STATE OF WASHINGTON
HEALTH CARE AUTHORITY
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August 28, 2015

Shanna Wiley
Project Officer
Division of State Demonstrations and Waivers
Centers for Medicare and Medicaid Services
7500 Security Boulevard, MS S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Wiley:

SUBJECT: Washington State Family Planning Section 1115 Demonstration Waiver – TAKE CHARGE Year Fourteen Quarter Four Report

Enclosed is Washington State Health Care Authority's Quarterly Report for our 1115 Family Planning Demonstration Waiver, TAKE CHARGE. The report covers Fourth Quarter Demonstration Year Fourteen – April 1, 2015 through June 30, 2015.

We look forward to continuing to work with you to accomplish our shared goals to reduce unintended pregnancies and related Medicaid expenditures in Washington State.

If you have any questions, please contact Stacey Bushaw, Section Supervisor, at 360-725-1829 or by email at stacey.bushaw@hca.wa.gov.

Sincerely,

[redacted]

Todd Slettvet
Section Manager

Enclosure:

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WASHINGTON STATE
TAKE CHARGE MEDICAID SECTION 1115
DEMONSTRATION WAIVER

04/01/2015 -06/30/2015 Fourth Quarter Year Fourteen

August 28, 2015

Introduction

Washington State's TAKE CHARGE program, which began July 2001, expanded Medicaid coverage for family planning services to men and women with family incomes at or below 200% of the federal poverty level (FPL). Beginning on October 1, 2012, clients with incomes up to 250% of FPL were eligible to apply for TAKE CHARGE. Program goals are to improve the health of women, children and families by decreasing unintended pregnancies and lengthening intervals between births, and to reduce state and federal Medicaid expenditures for births from unintended pregnancies. The Centers for Medicare and Medicaid Services (CMS) approved the TAKE CHARGE program as a family planning demonstration program (§1115 waiver). For the first ten years of the waiver, TAKE CHARGE was administered by the Washington State Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA). On July 1, 2011, Washington State Medicaid merged with the Washington State Health Care Authority (HCA). The reorganized Health Care Authority now administers the TAKE CHARGE program.

Executive Summary

Demonstration Population:
The TAKE CHARGE family planning demonstration includes three groups of clients:

- Recently pregnant women who would otherwise lose Medicaid coverage after their maternity coverage ends;
- Women with family incomes at or below 250% of the FPL, seeking to prevent an unintended pregnancy; and
- Men with family incomes at or below 250% of the FPL, seeking to prevent an unintended pregnancy.

Goals of Demonstration:

- Decrease unintended pregnancies, and;
- Reduce state and federal Medicaid expenditures for births from unintended pregnancies.

Program Highlights:

- TAKE CHARGE will continue to cover nearly every FDA approved birth control method and a narrow range of family planning services that help clients to use their contraceptive methods safely, effectively and successfully to avoid unintended pregnancy. The types of birth control include:
- Oral Contraceptives

- Contraceptive Ring and Patch
- Male and Female Condoms
- Spermicides
- Contraceptive Injections
- Contraceptive Implants
- Intrauterine Devices
- Emergency Contraception
- Male and Female Sterilizations
- Diaphragms
- Natural Family Planning
- Abstinence Counseling
- Family planning-related services for women include an annual comprehensive family planning preventive medicine visit and a GC/CT screening for women ages 13 – 25.
- Men's family planning-related services include one counseling session for reducing the risk of unintended pregnancy, condoms and spermicides and services directly related to vasectomies.

Demonstration Year (DY)	Begin Date	End Date	Quarterly Report Due Date (60 days following end of quarter)
Quarter 1	July 1st	September 30th	November 29th
Quarter 2	October 1st	December 31st	March 1st
Quarter 3	January 1st	March 31st	May 30th
Quarter 4	April 1st	June 30th	August 29th

Significant program changes:

- There have been no significant program or policy changes since last quarter.

Policy issues and challenges:

- We are diligently working to increase access to Long Acting Reversible Contraceptives (LARC's) by:
    - Disseminating the TAKE CHARGE evaluation team's published briefing paper about "Use of Long-Acting Reversible Contraception by Washington Women on Medicaid."
    - Negotiating an increased reimbursement for the insertion of LARC's.

Based on further review of agency policies regarding LARC, there are no system barriers to reimbursement for immediate postpartum LARC insertion.

Enrollment

The following tables (below) show data on enrollees, participants, and member months within the demonstration.

Throughout the first three quarters of DY14, overall enrollment has generally continued to decline for all three eligible populations. Total enrollees declined from 30,383 in DY13 Quarter 4 to 20,693 in DY14 Quarter 1, 14,721 in Quarter 2, 11,064 in Quarter 3, and 10,454 in Quarter 4. Similar declines were observed in all three populations, with the greatest declines in Population 2 and Population 3: from DY14 Quarter 1, with 12,532 women in Population 2, this group declined by more than 60%, to 4,153. While the proportional decline was similar for Population 3 (men), the numbers of men enrolled were much smaller.

Washington's health insurance exchange was implemented October 1, 2013. From August 2014 to July 2015, total Medicaid enrollment increased from 1.667 million to 1.812 million. This expanded enrollment in Medicaid has contributed to the decline in the Populations 2 and 3 and possibly to the small increase in new enrollees in Population 1, from 1,756 in Quarter 3 to 2,067 in Quarter 4. In addition, as of March 2015, more than 165,000 people had enrolled in private health insurance plans through Washington's exchange.

Enrollees are defined as all individuals enrolled in the demonstration for the specified quarter of the demonstration years, including those newly enrolled and the total enrollees during the quarter. Participants are defined as all individuals who obtain one or more covered family planning service through the demonstration. Member months refer to the number of months in which persons enrolled in the demonstration are eligible for services.

This demonstration has three eligible populations:

- Population 1: Women losing Medicaid coverage at the conclusion of the 60-day postpartum period
- Population 2: Women who have an income at or below 250% of the FPL
- Population 3: Men who have income at or below 250% of the FPL

DY 14: SFY2015	**Quarter 1 July 1, 2014 to September 30, 2014**			
	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled	1,953	904	14	2,871
# of Total Enrollees	8,041	12,532	124	20,693
# of Participants	268	2,028	11	2,307
# of Member Months	17,580	29,988	301	47,869

DY 14: SFY2015	**Quarter 2 October 1, 2014 to December 31, 2014**			
	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled	3,108	718	12	3,838
# of Total Enrollees	7,662	6,989	72	14,721
# of Participants	274	1,145	1	1,420
# of Member Months	17,711	15,690	156	33,557

DY 14: SFY2015	**Quarter 3 January 1, 2015 to March 31, 2015**			
	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled	1,756	788	6	2,550
# of Total Enrollees	6,533	4,493	38	11,064
# of Participants	232	940	7	1,179
# of Member Months	15,463	11,623	100	27,186

DY 14: SFY2015	**Quarter 4 April 1, 2015 to June 30, 2015**			
	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled	2,067	747	6	2,820
# of Total Enrollees	6,267	4,153	37	10,454
# of Participants	175	862	3	1,040
# of Member Months	14,812	10,580	98	25,490

Service Utilization

Since providers have a year to bill for services provided, utilization reviews are done once each year at the time of the annual report.

Provider Participation

As of December 31, 2014, the TAKE CHARGE waiver had 51 providers serving clients at 164 sites. We have good provider distribution across the state that reflects Washington's population density. There is at least one TAKE CHARGE provider in most counties and more in the more populous counties. As expected, fewer clinics are located in sparsely populated counties of Eastern Washington. In these counties, residents routinely travel to small towns to access goods and services such as groceries, banks, local government agencies, and medical care.

We have several small free standing agencies that are struggling to keep their doors open. They have always operated with slim margins as non-profits. All of the changes under the ACA were challenging for them to prepare for with their scarce resources. They are looking at consolidating some administrative functions and two of them are in dialogue with larger providers to become satellite clinics of those larger entities.

Program Outreach Awareness and Notification

General Outreach and Awareness

- No general public outreach was conducted these past two quarters regarding the Waiver. However, the Health Care Authority has been actively engaged in multimedia outreach regarding health care reform, promoting Washington's Apple Health and access to insurance through the state's insurance exchange.

Target Outreach Campaign(s) (if applicable)

- We have had targeted mailings to prescribers and providers about the 12 month supply requirement and will continue to send out those reminders.

Program Evaluation, Transition Plan and Monitoring

Findings from the TAKE CHARGE Health Insurance Survey report, an interim evaluation report, were presented to the statewide Family Planning Leadership Team on June 2, 2015. Based on these findings, HCA will enter into dialogue with stakeholders to discuss how to better support and encourage clients to transition to comprehensive insurance coverage. We will also continue to support providers in their efforts to help clients become enrolled in Apple Health or insurance through Washington's Health Plan Finder.

Quarterly Expenditures

	Demonstration Year 11 (April 1, 2012 – June 30, 2012)			
	Service Expenditures as Reported on the CMS-64	Administrative Expenditures as Reported on the CMS-64	Total Expenditures as Reported on the CMS-64	Expenditures as requested on the CMS- 37
Quarter 4 Expenditures	$9,326,493	$164,514	$9,491,007	$3,485,754
Total Annual Expenditures	$9,326,493	$164,514	$9,491,007	$3,485,754

	Demonstration Year 12 (July 1, 2012 – June 30, 2013)			
	Service Expenditures as Reported on the CMS -64	Administrative Expenditures as Reported on the CMS -64	Total Expenditures as Reported on the CMS -64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures	$3,848,004	$151,670	$3,999,674	$4,121,158
Quarter 2 Expenditures	$4,283,712	$166,647	$4,450,359	$3,566,530
Quarter 3 Expenditures	$4,535,704	$191,502	$4,727,206	$3,912,507
Quarter 4 Expenditures	$9,326,493	$164,514	$9,491,007	$3,643,423
Total Annual Expenditures	$21,993,913	$674,333	$22,668,246	$15,243,618

	Demonstration Year 13 (SFY 2014) (July 1, 2013 – June 30, 2014)			
	Service Expenditures as Reported on the CMS -64	Administrative Expenditures as Reported on the CMS -64	Total Expenditures as Reported on the CMS -64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures	$4,933,555	$23,593	$4,957.148	$4,394,192
Quarter 2 Expenditures	$5,338,249	$65	$5,338,314	$3,679,638
Quarter 3 Expenditures	$2,115,013	$310,773	$2,425,786	$3,736,993
Quarter 4 Expenditures	$2,115,013	$234,787	$2,040,364	$4,088,678
Total Annual Expenditures	$14,192,394	$569,218	$14,761,612	$15,899,501

	Demonstration Year 14 (SFY 2015) (July 1, 2014 – June 30, 2015)			
	Service Expenditures as Reported on the CMS -64	Administrative Expenditures as Reported on the CMS -64	Total Expenditures as Reported on the CMS -64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures	$858,950	$149,722	$1,008,672	$5,100,262
Quarter 2 Expenditures	$155,792	$50,476	$206,267	$4,693786
Quarter 3 Expenditures	$358,459	$64,877	$423,336	$4,600,969
Quarter 4 Expenditures	$423,789	$57,323	$481,112	$4,469,932
Total Annual Expenditures	$1,373,201	$265,075	$1,638,276	$18,864,949

Activities for Next Quarter

- We will continue to counsel and educate providers and pharmacists about the requirement for providing a 12 month supply of hormonal contraceptives. We will monitor compliance and focus our efforts on the prescribers who are consistently writing for less than a 365 day supply.

- HCA will continue discussions with CMS about extending the TAKE CHARGE Waiver, as is, for an additional year while we continue to transition clients to comprehensive insurance coverage.

July 2015 | RDA Report 9.108
Olympia, Washington

Use of Long-Acting Reversible Contraception by Washington Women on Medicaid

Laurie Cawthon, MD, MPH

MORE THAN ONE-THIRD OF WASHINGTON BIRTHS RESULT FROM UNINTENDED PREGNANCIES. The number of births to Medicaid women resulting from unintended pregnancy is estimated to be 21,323, just over half the 41,809 total Medicaid-paid births in 2014. Unintended pregnancy mainly results from the lack of, inconsistent, or incorrect use of effective birth control methods. A key strategy to reduce unintended pregnancy is to provide women seeking birth control with the most effective methods, such as Long-Acting Reversible Contraception (intrauterine devices (IUDs) and contraceptive implants).

This report summarizes use of Long-Acting Reversible Contraception (LARC) among Washington women and teens on Medicaid, including yearly numbers of LARC insertions from 2010-2014, and describes the medical specialty and licensure of practitioners who performed LARC insertions for Medicaid clients and the clinical settings in which LARCs were inserted.

Key Findings

1. **Teen pregnancy rates in Washington State have declined dramatically since 1990.** The birth rate for Washington teenagers age 15-19, 20.5 per 1000 in 2013, was significantly lower than the U.S. rate, 26.5 per 1000. Since 1990, the birth rate for Washington teens age 18-19 decreased by 57%, the birth rate for teens age 15-17 decreased by 70%, the abortion rate for teens age 18-19 decreased by 72%, and the abortion rate for teens 15-17 decreased by 79%.
2. **More than 100,000 women and teens on Medicaid received LARCs in the past five years, 2010-2014.** Among female Washington Medicaid clients age 13-44 who received any family planning method in 2013, 20.6% received LARCs. In 2014, 24,543 women and teens on Medicaid received LARCs, an increase of more than 16% compared to 2013. The number of Medicaid women who received a contraceptive implant tripled in the past five years, from 2,829 in 2010 to 8,831 in 2014.
3. **More than 2,000 medical providers performed LARC insertions for Medicaid clients in 2014.** More than half of LARC insertion procedures for Medicaid clients were performed by specialists in women's health care, either physicians specializing in obstetrics/gynecology (32.8%) or Certified Nurse Midwives (30.1%). Family physicians, Physician Assistants, and Nurse Practitioners performed one-third (32.8%) of LARC insertions.
4. **Women on Medicaid receive LARCs in a wide range of clinical practice settings.** LARC insertion procedures are usually performed in medical offices or clinics and may also be performed in the delivery room immediately after childbirth or in the operating room, at the same time as a surgical procedure.

This brief report is based on analysis of Medicaid claims and encounter data from ProviderOne, Washington's Medicaid Management Information System. The source of pregnancy rates for Washington teens is the Department of Health Center for Health Statistics.

BACKGROUND

Overall, more than one-third of Washington State births result from unintended pregnancies. The rate is significantly higher for women with Medicaid coverage (51%) than for women not receiving Medicaid (23%). While the rate has slowly declined over time for both groups, the number of births to Medicaid women resulting from unintended pregnancy is estimated to be 21,323, just over half the 41,809 total Medicaid-paid births in 2014 (preliminary data for 2014). Unintended pregnancy mainly results from the lack of, inconsistent, or incorrect use of effective birth control methods.[1] A key strategy to reduce unintended pregnancy is to provide women seeking birth control with the most effective methods, such as Long-Acting Reversible Contraception (intrauterine devices (IUDs) and contraceptive implants).

Long-Acting Reversible Contraception (LARC) is now recommended as first-line birth control for all women and adolescents.[2] LARCs are the most highly effective form of contraception available. LARCs require only a single act of insertion for long term use, and their effectiveness is independent of user motivation and adherence. The National Institutes of Health reports that Long Acting Reversible Contraception methods have a failure rate of 0.27%, as compared to a 4.55% failure rate among birth control pill, patch, and ring users.[3]

Washington State is recognized as a national leader in developing innovative and strategic family planning initiatives. The State Legislature, the Health Care Authority (HCA), and Department of Health (DOH) have implemented initiatives to decrease unintended pregnancy:

- The TAKE CHARGE §1115 family planning waiver, implemented July 1, 2001, has provided contraceptive services to more than 350,000 female and male clients with family incomes up to 250% (now 260%) of the FPL. With implementation of the ACA, and expanded full-scope medical coverage, enrollment in TAKE CHARGE diminished greatly in 2014 – 2015. The HCA has requested an extension from CMS for this waiver through December 31, 2016, to ensure access to family planning services for eligible women without other insurance coverage.
- The WA State Legislature (SSB6002) directed the HCA to require pharmacies to dispense contraceptive drugs with a one-year supply, provided at a single visit, unless the patient requests or the physician instructs otherwise. This policy took effect January 1, 2014. HCA staff from pharmacy, managed care, and family planning worked together with providers to educate, promote, and encourage changes in prescribing and dispensing practices.
- To promote immediate postpartum and post-abortion LARC insertion, the DOH funded production of an on-line learning module for medical providers, with Continuing Medical Education (CME) credits.[4] To date, 174 medical professionals have registered for this training.

With such programs in place to increase access to family planning, more than 100,000 women on Medicaid have received LARCs in the past five years, and pregnancy rates for Washington teens have declined dramatically in recent years.

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[1] Unintended Pregnancy Prevention, available at: http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/index.htm

[2] American College of Obstetricians and Gynecologists. (2012) Committee Opinion No. 539: Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices.

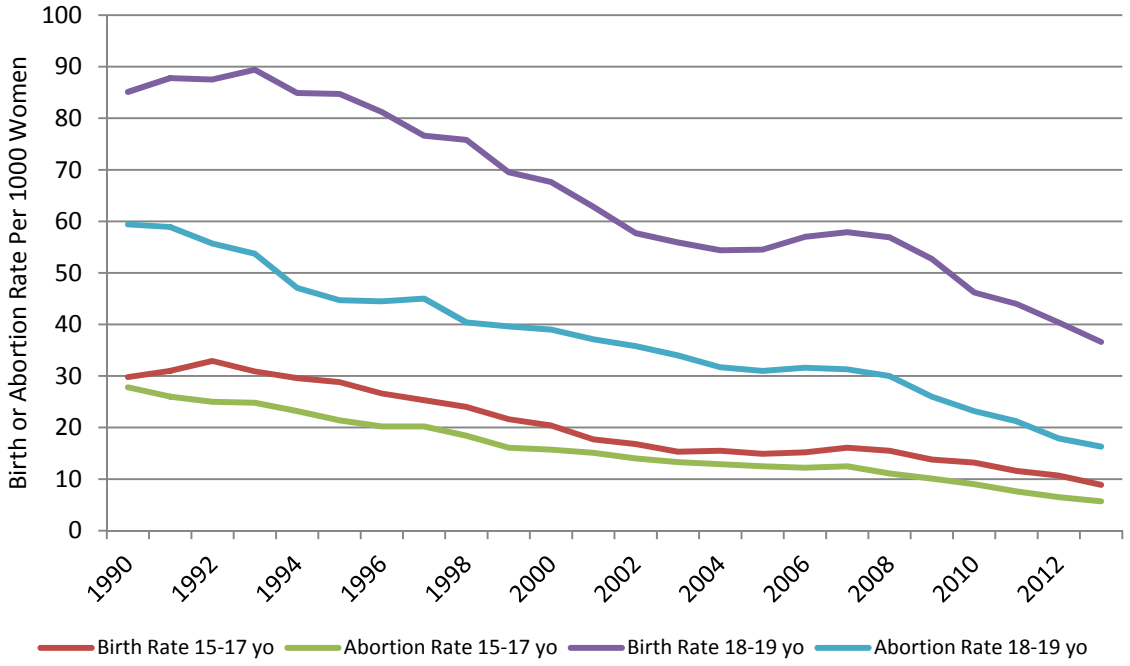
[3] One-year failure rates cited are based on Winner et al. 2012. Effectiveness of Long-Acting Reversible Contraception. *New England Journal of Medicine*, *366*:1998-2007.

[4] Available at: http://www.cardeaservices.org/resourcecenter/inserting-long-acting-reversible-contraception-larc-immediately-after-childbirth

Teen pregnancy rates in Washington State have declined dramatically since 1990.

Birth rates for teenagers in the United States have generally fallen since peaking in 1957.[5] The U.S. rate fell 57% between 1991 and 2013. Trends in Washington State have been similar to those of the nation overall. The birth rate for Washington teenagers age 15-19, 20.5 per 1000 in 2013, was significantly lower than the U.S. rate, 26.5 per 1000. Based on results from the CDC/NCHS' National Survey of Family Growth (NSFG), Ventura et al. (2014) attribute the declines in teen birth rates to a number of behavioral changes, including decreased sexual activity, increases in contraceptive use at first sex and at most recent sex, and increased use of hormonal contraception, injectables, and intrauterine devices (IUDs).

Birth and Abortion Rates for Washington Teens, 15-17 and 18-19 Years Old
1990-2013[6]



- For Washington teens age 18-19, the birth rate declined from 85.1 per 1000 in 1990 to 36.6 per 1000 in 2013. This represents a decrease of 57%.
- For Washington teens age 18-19, the abortion rate declined from 59.4 per 1000 in 1990 to 16.3 per 1000 in 2013. This represents a decrease of 72%.
- For Washington teens age 15-17, the birth rate declined from 29.8 per 1000 in 1990 to 8.9 per 1000 in 2013. This represents a decrease of 70%.
- For Washington teens age 15-17, the abortion rate declined from 27.8 per 1000 in 1990 to 5.7 per 1000 in 2013. This represents a decrease of 79%.

[5] Ventura SJ, Hamilton BE, Mathews TJ. National and state patterns of teen births in the United States, 1940-2013. National vital statistics reports; vol 63 no 4. Hyattsville, MD: National Center for Health Statistics. 2014.
[6] Data Source: Washington State Department of Health, Center for Health Statistics, Table 3, available at: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsandPopulationData/AbortionPregnancy/AbortionPregnancyTrendTables

More than 100,000 Medicaid women and teens received LARCs in the past five years.

Washington Medicaid programs provide family planning and reproductive health coverage to teens and adult men and women. The Family Planning Program offers the most comprehensive family planning coverage of any insurance company in Washington State, and Medicaid family planning programs cover nearly every Food and Drug Administration (FDA) approved birth control method. Clients enrolled in standard Medicaid, with full-scope medical coverage, receive coverage for reproductive health services, and contraceptive products and counseling.[7] Clients enrolled in the TAKE CHARGE waiver and postpartum Family Planning Only programs receive coverage for contraceptive products and counseling and a narrow range of family planning services that help clients use their contraceptive methods safely, effectively, and successfully, to avoid unintended pregnancy.

Among female Washington Medicaid clients age 13-44 who received any family planning method in 2013 (a total of 124,358 unduplicated clients), 20.6% received LARCs (Intrauterine device (IUD) or contraceptive implant). Birth control pills were provided to 50% of female Medicaid clients who received a family planning method. The proportion of female Washington Medicaid contraceptive users who received an IUD or contraceptive implant rose substantially between 2007 and 2013, from 7.2% to 20.6%. During the same time period, the proportion of women who received birth control pills decreased from 58% to 50%.

Number of Medicaid Women with LARC Device or Insertion 2010-2014
Annual Totals by LARC Type

LARC Type	2010	2011	2012	2013	2014
Implant	2,829	4,258	5,065	6,812	8,831
Mirena	14,383	16,468	12,286	10,756	11,616
Paragard	3,653	3,260	2,962	2,781	3,127
Skyla	0	0	0	16	312
IUD (type unknown)	1,002	900	1,629	953	989
Total Unduplicated Women	21,669	24,524	21,697	21,048	24,543

- During the five-year period from 2010 to 2014, more than 100,000 Medicaid women and teens received LARCs (unduplicated total of 103,767 women and teens).
- In 2014, 24,543 women and teens on Medicaid received LARCs. That number represents an increase of more than 16% compared to 2013.
- The number of Medicaid women who received a subdermal contraceptive implant (Implanon or Nexplanon) tripled over this five-year time period, from 2,829 in 2010 to 8,831 in 2014.
- Mirena remains the most frequently used IUD. Skyla, a new type of IUD, was released in 2013. In 2015, marketing of Liletta, another new IUD, began.

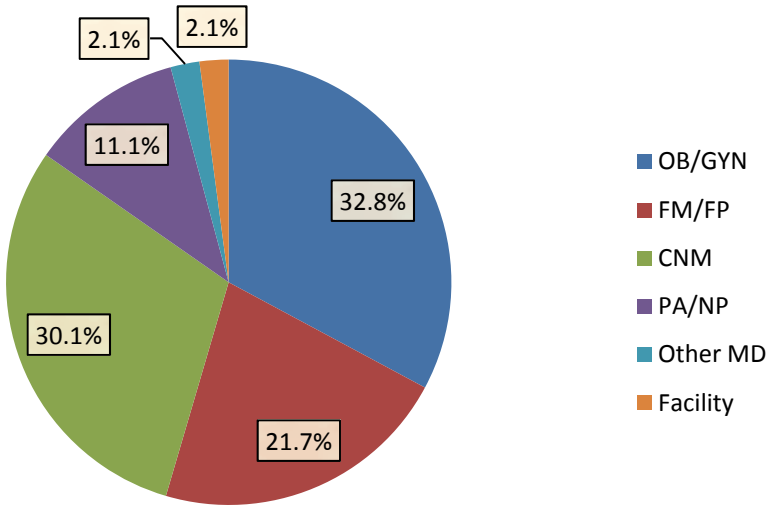
[7] See Washington Medicaid Family Planning Provider Guide, available at: http://www.hca.wa.gov/medicaid/billing/documents/guides/familyplanningprovider_bi.pdf

More than 2,000 medical providers performed LARC insertions for Medicaid clients in 2014.

Medical providers across Washington State routinely perform LARC insertion procedures for Medicaid clients. Medical providers of any specialty or licensure, with appropriate training in the procedures, may perform LARC insertions, as long as this procedure is consistent with their authorized scope of practice. More than 2,000 individual practitioners (N=2,173) performed LARC insertions for Medicaid clients in 2014.

Using physician/medical codes for professional services, providers may bill for an office visit, the insertion procedure, and the product itself (a HCPCS supply code). Medicaid reimbursement amounts for these codes originate with national code values distributed by CMS and Medicare, and they apply to all providers billing under this methodology. Exceptions to the standard methodology for determining reimbursement are permitted.

Distribution of 2014 LARC Insertions for Medicaid Clients
By Performing Provider Specialty/Licensure



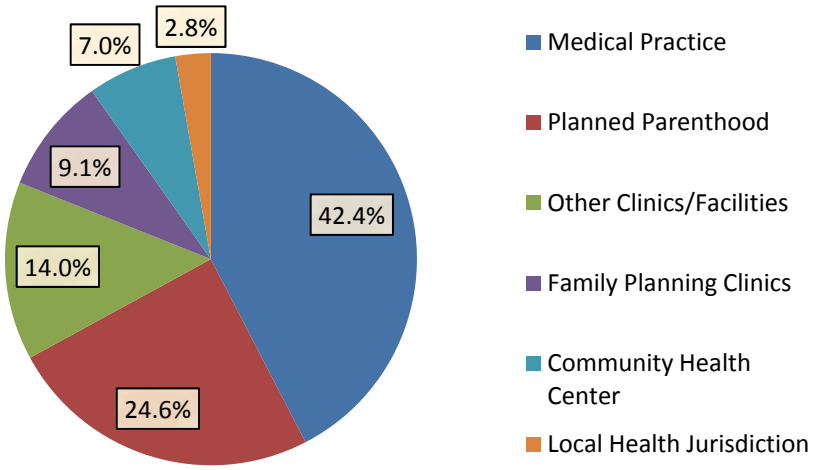
- More than half of all LARC insertion procedures for Medicaid clients were performed by specialists in women's health care: one-third (32.8%) were performed by physicians specializing in obstetrics/gynecology (OB/GYN) and nearly one-third (30.1%) were performed by Certified Nurse Midwives (CNM).
- More than one-fifth (21.7%) of LARC insertions for Medicaid clients were performed by physicians specializing in family medicine (or family practice) (FM/FP).
- Physician Assistants (PA) and Nurse Practitioners (NP) performed 11.1% of LARC insertions for Medicaid clients in 2014.
- For less than 5% of total LARC insertions, the specialty of the provider could not be determined (2.1%) or the provider was identified only as a facility (2.1%).
- The number of individual practitioners who inserted LARCs in 2014 was greatest for family physicians (N=845), followed by OB/GYNs (N=577) and nurse-midwives (N=427).

Women on Medicaid receive LARCs in a wide range of clinical settings.

From publicly-funded clinics to specialty medical practices, women on Medicaid may receive LARCs in a wide range of settings. LARCs require either insertion into the uterus (IUDs) or implantation under the skin (implants). These procedures are usually performed in a medical office or clinic and may also be performed in the delivery room immediately after child birth or in the operating room, at the same time as a surgical procedure.

Training opportunities for LARC insertion procedures are widely available, including training provided by device manufacturers.[8] Residency training in LARC insertion procedures has extended from programs in obstetrics/gynecology to many family practice residencies. As more clinicians receive training in LARC insertion procedures, the number of clinical settings where LARCs are provided is expected to grow.

Distribution of 2014 LARC Insertions for Medicaid Clients
By Clinical Setting



- More than forty percent (42.4%) of Medicaid clients with LARC insertions in 2014 received their LARCs from providers in medical practices, including 10.8% identified as OB/GYN or nurse midwife practices and 7.7% identified as family medicine or general practice. Medical specialty was not identified for the other multi- or single-specialty medical practices.

- Nearly one-quarter (24.6%) of LARC insertions were performed by Planned Parenthood clinics.

- Nearly one-fifth (18.9%) of LARC insertions were performed by other family planning clinics including Federally Qualified Health Centers (FQHCs) (9.1%), community health centers (7.0%), and local health jurisdictions (LHJs) (2.8%).

- Title X Family Planning Providers including Planned Parenthood clinics, other family planning clinics, and LHJs accounted for 28.1% of 2014 LARC insertions. Title X, sponsored by the DHHS Office of Population Affairs, is a grant-funded program that distributes funds to grantees. In Washington, Title X is administered by DOH.

[8] See:http://www.cardeaservices.org/resourcecenter/inserting-long-acting-reversible-contraception-larc-immediately-after-childbirth, http://www.acog.org/-/media/Departments/LARC/LARCClinTraining.pdf?la=en, http://www.reproductiveaccess.org/training-support/hands-on-training/getting-started/

DISCUSSION

Washington's innovative and strategic family planning programs have expanded access for Medicaid women and teens to highly effective contraceptive methods such as LARCs. With the 2014 expansion of Medicaid eligibility through the ACA, the TAKE CHARGE family planning waiver of fifteen years' duration, and a state-funded program for postpartum family planning coverage for undocumented women, a variety of Medicaid programs provide coverage for contraceptive products and counseling.

One indication of the success of these programs in providing access to LARCs is the proportion of Medicaid women with an identified family planning method who received LARCs. In 2013, more than one-fifth (20.6%) of Medicaid women with an identified family planning method used LARCs—nearly three times the proportion (7.2%) who used LARCs in 2007. Washington State has already achieved a higher use-rate for LARCs than Colorado achieved after implementation of the Colorado Family Planning Initiative. LARC use in Colorado increased from 4.5% in 2008 to 19.4% in 2011.[9] As the number of clients enrolled in Medicaid increased greatly in 2014 with expanded eligibility to 138% of the FPL, an even larger number of women and teens have access to highly effective contraception, and we report an increase of more than 16% in the number of women who received LARCs, from 21,048 in 2013 to 24,543 in 2014. Preliminary data for early 2015 suggest this trend will continue, with claims for nearly 10,000 LARC insertions already submitted to the HCA in 2015.

Some groups, however, have limited access to Medicaid coverage for family planning services: undocumented women are not eligible for standard Medicaid, and their coverage through the postpartum Family Planning Only program is limited to women who have been pregnant. Women who would otherwise be eligible for the TAKE CHARGE family planning waiver may decline to apply for standard Medicaid; if this occurs, they are not eligible for TAKE CHARGE because clients at or below 150% of the FPL must provide documentation that they applied for Medicaid and were denied coverage in order to be eligible for TAKE CHARGE. For women with health insurance obtained through Washington's Health Benefit Exchange, insurance carriers' compliance with the ACA requirement that plans cover all FDA-approved contraceptive methods without cost-sharing for all women with reproductive capacity has been mixed, as reported in a recent report from the Washington Office of the Insurance Commissioner.[10] With greater awareness at both the state and national level of the lack of full compliance with this provision of the ACA, access to contraceptive methods without cost-sharing for women with qualified health plans should improve in the short-term.

With more than half of Medicaid-paid births in Washington resulting from unintended pregnancies, state agencies, policy makers, and stakeholders recognize the need for high-quality family planning services. The HCA and the DOH share a common goal to reduce unintended pregnancies, as one facet of numerous interventions to improve birth outcomes across the state. Even with such a strong foundation in providing access to family planning methods, state agencies and provider communities will need to work together to resolve remaining challenges.

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[9] Ricketts S, Klinger G, Schwalberg R. 2014. Game Change in Colorado: Widespread Use of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women. *Perspectives on Sexual and Reproductive Health* 46(3):125-132.

[10] Smith E, Kwiatkowski S, and Varon J. Contraceptive Coverage in Washington State's Qualified Health Plans: A "Secret Shopper" Survey and review of Carrier Filings and Formularies, April 15, 2015. Accessed April 27, 2015, at: http://insurance.wa.gov/about-oic/news-media/news-releases/2015/documents/contraceptive-coverage.pdf

TECHNICAL NOTES

This brief report is based on analysis of Medicaid claims and encounter data from ProviderOne, Washington's Medicaid Management Information System. The source of pregnancy rates for Washington teens is the Washington Department of Health Center for Health Statistics.

IDENTIFICATION OF CLAIMS/ENCOUNTERS FOR LARCS

The number of Medicaid women with LARC device or insertion claims was determined using coding from Medicaid claims/encounter data.

Contraceptive implants were identified by CPT/HCPCS codes A4260, 11975, 11977, S0180, J7307, 11981 (with ICD-9 diagnosis code of V25.5), 11983 (with ICD-9 diagnosis code of V25.5) or NDC codes 12860027209, 0052027201, 00052027210, 00052027280, 00052027281, 00052027211, 00052027401, 00052027480, 00052433001.

IUDs were identified by CPT/HCPCS codes J7300 (Paragard), J7301 (Skyla), J7302 (Mirena), S4981 (Mirena), S4989, 58300, and by NDC codes for Mirena (50419042101, 67207042101, 50419042301), Paragard (51285020401, 51285020402), and Skyla (50419042201, 50419042208, 50419042271). Women were unduplicated by year and by category of implant or IUD type.

PROVIDER SPECIALTY/LICENSURE

The medical specialty and/or professional licensure for the servicing providers for LARC insertion claims/encounters was determined by previously established specialties/licensure as described in *County Profiles: Birth Statistics and Maternity Care Access* (April 2010, available at: https://www.dshs.wa.gov/sesa/rda/research-reports/county-profiles-birth-statistics-and-maternity-care-access-2000-2008). If the specialty/licensure of the servicing provider had not been determined previously, then servicing taxonomy codes from the Medicaid claim/encounter were used to determine specialty. If a nurse practitioner had been previously identified as a Certified Nurse Midwife, then that designation was retained; providers designated as nurse practitioners exclude CNMs.

CLINICAL SETTING

The clinical settings in which medical providers who inserted LARCs practiced were based on the billing providers for LARC insertion claims/encounters. Provider categories had been previously established for family planning providers as described in *TAKE CHARGE Final Evaluation, First Five Years: July 2001 – June 2006* (September 2006, available at: https://www.dshs.wa.gov/sesa/rda/research-reports/take-charge). If a previous category had not been assigned to a billing provider's NPI, then billing provider taxonomy codes from Medicaid claims/encounters were used to assign the billing provider to a clinical setting. Three of 12 LHJs that performed LARC insertions in 2014 were not Title X, and 3 of 25 other family planning clinics (excluding LHJs and Planned Parenthood clinics) were Title X.

Data are subject to change as claims are paid and encounter records are processed.

Copies of this paper may be obtained at https://www.dshs.wa.gov/SESA/research-and-data-analysis or by calling DSHS Research and Data Analysis Division at 360.902.0701.
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