MERCER

1115 Demonstration Extension Application
Attachment 11

State of Missouri Department of Social Services

Evaluation of the Women's Health Services Program

Section 1115 Demonstration Project

EVALUATION YEAR 8: January 1, 2015 – December 31, 2015

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EXECUTIVE SUMMARY

This is the eighth evaluation of the Missouri Women's Health Services Program 1115 Demonstration (the Program). The demonstration was originally approved as a part of Missouri's Section 1115 Managed Care Plus (MC+) waiver in 1998. The current demonstration program started on October 1, 2007 and was recently extended until December 31, 2017. The evaluation has covered every year since Year 1 of the waiver in 2007-2008.

The recent waiver extension resulted in a shift in the reporting period, from fiscal years to calendar years. This report is for calendar year 2015. However, note that trends and comparisons to previous reports are between fiscal year 2014 and calendar year 2015. Since the previous report covered fiscal year 2014 (October 1, 2013 to September 30, 2014), this left the period from October 1, 2014 to December 31, 2014 unreported. We have included that period in this report as Appendix II for the sake of completeness, although the figures associated with that quarter are not comparable to the full year period in this report, as well as previous reports.
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 the respective hypotheses, and the findings are summarized below for calendar year (CY) 2015.

Several significant changes are likely to be still affecting the program:

- Effective January 1, 2014 Missouri statutes were revised to require eligibility determinations through the Modified Adjusted Gross Income (MAGI) methodology. Income assets are no longer regarded in the determination and the Federal Poverty Level upper income limit was changed from 185% to 201%.

- The federal Health Insurance Exchange was implemented and the Individual Mandate of the Affordable Care Act (ACA) took effect.

- Effective 10/1/2015, Missouri Medicaid began accepting only claims using ICD-10 diagnostic codes.

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 105,929 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 an estimated total of 1,882 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 an estimated 1,882 births among program enrollees, the program resulted in total state and federal savings of $7,594,150. The savings are derived from the avoided costs of pregnancy, labor, and delivery. Savings are even greater ($16,830,206) 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: During the program year, 26.1% 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: During the program year, 11.7% 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: During the program year, 1.5% of the program population had at least one claim for sexually transmitted infection treatment or testing.

PROGRAM OVERVIEW

Unintended pregnancies account for nearly half (45%) 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] 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).[3] Mothers who have unintended pregnancies are less likely to breastfeed and have lower levels of psychological well-being during pregnancy and after the birth.[4] [5] For teen mothers and their children, the consequences of an unintended pregnancy can be even more profound. Unintended pregnancy rates are highest among poor and low-income women, women between the ages of 18–24, cohabiting women and minority women. Rates tend to be lowest among higher-income women, Caucasian women, college graduates, and married women. For example, in 2011, the rate of unintended pregnancy among higher-income Caucasian women was less than half of the national rate (18 versus 45

[1] Guttmacher Institute, Unintended Pregnancy in the United States, March 2016.
[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] 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.
[4] 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.
[5] 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.

per 1,000).[6] 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 they are in their twenties.[7]

In addition to the health impact that an unintended pregnancy can have for the 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. Moreover, the Medicaid/CHIP programs covered 65% of those births. Using Pregnancy Risk Assessment Monitoring System (PRAMS) data, state surveys, and other methodology, the study concluded 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.[8] 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.[9] 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 Program, 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.[10] 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 reviewing total state and federal costs.[11] [12] Comparable cost savings were noted in a 2014 article published by the authors of the Milbank Quarterly, a peer-reviewed healthcare journal examining health care policy issues. In the article, the authors reviewed 2010 national data and concluded that the investment in family planning programs resulted in a net government savings of $13.6 billion in 2010, or $7.09 for every public dollar spent.[13]

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-

[6] Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, New England Journal of Medicine, 2016, 374(9):843–852, http://nejm.org/doi/full/10.1056/NEJMsa1506575.

[7] N g A, Kaye K. Why It Matters: Teen Childbearing and Child Welfare. Washington: National Campaign to Prevent Teen Pregnancy; 2013. https://thenationalcampaign.org/resource/why-it-matters-teen-childbearing-and-child-welfare .

[8] 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

[9] Ibid.

[10] 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

[11] 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

[12] 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.

[13] Frost JJ, Sonfield A, Zolna MR, Finer LB, Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program. Milibank Quarterly. 2014 Dec;92(4):696-749.

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 2007-2012 data report, which is the most recent report available:[14]

- Nearly half (43%) of live births in Missouri during 2007, 2008 2009, 2010, 2011, and 2012 resulted from unintended pregnancy, including 63.1% 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, were located in a rural community, had a Non-Hispanic, African-American, or Hispanic background, were unmarried, and covered by Medicaid before pregnancy.
- Among women reporting an unintended pregnancy, 53.8% were not using any type of contraception.
- Of the women who did not use birth control and had unintended pregnancies, 9.1% 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 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 between 18 and 55 years of age with family net incomes of 201% FPL or below (measured using MAGI methodology) are also eligible for program services as long as they continue to meet eligibility requirements.

The program 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 Demonstration. Effective January 1, 2009, eligibility was expanded to include uninsured women between 18 and 55 years of age whose income was below 185% of the federal poverty level. Effective January 1, 2014, eligibility determinations were converted to MAGI methodology and the income threshold increased to 201% of the federal poverty level calculated using MAGI methods, with no asset or resource test being applied in the eligibility determination. The Centers for Medicare and Medicaid Services (CMS) have approved extensions of the program, with the program currently being authorized until December 31, 2017.

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.*

[14] Missouri Pregnancy Risk Assessment Monitoring System (PRAMS) 2007-2012 report obtained from state officials

Family planning services and supplies include:

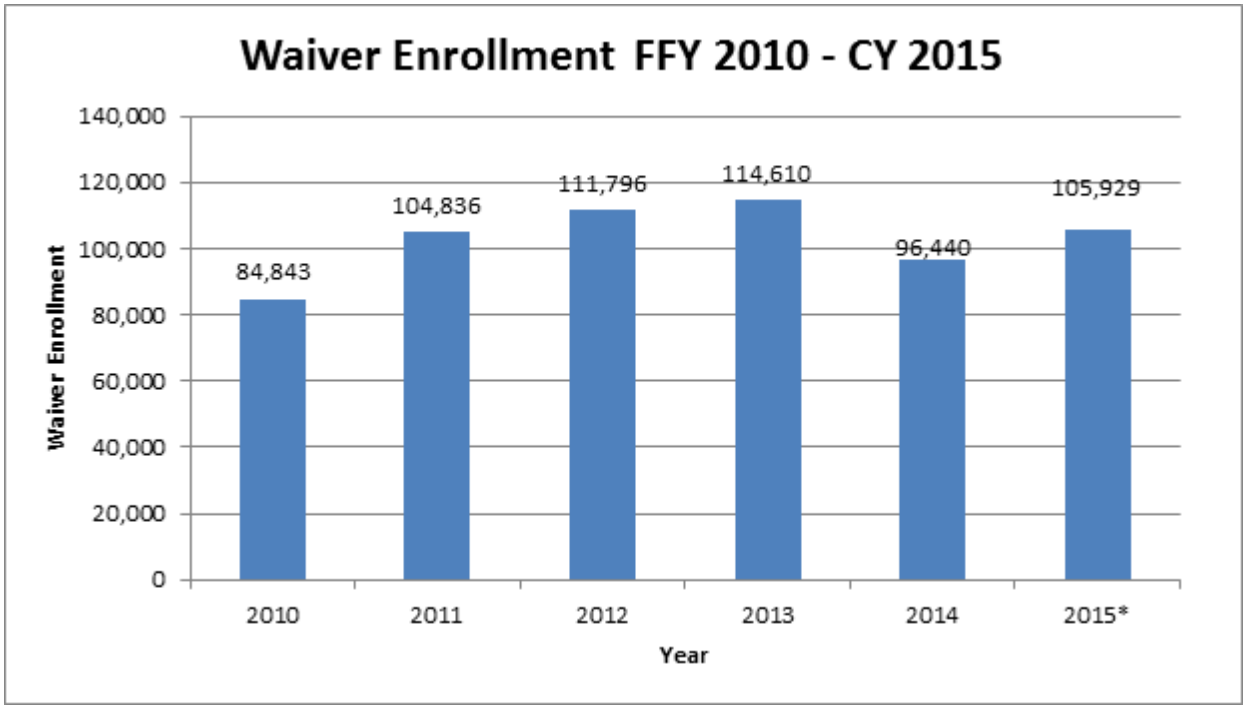
- Department of Health and Human Services approved methods of contraception;
- Family planning counseling/education on various methods of birth control;
- Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
  - Note: The laboratory tests done 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 2010.



**The enrollment numbers for 2015 in this chart reflect calendar year 2015. Previous years indicate enrollment for fiscal years.*

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.

Butler County Health Department

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

Center for Contraceptive Choice (The)

- The Center for Contraceptive Choice – St Louis

Children's Mercy Hospital (The)

- CMH Teen Clinic – Kansas City
- CMH Northland Teen Clinic – Kansas City
- Synergy Youth Resiliency Center – Kansas City

East Missouri Action Agency

- EMAA Women's Wellness Center – Park Hills

- EMAA Women's Wellness Center – Cape Girardeau
- Madison County Health Department - Fredericktown

Economic Security Corporation of Southwest Area

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

Family Care Health Centers

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

Family Planning Clinic of Franklin County, Inc.

- FPCFC – St Clair

Green Hills Community Action Agency

- Hamilton Methodist Church - Hamilton
- GHCAA/Women's Health Services-Trenton
- Harrison County Health Department - Bethany
- Linn County Health Department - Brookfield
- GHCAA/Women's Health Services-Chillicothe
- Putnam County Health Department - Unionville
- Carroll County Health Department – Carrollton
- Ray County Health Department - Richmond
- Chariton County Health Department – Keytesville

Jefferson County Health Department

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

Katy Trail Community Health

- Katy Trail Community Health – Sedalia
- Katy Trail Community Health – Warsaw
- Prairie Hills Clinic - Versailles
- Katy Trail Community Health - Marshall

North East Community Action Corporation

- NECAC Family Planning Center – Hannibal
- NECAC Family Planning Center – Bowling Green
- NECAC Family Planning Center – Warrenton
- NECAC Family Planning Center – O'Fallon
- Monroe County Health Department - Paris
- Adair County Health Department - Kirksville
- Boone County Health Department – Columbia
- Randolph County Health Department - Moberly

Ozarks Area Community Action Corporation

- OACAC Family Planning - Springfield
- Barry County Health Department – Cassville
- Barry County Health Department – Monett
- Dade County Health Department - Greenfield
- Lawrence County Health Unit – Mt. Vernon
- Polk County Health Department - Bolivar
- Stone County Health Department – Branson West
- 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 – Kansas City
- North Kansas City Center – Kansas City
- Columbia Center - Columbia
- Independence Center – Independence

Planned Parenthood of the St. Louis Region and Southwest Missouri

- Central West End Health Center – St Louis
- South Grand Health Center – St Louis

Social Welfare Board

- Social Welfare Board – St. Joseph

Stoddard County Public Health Center

- Mississippi County Health Department – Charleston
- New Madrid County Health Department – New Madrid
- Pemiscot Health Center – Hayti
- Scott County Health department – Sikeston
- Stoddard County Public Health Center – Bloomfield

Swope Health Services

- Swope Health Central – Kansas City

Tri-Rivers Family Planning, Inc.

- Rolla Center – Rolla
- Lake Center – Lake Ozark
- Lewis County Health Department – Monticello
- Clark County Health Department – Kahoka
- Howell County Health Department – West Plains

West Central Missouri Community Action Agency

- WCMCAA – Butler
- WCMCAA – Cottey College
- WCMCAA – Clinton
- WCMCAA – Appleton City
- WCMCAA – Nevada
- 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.

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 during the program year, 68.39 per 1,000 program enrollees, than women in the base year of FFY 2000, when the birthrate 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 1,882 pregnancies in the period.

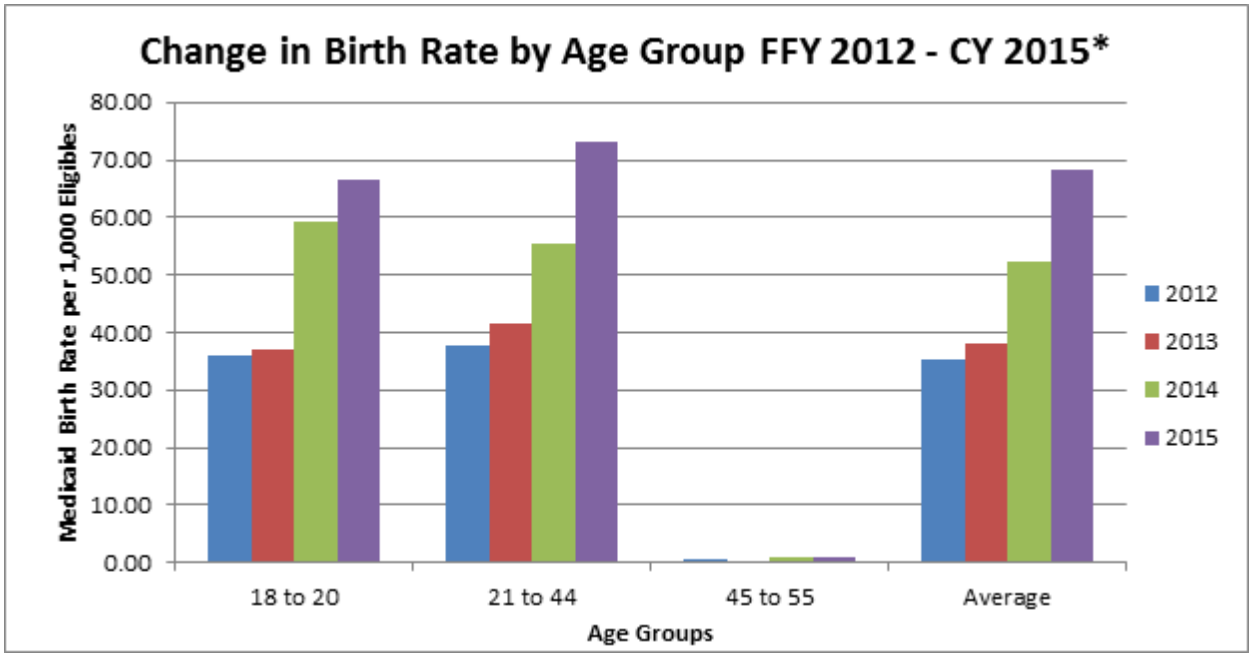
Table 1: Estimated Averted Pregnancies by Age Group, CY 2015

Age Group	Medicaid Birthrate in 2000	Count of Program Pregnancies	Program Population	Program Birthrate per 1,000	Estimated Expected Pregnancies	Estimated Averted Pregnancies
18 to 20	89.16	387	5,831	66.37	520	133
21 to 44	91.98	6850	93,524	73.24	8,603	1,753
45 to 55	0.53	7	6,574	1.06	3	-4
Total	**78.53**	**7244**	**105929**	**68.39**	**9,126**	**1,882**

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. Age group cohorts are those used in the budget neutrality calculations.

Comparisons between calendar year 2015 and previous fiscal years show a continued increase in birth rates. The overall program birth rate has increased from 35.16 births per 1,000 in FFY 2012 to 68.39 births per 1,000 in CY 2015. MHD will continue to monitor this trend through budget neutrality reporting.

Missouri 1115 Family Planning Evaluation



**2015 reflects birthrates for calendar year 2015. Previous years reflect fiscal years.*

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 1,882 pregnancies among program enrollees, the program achieved savings of about $7.6 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 the program year and subtracting the program spending. The total savings are even greater at $16.8 million, when actual CY 2015 Medicaid costs in the first year of life are included.[15]

Table 2: Program Costs and Savings, FFY 2014 and CY 2015[16]

	FFY 2014	CY 2015
Births Averted	3,210	1,882
Costs Per Birth	$5,720	$7,138
Costs Per First Year	$8,594	$4,908
FP Waiver Costs	$7,106,201	$5,839,555
Total Savings for Births	$11,255,491	$7,594,150
Total Savings for Births and First Years	$38,842,859	$16,830,206

[15] 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 (1,882) by the average Medicaid cost of a birth during the period, ($7,138) and the average Medicaid cost of the first year of life during the period, ($4,908), and subtracting program spending ($5,839,555). 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.

[16] 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 comparable 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, 26.1% of the program population had at least one claim for a program-covered service in the reporting period. 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 30.7% and 28.1%, respectively.

Table 3: Program Service use, CY 2015

Age group	Service Users	Program Population	Share (in percent)
18 to 24	8,893	28,955	**30.7%**
25 to 29	7,443	26,480	**28.1%**
30 to 34	4,995	19,138	**26.1%**
35 to 39	2,503	11,459	**21.8%**
40 to 44	1,098	6,116	**18.0%**
45 to 55	677	5,902	**11.5%**
Total	**25,609**	**98,050**	**26.1%**

Source: Mercer analysis of claims data and enrollment data from Missouri DSS MMIS
Notes: The 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 between 1/1/2015 and 12/31/2015, while the program population for the service usage sections is based on the period of enrollment during for that period, a shift of approximately two weeks. Age of service users is as of the end date of the evaluation period (December 31, 2015), and thus includes women who were 56 at the end of the period but would have had a period of eligibility during CY 2015 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 23. Age categories 45 - 50 and 51 - 55 were combined due to small population ranges.

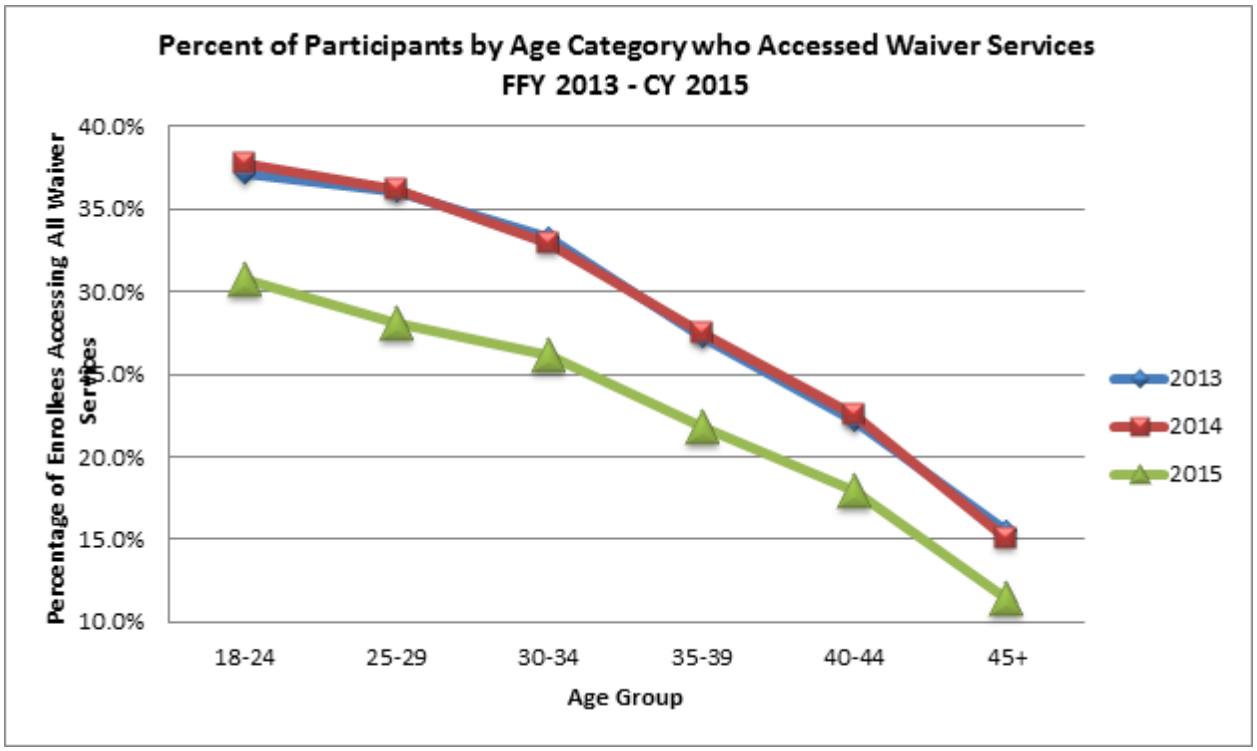
The percentage and number of program enrollees who used at least one women's health service decreased from 32.8% in FFY 2014 to 26.1% during this period, as reflected in the charts below:

Table 4: Number of Enrollees Using Program Services, FFY 2013 - CY 2015

Year	Service Users	Percent Share
2013	37,172	32.6%
2014	31,289	32.8%
2015	25,609	26.1%

Table 5: Percentage of Enrollees by Age Groups Accessing Program Services, FFY 2013-CY 2015

Age Group	2013	2014	2015
18-24	37.2%	37.8%	30.7%
25-29	36.1%	36.1%	28.1%
30-34	33.3%	32.9%	26.1%
35-39	27.2%	27.5%	21.8%
40-44	22.2%	22.5%	18.0%
45+	15.6%	15.0%	11.5%
Total	**32.6%**	**32.8%**	**26.1%**



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

Providing access to contraceptive services and 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, 11.7% 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 15.3% 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, CY 2015

Age group	Service Users	Program Population	Share (in percent)
18 to 24	4,424	28,955	**15.3%**
25 to 29	3,489	26,480	**13.2%**
30 to 34	2,168	19,138	**11.3%**
35 to 39	909	11,459	**7.9%**
40 to 44	322	6,116	**5.3%**
45 to 55	165	5,902	**2.8%**
Total	**11,477**	**98,050**	**11.7%**

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 between 1/1/2015 and 12/31/2015, while the program population for the service usage sections is based on the period of enrollment during for that period, a shift of approximately 2 weeks. Age of service users is as of the end date of the evaluation period (December 31, 2015), and thus includes women who were 56 at the end of the period but would have had a period of eligibility during CY 2015 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 23. Age categories 45 - 50 and 51 - 55 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 decreased slightly between FFY 2014 and the current period in every age group except those over 45. 11.7% of program enrollees had a claim for contraceptive supplies or services in the CY 2015, as opposed to 12.8% in FFY 2014.

Table 7: Contraceptive Services Usage, CY 2015

Age Group	2013	2014	2015
18 - 24	19.4%	16.7%	15.3%
25 - 29	17.1%	14.8%	13.2%
30 - 34	14.2%	12.3%	11.3%
35 - 39	9.5%	8.4%	7.9%
40 - 44	5.9%	5.5%	5.3%
45 - 55	2.4%	2.2%	2.8%
Total	**14.7%**	**12.8%**	**11.7%**

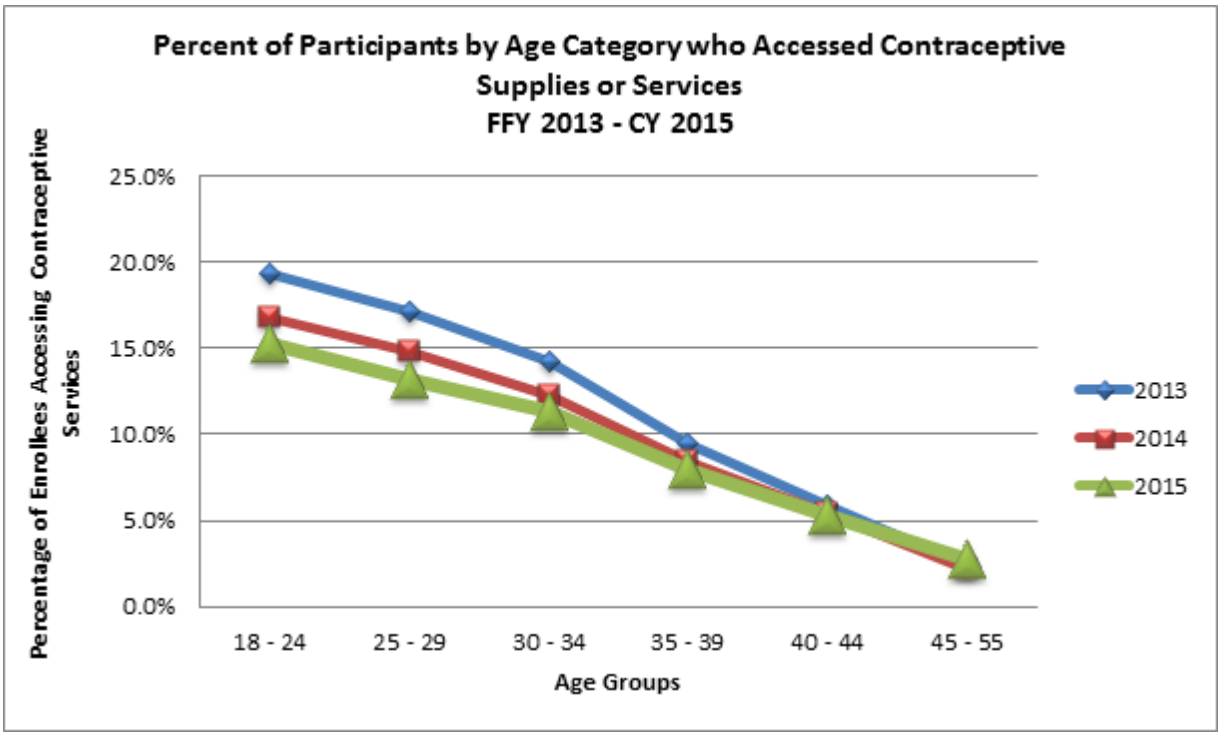


Table 8: Contraceptive Methods

Contraceptive Methods	Number Dispensed	Number of Unique Users	Data Source
Male Condom	NA		MMIS
Female Condom	NA		MMIS
Sponge	Not Identified		MMIS
Diaphragm	1	1	MMIS
Pill	42,080	9,370	MMIS
Patch	1,674	415	MMIS
Ring	3,121	765	MMIS
Injectable	4,696	2,234	MMIS
Implant	700	697	MMIS
IUD	763	754	MMIS
Emergency Contraception	Not Identified		MMIS
Sterilization	314	286	MMIS

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.[17] 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.[18]

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. As required by federal law, the MO HealthNet Division began accepting International Classification (ICD), 10th Revision, Clinical Modification/Procedure Coding System codes on claims with a date of service on and after October 1, 2015. With the implementation of ICD-10, the covered diagnostic range is Z30.011 – Z30.9.

This change reflects the intention of the State 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

[17] 2010 Sexually Transmitted Disease Surveillance, Centers for Disease Control and Prevention at http://www.cdc.gov/std/stats10/trends.htm
[18] *Ibid*.

treatments or testing that are performed during an episode with any other primary diagnosis are not intended to be covered by this waiver.

Based on analysis of claims data, this evaluation found that 1.5% of the program population received services for an STI. The rate of those tested or treated was highest among the 18-24 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.

Table 9: Sexually Transmitted Infections testing, CY 2015

Age group	Service Users	Program Population	Share (in percent)
18 to 24	550	28,955	**1.9%**
25 to 29	459	26,480	**1.7%**
30 to 34	299	19,138	**1.6%**
35 to 39	123	11,459	**1.1%**
40 to 44	58	6,116	**0.9%**
45 to 55	24	5,902	**0.4%**
Total	**1,513**	**98,050**	**1.5%**

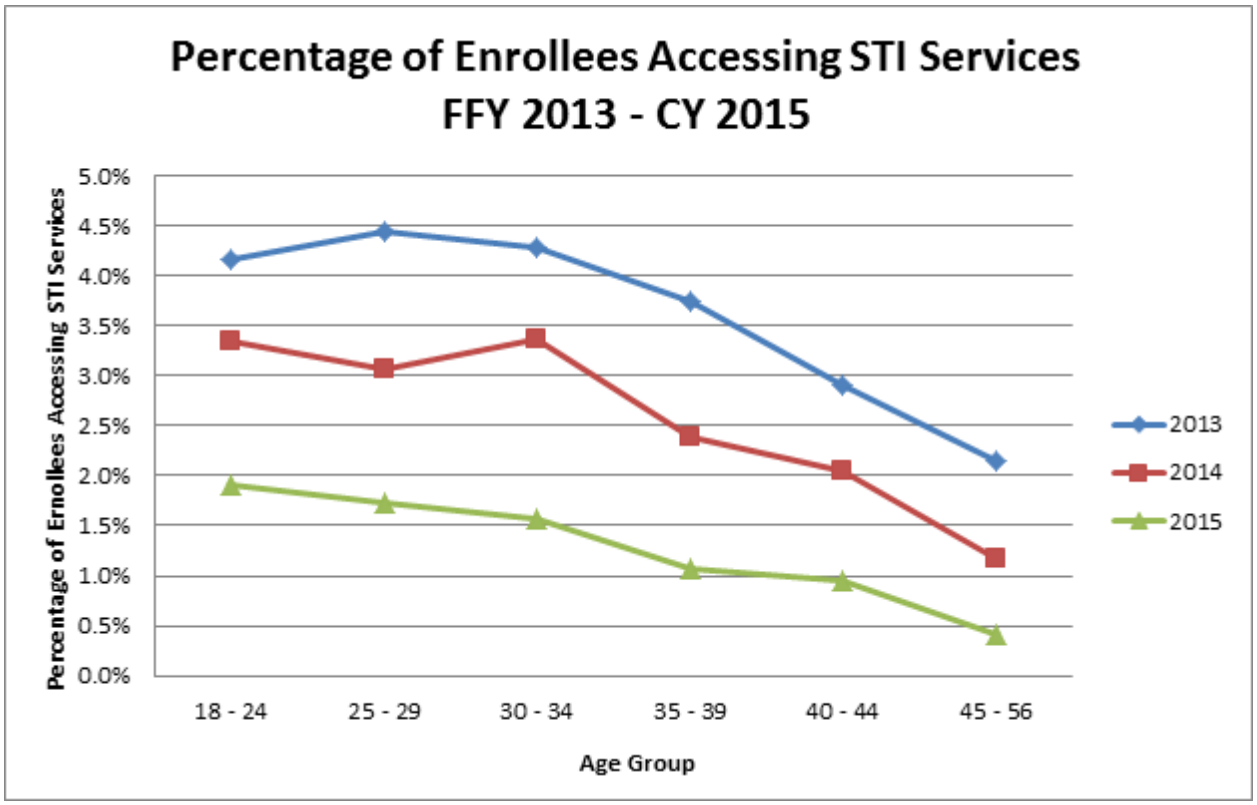
Source: Mercer analysis of claims data and enrollment data from Missouri DSS MMIS

Notes: The slight discrepancy in enrollment numbers between the analysis performed for Hypothesis 5 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 between 1/1/2015 and 12/31/2015, while the program population for the service usage sections is based on the period of enrollment during for that period, a shift of approximately 2 weeks. Age of service users is as of the end date of the evaluation period (December 31, 2015), and thus includes women who were 56 at the end of the period but would have had a period of eligibility during CY 2015 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 23. Age categories 45 - 50 and 51 - 55 were combined due to small population ranges.

As seen below, rates of STI service use have declined in every age group, and overall, for the past three reporting periods.

Table 10: Sexually Transmitted Infections testing, FFY 2013 – CY 2015

Age Group	2013	2014	2015
18 - 24	4.2%	3.3%	1.9%
25 - 29	4.4%	3.1%	1.7%
30 - 34	4.3%	3.4%	1.6%
35 - 39	3.7%	2.4%	1.1%
40 - 44	2.9%	2.0%	0.9%
45 - 56	2.2%	1.2%	0.4%
Total	**4.0%**	**2.9%**	**1.5%**



SUMMARY AND CONCLUSIONS

Data from this evaluation period shows that the birthrate for women in the program continues to be 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 $7,594,150 in birth costs, and a total of $16,830,206 including first year costs, during CY 2015. 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. For example, 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 program services, contraceptive services and STI services. Women of ages 18-34 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 rate in comparison to 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. In comparing the program year covered in this report to the previous reporting period (FFY 2014), the overall service use rate decreased. MHD will monitor this in subsequent reports.

Program enrollment increased from 2014 to 2015. This may indicate that the decrease in enrollment seen in last year's report was reflective of data and application process changes during the implementation of the new eligibility system and MAGI, as hypothesized in last year's report.

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 alleviating those barriers.

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 2014 and gave birth in CY 2015 are counted in CY 2015; women who became pregnant in CY 2015 and will give birth in CY 2016 will be counted in CY 2016. To count the number of women 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 CY 2015 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 (12/31/2015). The second file, a use and spending file extracted from the State's MMIS contained any claim with an ME code of 80 or 89 on it that had paid dates, within the reporting period.

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.[19] 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. The State will review possible reporting options that could provide additional information about the extent to which program enrollees receive treatment.

[19] 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; this included 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.

2007-2008-2009-2010-2011-2012 PRAMS report obtained from the State

APPENDIX I

Covered Services

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
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

Procedure Code	Description
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)
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

Procedure Code	Description
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
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

Procedure Code	Description
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, 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

Procedure Code	Description
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
87623	HUMAN PAPILLOMAVIRUS (HPV), LOW-RISK TYPES
87624	HUMAN PAPILLOMAVIRUS (HPV), HIGH-RISK TYPES
87625	HUMAN PAPILLOMAVIRUS (HPV), TYPES 16 AND 18 ONLY
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 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

Procedure Code	Description
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
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

Procedure Code	Description
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

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	DIAPHRAGMS/CERVICAL CAP
X1C	INTRA-UTERINE DEVICES
Z2G	IMMUNOMODULATORS (Aldera)

APPENDIX II

Quarter 4, Calendar year 2014

This appendix reports data for the period from 10/1/2014 to 12/31/2014, which is not covered in any other reporting period, due to the switch from fiscal year reporting to calendar year reporting implemented in the waiver extension. Because this period only accounts for 3 months, figures derived from this period cannot be compared to this report, or previous reports and we have not included trend or comparison tables for discussion.

Table 1 summarizes the key statistics for the period. Due to the absence of a quarterly baseline, we have not attempted to calculate averted births. Tables 2-4 show usage of all services, contraceptive services, and STI services by age during the quarter.

Table 1: Summary Statistics, Q4 of CY 2014

	Q4, CY 2014
Program Population	80,917
Program Pregnancies	4,767
Program Birthrate	58.93
FP Waiver Costs	$1,652,276
Percent using Any Service	15.4%
Percent using Contraceptive Services	7.7%
Percent using STI Services	0.7%

Table 2: Number of Enrollees Using Program Services, Q4 of CY 2014

Age group	Service Users	Program Population	Share (in percent)
18 to 24	3,827	20,205	**18.9%**
25 to 29	3,678	21,205	**17.3%**
30 to 34	2,613	16,520	**15.8%**
35 to 39	1,268	10,180	**12.5%**
40 to 44	532	5,702	**9.3%**
45 to 55	355	5,908	**6.0%**
Total	**12,273**	**79,720**	**15.4%**

Table 3: Number of Enrollees Using Contraceptive Services, Q4 of CY 2014

Age group	Service Users	Program Population	Share (in percent)
18 to 24	2,088	20,205	**10.3%**
25 to 29	1,877	21,205	**8.9%**
30 to 34	1,258	16,520	**7.6%**
35 to 39	587	10,180	**5.8%**
40 to 44	197	5,702	**3.5%**
45 to 55	110	5,908	**1.9%**
Total	**6,117**	**79,720**	**7.7%**

Table 4: Number of Enrollees Using STI Services, Q4 of CY 2014

Age group	Service Users	Program Population	Share (in percent)
18 to 24	176	20,205	**0.9%**
25 to 29	164	21,205	**0.8%**
30 to 34	135	16,520	**0.8%**
35 to 39	66	10,180	**0.6%**
40 to 44	25	5,702	**0.4%**
45 to 55	10	5,908	**0.2%**
Total	**576**	**79,720**	**0.7%**