hypotheses 1 and 2 came from the Missouri DSS MMIS. To determine the number of pregnancies among Women's Health Waiver Program enrollees, DSS staff requested a data extract of women who were pregnant in the evaluation period and whose ME code switched from one indicating enrollment in the Women's Health Waiver Program (ME codes 80 and 89) to an eligibility code indicating pregnancy. Pregnancies for Program enrollees are attributed to the year in which the woman gave birth. For example, women who became pregnant (and had an ME code switch) in FFY 2012 and gave birth in FFY 2013 are counted in FFY 2013; women who became pregnant in FFY 2013 and will give birth in FFY 2014 will be counted in FFY 2014. To count the number of women ever enrolled in the Program during the fiscal year, DSS staff pulled an extract of women with Program ME codes during the year and determined the number of women in each age category.

MO HealthNet cost of pregnancy, labor, and delivery were determined by retrieving actual paid claims through the MMIS. Fee for service claims were identified for pregnant women recipients (ME Codes 18, 43, 44, 45, and 61) eligible under the Missouri Medicaid State Plan during the reported FFY by delivery procedure codes and/or delivery diagnosis codes. Managed Care costs were identified by calculating the portion of the managed care capitation payments applicable to pregnancy and delivery costs. MO HealthNet costs in the first year of life were determined by retrieving actual FFY 2013 paid claims retrieved through the MMIS for infants through their first birthday.

Data to address hypotheses 3 through 5 related to unique users of services came from two files. The first file contained eligibility information and date of birth for all women enrolled in the Program during the evaluation period. Women were assigned to an age category using their age as of the end date of the evaluation period (September 30, 2013). The second file, a use and spending file extract from the state's MMIS, contained any claim with an ME code of 80 or 89 on it that had a paid date of October 1, 2012 through September 30, 2013. Paid dates, rather than service dates, were used to identify claims for analysis to ensure that data could be extracted and analyzed in time to meet CMS's deadline for the evaluation.

Claims were coded as contraceptive, STI, or other women's health services based on the procedure codes, National Drug Codes (NDCs), Generic Code Number (GCN) and drug names in the file.[22] To categorize codes, the state provided the list of procedure codes to be counted as contraceptive services, STI testing, or other women's health services. It also provided a list of NDCs/drug names to be counted as contraceptive codes. The state did not provide a way to classify other drugs, such as antibiotics into broad categories, so they were counted as waiver services but not categorized specifically as STI treatment. If drugs could be more specifically categorized as STI treatments, subsequent evaluations of STI service use among populations could link claims for testing with claims for treatment. This could provide the state with additional information about the extent to which Program enrollees receive treatment.

[22] Appendix I contains the list of procedure codes and drug classes covered under this program.

The decision rule for counting a claim in the final analysis file was to count all procedure codes and drug codes/names affirmatively identified by the state as a covered waiver service. Once all valid claims were identified, unique DCNs, categorized by age, were counted for each type of claim: any waiver service, contraceptive products and services, and STI testing procedures.

SOURCES

National Campaign to Prevent Teen Pregnancy http://www.thenationalcampaign.org

Guttmacher Institute

Journal: Perspectives on Sexual and Reproductive Health

Journal: Contraception

Journal: Family Planning Perspectives

Journal of Health care for the Poor and Underserved

Hoffman S, Maynard R, eds. Kids having Kids; Economic Costs and Social Consequences of Teen Pregnancy, 2nd ed. Washington: Urban Institute Press; 2008.

2009-2010-2011 PRAMS report obtained from the state

APPENDIX I

Covered Services[23]

Procedure Code	Description
00851	ANESTHESIA FOR TUBAL LIGATION/ TRANSACTION
00952	ANESTHESIA FOR HYSTEROSCOPY AND/OR HYSTEROSALPINGOGRAPHY
11976	REMOVABLE, IMPLANTABLE CONTRACEPTIVE CAPSULES
11981	INERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11982	REMOVAL, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11983	REMOVAL WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
56820	COLPOSCOPY OF THE VULVA
56821	COLPOSCOPY OF THE VULVA; WITH BIOPSY
57420	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX, IF PRESESNT
57421	COLPOSCOPY OF THE ENTIRE VAGINA
57452	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA
57454	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH BIOPSY OF THE CERVIX AND ENDOCERVICAL CURETTAGE
57455	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH BIOPSY OF THE CERVIX
57456	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH ENDOCERVICAL CURETTAGE
57460	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH LOOP ELECTRODE BIOPSY OF THE CERVIX
57461	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA, WITH LOOP ELECTRODE COLONIZATION OF THE CERVIX
57505	ENDOCERVICAL CURETTAGE (NOT DONE AS PART OF A DILATION AND CURETTAGE)
57510	CAUTERY OF CERVIX, ELECTRO OR THERMAL
57511	CAUTERY OF CERVIX, CRYOCAUTERY, INITIAL OR REPEAT
57513	CAUTERY OF CERVIX; LASER ABLATION.
58300	INSERTION OF INTRAUTERINE DEVICE (IUD)
58340	CATHETERIZATION AND INTRODUCTION OF SALINE OR CONTRAST MATERIAL FOR SALINE INFUSION SONOHYSTEROGRAPHY OR HYSTEROSALPINGOGRAPHY
58565	HYSTEROSCOPY, WITH BILATERAL FALLOPIAN TUBE CANNULATION TO INDUCE OCCLUSION BY PLACEMENT OF PERMANENT IMPLANTS
58600	LIGATION OR TRANSECTION OF FALLOPIAN TUBES

[23] Note: A Provider Bulletin dated March 21, 2013 and found online here: http://www.dss.mo.gov/mhd/providers/pdf/bulletin35-24_2013mar21.pdf deleted many of the procedure codes that had been used in previous analyses after it was determined that some of the procedure codes were not directly related to sexually transmitted diseases or family planning. Effective March 6, 2013, the following codes were no longer covered: 80061, 80076, 80100, 80101, 80102, 82040, 82042, 82043, 82150, 82247, 82310, 82330, 82435, 82465, 82520, 82550, 82553, 82565, 82570, 82575, 82607, 82728, 82746, 82950, 83020, 83021, 83026, 83036, 83518, 83520, 83690, 84-75, 84425, 84520, 84550, 85045, 85300, 85378, 85576, 85597, 85660, 86255, 86698

Procedure Code	Description
58611	LIGATION OR TRANSECTION OF FALLOPIAN TUBES
58615	OCCLUSION OF FALLOPIAN TUBES BY DEVICE
58670	LAPAROSCOPY, SURGICAL; W/ FULGURATION OF OVIDUCTS BY DEVICE (WITH OR WITHOUT TRANSECTION)
58671	LAPAROSCOPY, SURGICAL; WITH OCCLUSION OF OVIDUCTS BY DEVICE (E.G., BAND, CLIP, ETC.)
74740	HYSTEROSALPINGOGRAPHY RADIOLGOICAL SUPERVISION AND INTERPRETATION
74742	TRANSCERVICAL CATHETERIZATION OF FALLOPIAN TUBE RADIOLOGICAL SUPERVISION AND INTERPRETATION
76830	ULTRASOUND TRANSVAGINAL
76831	ECHO EXAM UTERUS
76856	US EXAM PELVIC COMPLETE
76857	ULTRASOUND PELVIC (NONOBSTETRIC) B-CAN &/OR REAL TIME W/ IMAGE DOCUMENTATION
80047	BASIC METABOLIC PANEL (CALCIUM, IONIZE)
80048	BASIC METABOLIC PANEL (CLIA PANEL PROC)
80050	GENERAL HEALTH PANEL
80051	ELECTROLYTE PANEL (CLIA PANEL PROC)
80055	OBSTETRIC PANEL
80074	ACUTE HEPATITIS PANEL
81000	URINALYSIS BY DIPSTICK/TABLET REAGENT; NON- AUTOMATED W/MICROSCOPY
81001	URINALYSIS ETC. AUTOMATED WITH MICROSCOPY
81002	URINALYSIS BY DIP STICK/TABLET REAGENT;NON-AUTOMATED W/OUT MICROSCOPY(CLIA WAIVER LIST)
81003	URINALYSIS BY DIP/TABLET;AUTOMATED W/O MICROSCOPY
81005	URINALYSIS; QUALITATIVE OR SEMIQUANTITATIVE EXCEPT IMMUNOASSAYS
81015	URINALYSIS MICROSCOPIC ONLY (PPMP CLIA LIST)
81020	URINALYSIS; 2 OR 3 GLASS TEST (PPMP CLIA LIST)
81025	URINE PREGNANCY TEST BY VISUAL COLOR COMPARISON METHODS (CLIA WAIVER LIST)
82105	ALPHA-FETOPROTEIN; SERUM
82120	AMINES VAGINAL FLUID QUALITATIVE
82670	ESTRADIOL
82671	ESTROGENS FRACTIONATED
82672	ESTROGENS TOTAL
82677	ESTRIOL
82679	ESTRONE
82947	GLUCOSE; QUANTITATIVE (CLIA WAIVER LIST)
82948	GLUCOSE; BLOOD REAGENT STRIP
82962	GLUCOSE BLOOD BY GLUCOSE MONITORING DEVICE(S) CLEARED/ FDA SPECIFICALLY/HOME USE
83001	GONADOTROPIN FOLLICLE STIMULATING HORMONE (FSH)
83002	GONADOTROPIN LUTEINIZING HORMONE (LH)

Procedure Code	Description
84144	PROGESTERONE
84146	PROLACTIN
84702	GONADOTROPIN CHORIONIC (HCG); QUANTITATIVE
84703	GONADOTROPIN CHORIONIC QUALITATIVE (CLIA WAIVER LIST)
85004	AUTOMATED DIFF WBC COUNT
85007	BL SMEAR W/DIFF WBC COUNT
85008	BL SMEAR W/O DIFF WBC COUNT
85009	MANUAL DIFF WBC COUNT B-COAT
85013	BLOOD COUNT; SPUN MICROHEMATOCRIT(CLIA WAIVER LIST)
85014	HEMATOCRIT
85018	HEMOGLOBIN
85025	COMPLETE CBC W/AUTO DIFF WBC
85027	COMPLETE CBC AUTOMATED
85032	MANUAL CELL COUNT EACH
85610	PROTHROMBIN TIME (CLIA WAIVER LIST)
85652	SEDIMENTATION RATE ERYTHROCYTE; AUTOMATED
85730	THROMBOPLASTIN TIME PARTIAL (PTT) PLASMA OR WHOLE BLOOD
86318	IMMUNOASSAY/INFECTI AGENT ANTIBODY QUALI/SEMIQUANTSINGLE STEP METHOD
86382	NEUTRALIZATION TEST VIRAL
86386	NUCLEAR MATRIX PROTEIN 22 (NMP22), QUALITATIVE
86403	PARTICLE AGGLUTINATION; SCREEN EACH ANTIBODY
86580	SKIN TEST TUBERCULOSIS INTRADERMAL (EXEMPT FROM CLIA EDITING)
86592	SYPHILIS TEST QUALITATIVE (EG VDRL RPR ART)
86593	SYPHILIS TEST QUANTITATIVE
86628	ANTIBODY; CANDIDA
86631	ANTIBODY; CHLAMYDIA
86632	ANTIBODY ; CHLAMYDIA IGM
86687	ANTIBODY; HTLV I
86688	ANTIBODY; HTLV-II
86689	ANTIBODY; HTLV OR HIV ANTIBODY CONFIRMATORY TEST (EG WESTERN BLOT)
86694	ANTIBODY; HERPES SIMPLEX NON-SPECIFIC TYPE TEST
86695	ANTIBODY; HERPES SIMPLEX TYPE I
86696	HERPES SIMPLEX TYPE 2
86701	ANTIBODY HIV 1
86702	ANTIBODY; HIV 2
86703	ANTIBODY; HIV-1 AND HIV-2 SINGLE RESULT
86706	HEPATITIS B SURFACE ANTIBODY (HBSAB)
86707	HEPATITIS BE ANTIBODY (HBEAB)
86762	ANTIBODY; RUBELLA
86787	ANTIBODY; VARICELLA-ZOSTER
86803	HEPATITIS C ANTIBODY
86900	BLOOD TYPING; ABO

Procedure Code	Description
86901	BLOOD TYPING; RH(D)
87015	CONCENTRATION (ANY TYPE) FOR PARASITES OVA OR TUBERCLE BACILLUS (TB AFB)
87040	BLOOD CULTURE FOR BACTERIA
87070	CULTURE BACTERIA OTHER
87071	CULTURE BACTERIA; QUANTITATIVE AEROBIC WITH ISOLATION & PRESUMPTIVE IDENTIFICATION OF ISOLATES
87073	CULTURE BACTERIAL; QUANTITATIVE ANEROBIC WITH ISOLATION & PRESUMPTIVE IDENTIFICATION OF ISOLATES
87075	CULTURE BACTERIA EXCEPT BLOOD
87076	CULTURE BACTERIAL ANY SOURCE DEFINITIVE IDENTIFICATION EACH ANAEROBIC ORGANISM
87077	CULTURE BACTERIAL;AEROBIC ISOLATE ADDITONAL METHODS REQUIRED FOR DEFINITIVE IDENTIFICATION
87081	CULTURE BACTERIAL SCREENING ONLY FOR SINGLE ORGANISMS
87086	CULTURE BACTERIAL URINE QUANTITATIVE COLONY COUNT
87088	URINE BACTERIA CULTURE
87102	CULTURE FUNGI ISOLATION OTHER SOURCE (EXCEPT BLOOD)
87110	CULTURE CHLAMYDIA
87147	CULTURE TYPING SEROLOGIC METHOD AGGLUTINATION GROUPING PER ANTISERUM
87164	DARK FIELD EXAMINATION ANY SOURCE (EG PENILE VAGINAL ORAL SKIN)
87184	SENSITIVITY STUDIES ANTIBIOTIC DISK METHOD PER PLATE (12 OR LESS DISKS)
87186	SENSITIVITY STUDIES ANTIBIOTIC MICROTITER MINIMUM INHIBITORY CONCENTRATION (MIC)
87205	SMEAR PRIMARY SOURCE WITH INTERPRETATION ROUTINE STAIN
87206	SMEAR PRIMARY SOURCE WITH INTERPRETATION FLUORESCENT AND/OR ACID FAST STAIN FOR BACTERIA FUNGI
87207	SMEAR SPECIAL STAIN
87210	SMEAR PRIMARY SOURCE WITH INTERPRETATION WET MOUNT WITH SIMPLE STAIN
87220	TISSUE EXAMINATION FOR FUNGI (EG KOH SLIDE)
87252	VIRUS IDENTIFICATION; TISSUE CULTURE INOCULATION AND OBSERVATION
87270	INFECT AGENT ANTIGEN DETECTION BY DIRECT FLUORESCENT ANTIBODY TECH; CHLAMYDIA TRACHOMATIS
87273	INFECTIOUS AGENT ANTIGEN DETECTION BY FLOURESCENT ANTIBODY; HERPES SIMPLEX VIRUS TYPE 2
87274	INFECTIOUS AGENT ANTIGEN DETECTION BY DIRECT FLUORESCENT ANTIBODY TECH; HERPES SIMPLEX VIRUS
87320	INFECT AGT ANTIGEN DETECTION BY ENZYME IMMUNOASSY METHOD; ADENOVIRUS ENTERIC TYPES 40/41 CHLAMYD
87340	HEPATITIS B SURFACE ANTIGEN
87350	HERPES SIMPLEX TYPE 2
87389	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE,

Procedure Code	Description
	QUALITATIVE
87390	HIV-1
87391	HIV-2
87470	INFECT AGT DETECT BY NUCLEIC ACID (DNA OR RNA); BARTONELLA HENSELAE AND BARTONELLA QUINTANA DIRECT
87480	CANDIDA SPECIES DIRECT PROBE TECHNIQUE
87481	CANDIDA SPECIES AMPLIFIED PROBE TECHNIQUE
87482	CANDIDA SPECIES QUANTIFICATION
87485	CHLAMYDIA PNEUMONIAE DIRECT PROBE TECHNIQUE
87486	CHLAMYDIA PNEUMONIAE AMPLIFIED PROBE TECHNIQUE
87487	CHLAMYDIA PNEUMONIAE QUANTIFICATION
87490	CHLAMYDIA TRACHOMATIS DIRECT PROBE TECHNIQUE
87491	CHLAMYDIA TRACHOMATIS AMPLIFIELD PROBE TECHNIQUE
87492	CHLAMYDIA TRACHOMATIS QUANTIFICATION
87495	CYTOMEGALOVIRUS DIRECT PROBE TECHNIQUE
87496	CYTOMEGALOVIRUS AMPLIFIED PROBE TECHNIQUE
87497	CYTOMEGALOVIRUS QUANTIFICATION
87510	GARDNERELLA VAGINALIS DIRECT PROBE TECHNIQUE
87511	GARDNERELLA VAGINALIS AMPLIFIED PROBE TECHNI
87512	GARDNERELLA VAGINALIS QUANTIFICATION
87528	HERPES SIMPLEX VIRUS DIRECT PROBE TECHNIQUE
87529	HERPES SIMPLEX VIRUS AMPLIFIED PROBE TECHNIQUE
87530	HERPES SIMPLEX VIRUS QUANTIFICATION
87531	HERPES VIRUS-6 DIRECT PROBE TECHNIQUE
87532	HERPES VIRUS-6 AMPLIFIED PROBE TECHNIQUE
87533	HERPES VIRUS-6 QUANTIFICATION
87534	HIV-1 DIRECT PROBE TECHNIQUE
87535	HIV-1 AMPLIFIED PROBE TECHNIQUE
87536	HIV-1 QUANTIFICATION
87537	HIV-2 DIRECT PROBE TECHNIQUE
87538	HIV-2 AMPLIFIED PROBE TECHNIQUE
87539	HIV-2 QUANTIFICATION
87590	NEISSERIA GONORRHOEAE DIRECT PROBE TECHNIQUE
87591	NEISSERIA GONORRHOEAE AMPLIFIED PROBE TECHNIQUE
87592	NEISSERIA GONORRHOEAE QUANTIFICATION
87620	PAPILLOMAVIRUS HUMAN DIRECT PROBE TECHNIQUE
87621	PAPILLOMAVIRUS HUMAN AMPLIFIED PROBE TECHNIQUE
87622	PAPILLOMAVIRUS HUMAN QUANTIFICATION
87660	TRICHOMONAS VAGIN DIR PROBE
87797	NOT OTHERWISE SPECIFIED DIRECT PROBE TECHNIQUE
87800	INFECT AGT DETECTION BY NUCLEIC ACID MULTIPLE ORGANISMS; DIRECT PROBE TECHIQUE
87801	INFECT AGT DETECTION BY NUCLEIC ACID MULTIPLE ORGANISMS; AMPLIFIED

Procedure Code	Description
	PROBE TECHNIQUE
87810	INFECTIOUS AGT DETECTION BY IMMUNOASSY WITH DIRECT OPTICAL OBSERVATION; CHLAMYDIA TRACHOMATIS
87850	INFECTIOUS AGT DETECTION BY IMMUNOASSY WITH DIRECT OPTICAL OBSERVATION; NEISSERIA GONORRHOEAE
88108	CYTOPATHOLOGY CONCENTRATION TECHNIQUE SMEARS AND INTERPRETATION (EG SACCOMANNO TECHNIQUE)
88141	CYTOPATHOLOGY CERVICAL OR VAGINAL
88142	CYTOPATHOLOGY CERVICAL OR VAGINAL, THIN LAYER PREPARATION; MANUAL SCREENING UNDER PHYS SUPERVISION
88143	CYTOPATHOLOGY CERVICAL OR VAGINAL, WITH MANUAL SCREENING AND RESCREENING
88147	CYTOPATHOLGY SMEARS CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM UNDER PHYSICIAN SUPERVISION
88148	CYTOPATHOLOGY SMEARS CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM WITH MANUAL RESCREENING
88150	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL; MANUAL SCREENING UNDER PHYSICIAN SUPERVISION
88152	CYTOPATHOLOGY SLIDE CERVICAL OR VAGINAL; W/ MANUAL & COMPUTER-ASSISTED RESCREENING UNDER PHYS SUPERVISION
88153	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL; WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION
88154	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL; WITH MANUAL SCREENINGS AND COMPUTER-ASSISTED RESCREENING
88155	CYTOPATHOLOGY SLIDE CERVICAL OR VAGINAL DEFINITIVE HORMONAL EVALUATION
88160	CYTOPATHOLOGY SMEARS ANY OTHER SOURCE; SCREENING AND INTERPRETATION
88161	CYTOPATHOLOGY SMEARS ANY OTHER SOURCE; PREPARATION SCREENING AND INTERPRETATION
88162	CYTOPATHOLOGY SMEARS ANY OTHER SOURCE; EXTENDED STUDY INVOLVING OVER 5 SLIDES AND/OR MULTIPLE STAINS
88164	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL(THE BETHESDA SYSTEM)
88165	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); UNDER PHYSICIAN'S SUPERVISION
88166	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); WITH MANUAL SCREENING AND COMPUTER-ASSISTED RESCREENING
88167	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); WITH MANUAL SCREENING AND COMPUTER-ASSISTED RESCREENING USING CELL SELECTION
88172	EVALUATION OF FINE NEEDLE ASPIRATE W/ OR W/O PREPARATION OF SMEARS; IMMEDIATE CYTOHISTOLOGIC STUDY
88173	EVALUATION OF FINE NEEDLE ASPIRATE W/ OR W/O PREPARATION OF SMEARS; INTERPRETATION AND REPORT
88174	CYTOPATH C/V AUTO IN FLUID

Procedure Code	Description
88175	CYTOPATH C/V AUTOMATED THIN LAYER PREPARATION, WITH SCREENING BY AUTOMATED SYSTEM AND MANUAL RESCREENING OR REVIEW, UNDER PHYSICIAN SUPERVISION
99070	SUPPLIES AND MATERIALS (EXCEPT SPECTACLES), PROVIDED BY THE PHYSICIAN OVER AND ABOVE THOSE USUALLY INCLUDED WITH THE OFFICE VISIT OR OTHER SERVICES RENDERED
99201-99205	NEW PATIENT OR ESTABLISHED PATIENT - OFFICE OR OTHER OUTPATIENT VISIT
99211-99215	NEW PATIENT OR ESTABLISHED PATIENT - OFFICE OR OTHER OUTPATIENT VISIT
99383-99386	PREVENTATIVE MEDICINE SERVICES/NEW PATIENT
99393-99396	PREVENTATIVE MEDICINE SERVICES/ESTABLISHED PATIENT
A4261	CERVICAL CAP FOR CONTRACEPTIVE USE
A4266	DIAPHRAGM
J7300	INTRAUTERINE COPPER CONTRACEPTIVE
J7302	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM
J7303	CONTRACEPTIVE VAGINAL RING
J7304	CONTRACEPTIVE HORMONE RING
J7306	LEVONORGESTREL IMPLANT
Q0111	WET MOUNTS, INCLUDING PREPARATIONS OF VAGINAL, CERVICAL, OR SKIN SPECIMENS
T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE

Covered Drug Classes[24]

Drug Class	Description
G2A	PROGESTATIONAL AGENTS (Used for Contraception)
G8A	CONTRACEPTIVES, ORAL
G8B	CONTRACEPTIVES, IMPLANTABLE
G8C	CONTRACEPTIVES, INJECTABLE
G8F	CONTRACEPTIVES, TRANSDERMAL
G9B	CONTRACEPTIVES, INTRAVAGINAL
L5A	KERATOLYTICS
Q4F	VAGINAL ANTIFUNGALS
Q4W	VAGINAL ANTIBIOTICS
Q5R	TOPICAL ANTIPAPASITICS
Q5V	TOPICAL ANTIVIRALS
W1A	PENICILLINS
W1B	CEPHALOSPORINS
W1C	TETRACYCLINES
W1D	MACROLIDES
W1F	AMINOGLYCOSIDES
W1K	LINCOSAMIDES
W1P	BETALACTAMS
W1Q	QUINOLONES
W1Y	CEPHALOSPORINS 3RD GENERATION
W2A	ABSORBABLE SULFONAMIDES
W3B	ANTIFUNGAL AGENTS
W3C	ANTIFUNGAL AGENTS (CONTINUED)
W4E	ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS
W5A	ANTIVIRAL, GENERAL
WG4	2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL
X1B	DIAPHRAMS/CERVICAL CAP
X1C	INTRA-UTERINE DEVICES
Z2G	IMMUNOMODULATORS (Aldera)

[24] Note: A Provider Bulletin dated March 21, 2013 and found online here: http://www.dss.mo.gov/mhd/providers/pdf/bulletin35-24_2013mar21.pdf deleted the drug classification Q6V (eye antivirals) that had been used in previous analyses after it was determined that its use was not directly related to sexually transmitted diseases or family planning.