



October 2013

CHIPRA Action Plan

1st Qtr, SFY14

Points of Interest:

- IME plans to report on 25 of the 26 CHIPRA quality measures in 2013.
- Health Homes are anticipated to increase accuracy in reporting BMI measurement.

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IME's CHIPRA Quality Measure History

In 2009, Title IV of the Children's Health Insurance Program Reauthorization Act (CHIPRA) directed the Health and Human Services Secretary to create a set of quality measures of health care provided to children. These efforts to promote quality healthcare were further bolstered by the 2010 Affordable Care Act.

Although some grants were available to assist states with implementation of the CHIPRA quality measures and associated quality improvement initiatives based on the results, Iowa was not one of the grantee states.

The Medicaid Value Management (MVM) program of the Program Integrity Unit began the work in 2011 of collaborating with other IME vendors to collect the data to begin the process of reporting Iowa Medicaid's results to CMS. With the assistance of Program Integrity, CORE, DHS Data Warehouse, Medical Services and Member Services Units along with the Iowa Department of Public Health (IDPH), Magellan and the Public Policy Center at the University of Iowa, IME began voluntarily reporting a portion of the CHIPRA quality measures

in 2011. IME also voluntarily submitted results for the 2012 reporting year.

In December, 2013, IME will again submit to CMS the results for the CHIPRA quality measures. These will be reported based on calendar year (measurement year) 2012, unless otherwise specified. The mechanisms for collecting the data to report are Iowa Medicaid claims, also referred to as administrative data, the CAHPS survey or medical record review.

The results are reported annually to CMS.

Below you will find a summary of CHIPRA quality measures for the 2013 reporting year. Three new measures were added in 2013; a previous measure which was never reported by IME was also retired from the CMS core set of quality measures.

Core Set of Children's Health Care Quality Measures for Medicaid and CHIP

The CHIPRA quality measures are classified in six categories:

- Population/Community Health
- Clinical Care
- Care Coordination
- Safety
- Efficiency and Cost Reduction
- Person and Caregiver Centered Experience

All six categories are important to promote optimal health outcomes and consumer involvement in the healthcare process.

Population/Community Health

HPV: Human Papillomavirus (HPV) Vaccine for Female Adolescents

This measure identifies the percentage of female adolescents that turned 13 years of age during the measurement year and had three doses of the HPV vaccine by their 13th birthday.

This measure is collected using administrative data.

WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index (BMI) Assessment for Children/Adolescents

This measure identifies the percentage of children ages three to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) and whose weight is classified on BMI percentile for age and gender.

This measure is collected using administrative data. It should be noted that relying on providers to report calculation of a BMI measurement despite not being reimbursed for the procedure code presents a barrier for accurate reporting of this measure.

Clinical Care

CAP: Child and Adolescent Access to Primary Care Practitioners

This measure identifies the percentage of children ages 12 months to 19 years that had a visit with a PCP; this measure is comprised of four separate percentages:

- Children ages 12 to 24 months that had a PCP

- visit during the measurement year;
- Children ages 25 months to six years who had a PCP visit during the measurement year;
- Children ages seven to 11 years who had a PCP visit during the measurement year or the year prior to the measurement year; and
- Adolescents ages 12 to 19 years who had a PCP visit during the measurement year or the year prior to the measurement year

This measure is collected using administrative data.

CIS: Childhood Immunization Status

This measure identifies the percentage of children that turned age two during the measurement year and had completed the recommended immunizations for children ages two and younger:

- Four diphtheria, tetanus and acellular pertussis (DTaP);
- Three polio (IPV);
- One measles, mumps and rubella (MMR);
- Three H influenza type B (HiB);
- Three hepatitis B (Hep B);
- One chicken pox (VZV);
- Four pneumococcal conjugate (PCV);
- One hepatitis A (Hep A);
- Two or three rotavirus (RV);
- Two influenza (flu)

This measure is collected using administrative data based on the above-noted vaccinations being received prior to the child's second birthday.

IMA: Immunization Status for Adolescents

This measure identifies the percentage of adolescents that turned 13 years of age during the measurement year and had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis

(Tdap) vaccine or one tetanus, diphtheria toxoids vaccine (Td).

This measure is collected using administrative data identifying children who have had the Tdap or Td vaccinations prior to their 13th birthday.

FPC: Frequency of Ongoing Prenatal Care

This measure identifies the percentage of Medicaid/CHIP deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that the following number of expected prenatal visits.

- < 21 percent of expected visits
- 21 - 40 percent of expected visits
- 41 - 60 percent of expected visits
- 61 - 80 percent of expected visits
- \geq 81 percent of expected visits

For the purpose of this measure expected visits are based on the number of weeks gestation at the time of delivery per the American College of Obstetricians and Gynecologist (ACOG)

- Uncomplicated pregnancy, visits every four weeks for the first 28 weeks of pregnancy;
- Uncomplicated pregnancy, visits every two to three weeks until 36 weeks of pregnancy;
- Uncomplicated pregnancy, visits weekly after 36 weeks of pregnancy

This measure is collected using administrative data.

PPC: Timeliness of Prenatal Care

This measure identifies the percentage of Medicaid/CHIP deliveries of live births between November 6 of the year prior to the

measurement year and November 5 of the measurement year that had a prenatal care visit in the first trimester or within 42 days of enrollment in Medicaid/CHIP.

This measure is collected using administrative data.

LBW: Live Births Weighing Less Than 2,500 Grams

This measure identifies the percentage of live births that weighed less than 2,500 grams in the state during the reporting period.

This measure is collected and provided to IME by IDPH.

CSEC: Cesarean Rate for Nulliparous Singleton Vertex

This measure identifies the percentage of women that had a cesarean section among women with first live singleton births at 37 weeks gestation or later.

This measure also is collected and provided to IME for reporting by IDPH.

BHRA Behavioral Health Risk Assessment (for Pregnant Women)

This measure identifies the percentage of women, regardless of age, that gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment. The screening assessment assessed:

- Depression
- Alcohol use
- Tobacco use
- Drug use
- Intimate partner violence

This measure is intended to be collected using

electronic medical records. Due to the low volume of providers currently enrolled to use the Iowa Health Information Network (IHIN) it was determined the accuracy of reporting this measure would be falsely low. Iowa Medicaid will not report on this measure during this reporting year. It is anticipated this IME may have sufficient providers using IHIN to complete for the 2014 reporting year.

DEV: Developmental Screening in the First Three Years of Life

This measure identifies the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

This measure will be collected using a hybrid method of chart review to be conducted by registered nurses in the Program Integrity, Medical Necessity Unit. A total of 411 developmental screenings conducted during the first, second and third years of life will be evaluated for the type of tool used and compliance with recommendations outlined by CMS for this measure.

An independent MVM study will be completed outlining the results of the analysis of the developmental screenings for this measure.

PA1C: Annual Pediatric Hemoglobin A1C Testing

This test identifies the percentages of children ages five to 17 with diabetes, type 1 or type 2, that had a Hemoglobin A1c (HbA1c) test completed during the measurement year.

This measure is collected using administrative data.

W15: Well-Child Visits in the First 15 Months of Life

This measure identifies the percentage of children

that turned 15 months old during the measurement year and had a well-child visit with a PCP during their first 15 months of life.

For the purpose of this measure, well-child visits are categorized as follows:

- No well-child visits
- One well-child visits
- Two well-child visits
- Three well-child visits
- Four well-child visits
- Five well-child visits
- Six or more well-child visits

This measure is based on the Centers for Medicare and Medicaid Services (CMS) and American Academy of Pediatrics (AAP) guidelines for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) visits.

This measure is collected using administrative data.

W34: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

This measure identifies the percentage of children ages three to six that had one or more well-child visits with a PCP during the measurement year.

This measure is collected using administrative data.

AWC: Adolescent Well-Care Visit

This measure identifies the percentage of enrolled adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a PCP or an OB/GYN during the measurement year.

This measure is collected using administrative data.

CHL: Chlamydia Screening in Women

This measure reports the percentage of women ages 16 to 20 that were identified as sexually active and had at least one test for Chlamydia during the measurement year.

This measure is collected using administrative data.

PDEnt: Percentages Of Eligibles That Received Preventive Dental Services

This measure identifies the percentage of individuals ages one to 20, enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services and received preventive dental services.

This measure is collected using administrative data.

TDEnt: Percentages Of Eligibles That Received Dental Treatment Services

This measure identifies the percentage of individuals ages one to 20, enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services and received dental treatment services.

This measure is collected using administrative data.

MMA: Medication Management for People with Asthma

This measure identifies the percentage of children ages five to 20 identified as having persistent asthma, and were dispensed appropriate controller medications, that they remained on during the treatment period. Two rates are collected for reporting of this measure:

- Percentage of children who remained on

an asthma controller medication for at least 50 percent of their treatment period.

- Percentage of children who remained on an asthma controller medication for at least 75 percent of their treatment period.

This measure is collected using administrative, claims, data.

FUH: Follow-Up After Hospitalization for Mental Illness

This measure identifies the percentage of discharges for children ages six to 20 that were hospitalized for treatment of selected mental health disorders and who had a follow-up outpatient visit, an intensive encounter, or partial hospitalization with a mental health practitioner. Two rates are collected for reporting of this measure:

- The percentage of discharges for which children received follow-up within 30 days of discharge.
- The percentage of discharges for which children received follow-up within seven days of discharge.

This measure is collected and provided to IME for reporting by Magellan, the contractor for the Iowa Plan for Behavioral Health.

ADD: Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication

This measure identifies the percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a ten-month period; at least one visit was within 30 days from the time the first ADHD medication was dispensed. Two rates are also collected for reporting of this measure:

- Initiation Phase: Percentage of children ages 6 to 12 as the Index of Prescription Start Date (IPSD) with a prescription dispensed for ADHD medication that had at least one follow

-up visit with practitioner (prescribing) during the 30-day initiation phase.

- Continuation and Maintenance (C&M) Phase: Percentage of children ages six to 12 as of the IPSP with a prescription for ADHD medication, that remained on the medication for at least 210 days and, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

This measure is collected in part by Magellan in collaboration with Medical Services using administrative data.

Safety

CLABSI: Pediatric Central-Line Associated Blood Stream Infections (CLABSIs)--Neonatal Intensive Care Unit and Pediatric Intensive Care Unit

This measure identifies the standardized infection ratio (SIR) of CLABSIs in pediatric and neonatal intensive care units (ICUs).

A bloodstream infection must first be determined to be a health-care associated infection (HAI) before it can be classified as a CLABSI.

In reporting year 2012, IME did not report this measure due to small sample size of claims billed meeting the coding specifications. Measures with fewer than 30 cases are not required for reporting.

Again, in 2013, this measure will not be reported to CMS due to small sample size. If this measure were to be reported, information would be collected using a hybrid method of chart review conducted by the Program Integrity Unit to determine if the central line infection was healthcare associated.

Efficiency and Cost Reduction

CWP: Appropriate Testing for Children with Pharyngitis

This measure identifies the percentage of children ages two to 18, diagnosed with pharyngitis, who were dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

This measure is collected using administrative data.

ASMER: Annual Percentage of Asthma Patients 2 through 20 Years Old with One or More Asthma-Related Emergency Room Visits

This measure identifies the percentage of children ages two to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room visits.

This measure is collected using administrative data.

AMB: Ambulatory Care--Emergency Department (ED) Visits

This measure identifies the rate of emergency department visits, per 1,000 enrollee months for children up to 19 years of age.

This measure is collected using administrative data.

Person and Caregiver Experience

CPC: Consumer Assessment of Healthcare Providers and Systems® (CAHPS) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)

This measure provides information on parents' experience with their child's health care.

Results summarize child experiences through ratings, composites and individual question summary rates.

This measure is collected and provided to IME by the Public Policy Center at the University of Iowa.

tified to be responsible for collecting the information. A change in the 2013 technical specifications manual resulted in measures being identified by an acronym in lieu of an assigned quality indicator number as in previous years.

The chart on the next page will also serve as a crosswalk to the previously assigned numbers associated with the specific quality indicator.

IME Collaboration

In a meeting held July 15, 2013, the three new CHIPRA quality measures developed for this year was discussed with Program Integrity, Medical Services, Member Services and DHS Policy staff that an effort would be made to report on two of the three new measures.

- HPV: Human Papillomavirus (HPV) Vaccine for Female Adolescents
- MMA: Medication Management for People with Asthma

The third measure, BHRA: Behavioral Health Risk Assessment (for pregnant women), was determined not feasible this year due to the need to extract information from an electronic medical record.

A follow up meeting is scheduled for October 22, 2013, to assess the status of data collection for this reporting year.

The tentative plan is to have all information collected by December 1, 2013, to allow the information to be submitted to CMS via the CARTs tool prior to the December 31, 2013, deadline. Program Integrity will complete the CMS reporting process for IME.

On pages [eight](#) and [nine](#) of this report, you will find a table identifying the specific measure and the IME unit stewards or other entity iden-

Recommendations

- Continue to collaborate with IME units to establish ability to collect data and report results to CMS.
- Work with provider services to promote education to provider community regarding the use of claims data for collecting quality indicator data to foster accurate completion of claims.
- Continue to support efforts to increase provider use and access to the IHIN to enable complete reporting of all measures.
- Complete a MVM study regarding other payers use of "G" codes for billing in an effort to improve the accuracy of reporting measures such as WCC and PA1C.
- Begin work with the HMO provider for Iowa Medicaid to develop a plan for inclusion of HMO data for the 2014 reporting year.

2013 Reporting Year Acronym	Measure Name	2010/2011 Reporting Year Measure Number	2012 Reporting Year Collection
HPV	Human Papillomavirus (HPV) Vaccine for Female Adolescents	NEW for 2013	Program Integrity
BHRA	Behavioral Health Risk Assessment (for pregnant women)	NEW for 2013	Not Reporting in 2013
MMA	Medication Management for People with Asthma	NEW for 2013	Member Services
PPC	Timeliness of Prenatal Care	1	Member Services
FPC	Frequency of Ongoing Prenatal Care	2	Member Services
LBW	Live Births Weighing Less than 2,500 Grams	3	IDPH
CSEC	Cesarean Rate for Nulliparous Singleton Vertex	4	IDPH
CIS	Childhood Immunization Status	5	Program Integrity
IMA	Immunizations for Adolescents	6	Program Integrity
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents	7	Program Integrity
DEV	Developmental Screening in the First Three Years of Life	8	Program Integrity
CHL	Chlamydia Screening in Women	9	Program Integrity
W15	Well-Child Visits in the First 15 Months of Life	10	Program Integrity
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	11	Program Integrity
AWC	Adolescent Well-Care Visits	12	Program Integrity
PDENT	Percentage of Eligibles That Receive Preventative Dental Services	13	CORE: CMS 416 Report (EPSDT)

2013 Reporting Year Acronym	Measure Name	2010/2011 Reporting Year Measure Number	2012 Reporting Year Collection
CAP	Children and Adolescents' Access to Primary Care Practitioners	14	Program Integrity
CWP	Appropriate Testing for Children with Pharyngitis	15	Medical Services
TDENT	Percentage of Eligibles That Received Dental Treatment Services	17	CORE: CMS 416 Report (EPSDT)
AMB	Ambulatory Care - Emergency Department Visits	18	Medical Services
CLABSI	Pediatric Central-Line Associated Bloodstream Infections	19	Program Integrity
ASMER	Annual Number of Asthma Patients with > 1 Asthma-Related Emergency Room Visit	20	Medical Services
ADD	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity (ADHD) Medication	21	Magellan and Medical Services
PA1C	Annual Pediatric Hemoglobin (HbA1c) Testing	22	Member Services
FUH	Follow-Up After Hospitalization for Mental Illness	23	Magellan
CPC	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey [5.0H), Child Version	24	University of Iowa, Public Policy Center

The plan as of the time of this report is to compile data for 25 of the 26 CHIPRA quality measures for the 2013 reporting year. Further guidance from CMS and/or other barriers that present during the data collection process may result in fewer measures being reported to CMS in December 2013 than was reported for 2012.

A follow-up MVM study will be conducted once the data has been collected analyzing the results compared to previous years when applicable. Any measures not reported will be noted in that MVM as well as the reason for omission from reporting in 2013.

Beginning on the next page of this report is a recap of the measures, and results, which were reported in 2012.

Iowa Medicaid CHIPRA Outcomes Reported for 2012 Using 2011 Data

The chart below, and the next several pages, outlines the results reported for the 2012 reporting year using data collected from claims processed in 2011. If a measure was previously reported on in 2011, using 2010 data, the information is also contained in the chart below for comparison.

Measure No.	Title	Measure Collection 2012	2011 Reporting Year Results	2012 Reporting Year Results
1	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Member Services	Not Reported	Numerator = 11,002 Denominator = 12,401 Rate = 88.72%
2	Frequency of Ongoing Prenatal Care	Member Services	Not Reported	<21 % of Expected Visits Numerator = 438 Denominator = 12,401 Rate = 3.53% 21-40% of Expected Visits Numerator = 2,399 Denominator , 12,401 Rate = 19.35% 41-60% of Expected Visits Numerator = 2,727 Denominator = 12,401 Rate = 21.99% 61-80% of Expected Visits Numerator = 1,880 Denominator = 12,401 Rate = 15.16% ≥ 81 of Expected Visits Numerator = 3,558 Denominator = 12,401 Rate = 28.69
3	Percentage of Live Births Weighing Less than 2,500 grams	IDPH	Rate = 7.16%	Numerator = 15,357 Rate = 6.6%
4	Cesarean rate for Nulliparous Singleton Vertex	IDPH	Rate = 26.9%	Numerator = 2,359 Denominator = 8,483 Rate = 27.8%

Measure No.	Title	Measure Collection 2012	2011 Reporting Year Results	2012 Reporting Year Results
5 *, **	Childhood Immunization Status	Program Integrity	Denominator = 13,546 Numerators: DTaP = 2,672 Rate = 19.73% IPV = 3,927 Rate = 28.99% MMR = 9,213 Rate = 68.01% HiB = 4,867 Rate = 35.93% HEPB = 2,127 Rate = 15.70% VZV = 8,875 Rate = 65.52% PCV = 2,955 Rate = 21.81% HEPA = 3,211 Rate = 23.70% RV = 2,196 Rate = 16.21% FLU = 3,526 Rate = 26.03%	Denominator = 13,387 Numerators: DTAP = 5,368 Rate = 40.10% IPV = 7,346 Rate = 54.87% MMR = 8,594 Rate = 64.20% HiB = 7,906 Rate = 59.06% HEPB = 3,129 Rate = 23.37% VZV = 8,393 Rate = 62.70% PCV = 5,484 Rate = 40.97% HEPA = 3,458 Rate = 25.83% RV = 4,813 Rate = 35.95% FLU = 3,642 Rate = 27.21% Rate = 2.42%
6	Immunizations for Adolescents	Program Integrity	Denominator = 8,243 Numerator 1 (Meningococcal) = 1,646 Rate = 19.97% Numerator 2 (Tdap or TD) = 1,860 Rate = 22.57% Numerator 3 (Combination 1) = 1,246 Rate = 15.12%	Denominator = 9,000 Numerator 1 (Meningococcal) = 2,053 Rate = 22.81% Numerator 2 (Tdap or TD) = 2,385 Rate = 26.50% Numerator 3 (Combination 1) = 1,644 Rate = 18.27%

* Technical specifications regarding the combination results can be found on page 5 of the CMS Initial Core Set of Children's Health Care Quality Measures: Technical Specifications and Resource Manual for Federal Fiscal Year 2012 Reporting, Updated November 2012. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResourceManual.pdf>

** For internal viewers only, the combination rates for Measure 5, and all other results can be found in the excel workbook titled Reporting Yr 2012 Measures information and assignments 03-06-2013, on IME Universal at <I:\CHIPRA\Reporting Year 2012>

Measure No.	Title	Measure Collection 2012	2011 Reporting Year Results	2012 Reporting Year Results
7	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents	Program Integrity	Age 3 - 11 Numerator = 183 Denominator = 84,711 Rate = 0.22% Age 12 - 17 Numerator = 99 Denominator = 39,115 Rate = 0.25% Combined Numerator = 282 Denominator = 123,826 Rate = 0.23%	Age 3 - 11 Numerator = 45 Denominator = 39,719 Rate = 0.11% Age 12 - 17 Numerator = 19 Denominator = 17,660 Rate = 0.10% Combined Numerator = 64 Denominator = 57,379 Rate = 0.11%
8	Developmental Screening in the First Three Years of Life	Program Integrity	Numerator 1 = 634 Denominator 1 = 17,740 Numerator 2 = 624 Denominator 2 = 14,752 Numerator 3 = 532 Denominator 3 = 13,942 Numerator 4 = 1,790 Denominator 4 = 46,434	Not reported due to need for hybrid method
9	Chlamydia Screening	Program Integrity	Denominator Total number of eligible members = 14,970 (continuous enrollment, sexually active, not excluded) Numerator Total number of screened members = 6,654	Denominator Total number of eligible members = 14,501 (continuous enrollment, sexually active, not excluded) Numerator Total number of screened members = 6,498
10	Well-Child Visits in the First 15 Months of Life	Program Integrity	Denominator = 15,217 Numerator 1 (0 visits) = 349 / 2.3% Numerator 2 (1 visit) = 361 / 2.4% Numerator 3 (2 visits) = 486 / 3.2% Numerator 4 (3 visits) = 730 / 4.8% Numerator 5 (4 visits) = 1,220 / 8.0% Numerator 6 (5 visits) = 1,864 / 12.2% Numerator 7 (≥ 6 visits) = 10,207 / 67.1%	Denominator = 18,508 Numerator 1 (0 visits) = 1,122 / 6.1% Numerator 2 (1 visit) = 607 / 3.3% Numerator 3 (2 visits) = 846 / 4.6% Numerator 4 (3 visits) = 1,162 / 6.3% Numerator 5 (4 visits) = 1,645 / 8.9% Numerator 6 (5 visits) = 2,491 / 13.5% Numerator 7 (≥ 6 visits) = 10,635 / 57.5%
11	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Program Integrity	Numerator = 32,029 Denominator = 51,358 Rate = 62.4%	Numerator = 31,166 Denominator = 54,396 Rate = 57.3%

Measure No.	Title	Measure Collection 2012	2011 Reporting Year Results	2012 Reporting Year Results
12	Adolescent Well-Care Visits	Program Integrity	Numerator = 22,116 Denominator = 70,545 Rate = 31.4%	Numerator = 21,678 Denominator = 79,346 Rate = 27.3%
13	Total Eligibles Who Receive Preventative Dental Services	CORE	Numerator = 109,616 Denominator = 274,480 (FFY 10/1/10—9/30/11)	Not reported due to instructions in 12/6/12 webinar.
14	Children and Adolescents' Access to Primary Care Practitioners	Program Integrity	Denominator Total number of eligible members = 173,464 Eligible Members (by age): 12-24 months = 16,454 Rate = 94.17% 25 months - 6 yrs = 64,132 Rate = 84.53% 7-11 yrs = 42,548 Rate = 83.62% 12-19 yrs = 50,330 Rate = 83.03% Numerator Eligible members (by age) with at least 1 PCP visit: 12-24 months = 15,495 25 months - 6 yrs = 54,213 7-11 yrs = 35,579 12-19 yrs = 41,788	Denominator Total number of eligible members = 183,607 Eligible members (by age): 12-24 months = 16,051 Rate = 94.82% 25 months - 6 yrs = 66,976 Rate: 85.16% 7-11 yrs = 46,124 Rate: 83.50% 12-19 yrs = 54,456 Rate = 82.94% Numerator Eligible members (by age) with at least 1 PCP visit: 12- 24 months = 15,219 25 months - 6 yrs = 57,036 7-11 yrs = 38,515 12-19 yrs = 45,164
15	Appropriate Testing for Children with Pharyngitis	Medical Services	Numerator = 3,618 Denominator = 7,820 Rate = 46.27% (CY2010 1/1/2010 -12/31/2010)	Numerator = 1,123 Denominator = 5,003 Rate = 22.4%
16	Otitis Media with Effusion (OME) - Avoidance of Inappropriate Use of Systemic Antimicrobials	Not Reported	Not Reported	Not reported due to instructions in 12/6/12 webinar.
17	Total Eligibles Who Received Dental Treatment Services	CORE	Numerator = 51,139 Denominator = 274,480 (Data from FFY 10/1/2010 - 9/30/2011)	Not reported due to instructions in 12/6/12 webinar.

Measure No.	Title	Measure Collection 2012	2011 Reporting Year Results	2012 Reporting Year Results
18	Ambulatory Care: Emergency Department Visits	Medical Services	<p>Age/ Member Months <1 yr = 79,805 1-9 yrs = 1,542,086 10-19 yrs = 1,093,630 20+ yrs = 33,686 Total = 2,749,207</p> <p>Age / ED Visits /ED visits per 1000 Member Months <1 yr = 10,383 visits; 130.10 1-9 yrs = 83,619 visits; 54.22 10-19 yrs = 44,735 visits; 40.91 20+ yrs = 3,196 visits; 94.88 Total = 141,933 visits; 51.63 (CY2010 1/1/2010 - 12/31/2010)</p>	<p>Age/ Member months <1 yr = 76,952 1-9 yrs = 1,299,392 10-19 yrs = 1,188,736 Total = 2,565,080</p> <p>Age / ED Visits /ED visits per 1000 Member Months <1 yr = 23,679 visits; 307.7 1-9 yrs = 82,135 visits; 63.2 10-19 yrs = 52,932 visits; 44.5 Total = 158,746 visits; 61.9</p>
19	Pediatric Central-Line Associated Bloodstream Infections	Program Integrity	Not Reported	Not reporting due to cases (4) < 30.
20	Annual Number of Asthma Patients with > 1 asthma-related Emergency Room Visit	Medical Services	<p>Numerator = 3393 Denominator = 13,876 Rate = 24.45%</p>	<p>Numerator = 2410 Denominator = 48,189 Rate = 5%</p>
21	Follow-Up Care for Children Prescribed ADHD Medication	Magellan and Medical Services	Not Reported	<p>Rate 1 - Initiation Phase Rate = 45.31% Numerator = 4,011 Denominator = 8,852</p> <p>Rate 2 - Continuation & Maintenance Rate = 73.76% Numerator = 7,568 Denominator = 10,260</p>
22	Annual Pediatric Hemoglobin (HbA1c) Testing and Control	Member Services	Not Reported	<p>Numerator = 360 Denominator = 431 Rate = 83.53%</p>
23	Follow-Up After Hospitalization for Mental Illness	Magellan	<p>7-day Rate = 60.2% 30-day Rate = 70.2% (CY2010)</p>	<p>7-day Rate = 69.3% 30-day Rate = 79.2%</p>
24	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0H, Child Version	Public Policy Center	CAHPS Survey Report	Measure asks for the CAHPS Health Plan Survey 4.0H but for Iowa, the 2011 report 4.0 will be the only one available to submit. Report saved in 2012 Measure 24 folder.

References

- Centers for Medicare & Medicaid Services (2013). Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2013 Reporting. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf>
- Iowa Medicaid Enterprise. (2013). Medicaid Value Management: 2012 CHIPRA Analysis Report.

Medicaid Value Management (MVM)

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Realizing the fiscal value of quality care.

About MVM

Medicaid Value Management (MVM) analyzes different areas of Iowa Medicaid to gain an understanding of the quality of the services provided to the Medicaid member. MVM analyzes the efficacy of services provided; best practices used and not used in Iowa and the overall impact on our Medicaid population; MVM also looks at individual programs within Iowa Medicaid. Ultimately MVM looks for ways to promote improved health outcomes within the constraints of Medicaid budget limits and with this information, MVM makes recommendations for policy and program changes.



October 2013

CHIPRA Developmental Screening in the First Three Years of Life

1st Qtr, SFY14

Point of Interest:

- In CY12, 79.3 percent of members received a global developmental screening test before their first, second or third birthday.

Inside this report:

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IME's CHIPRA Quality Measure History

In 2009, Title IV of the Children's Health Insurance Program Reauthorization Act (CHIPRA) directed the Health and Human Services Secretary to create a set of quality measures of health care provided to children. These efforts to promote quality healthcare were further bolstered by the 2010 Affordable Care Act.

Although some grants were available to assist states with implementation of the CHIPRA quality measures and any associated quality improvement initiatives based on the results, Iowa was not one of the grantee states.

The Medicaid Value Management (MVM) program of the Program Integrity Unit began the work in 2011 of collaborating with other IME vendors to collect the data to begin the process of reporting Iowa Medicaid's results to CMS. With the assistance of Program Integrity, CORE, DHS Data Warehouse, Medical Services and Member Services Units along with the Iowa Department of Public Health (IDPH), Magellan and the Public Policy Center at the University of Iowa, IME began voluntarily reporting a portion of the CHIPRA quality measures

in 2011. IME also voluntarily submitted results for the 2012 reporting year.

In the 2012 reporting year IME elected not to report on a measure targeting developmental screenings in the first three years of life. This decision was due to the need to obtain the needed information via a hybrid method which included manual chart review of developmental screening documentation to determine the scope of the screenings.

In December, 2013, IME will again submit to CMS the results for the CHIPRA quality measures. These will be reported based on calendar year (measurement year) 2012, unless otherwise specified. The mechanisms for collecting the data to report are Iowa Medicaid claims, also referred to as administrative data, the CAHPS survey or medical record review, also referred to as the hybrid method.

The results are reported annually to CMS.

This MVM report is the analysis of the developmental screenings chart review of the representative sample identified.

Measure DEV: Developmental Screening in the First Three Years of Life (technical specifications)

The objective of this measure is to identify the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.

Using three-age specific indicators to assess whether children are screened by their first, second or third birthdays, claims data was queried for providers who billed CPT code 96110--developmental testing, with interpretation and report, per standardized instrument form, for members whose ages were within the three-age specific categories. Ages were based on the members' date of birth in relation to the measurement year (2012).

For this measure, the eligible population was children who turned one, two or three years of age between January 1 and December 31, 2012. These children must have had 12 months continuous enrollment in Iowa Medicaid prior to their birthday. A gap in coverage of 45 days or less (total) within the 12 previous months was considered continuously eligible.

Because Iowa Medicaid does not have a policy requiring providers use a global developmental screening tool in order to submit claims for CPT 96110, a hybrid method of chart review was deemed necessary to differentiate the different tools being used.

The stratified sample of records to review were selected using the following guide to account for 411 records.

- **Denominator 1:** 137 children from the sample who turned one during the measurement year.
- **Denominator 2:** 137 children from the sample who turned two during the measurement year.
- **Denominator 3:** 137 children from the sample who turned three during the measurement

year.

- **Denominator 4:** The entire sample of 411 children.
- **Numerator 1:** Children in Denominator one who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented by their first birthday.
- **Numerator 2:** Children in Denominator two who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented by their second birthday.
- **Numerator 3:** Children in Denominator three who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented by their third birthday.
- **Numerator 4:** Children in Denominator four who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented by their first, second or third birthday (sum of numerators one, two and three).

CMS specifies to meet the criteria for a global developmental screening tool, the tool must meet the following criteria:

- **Developmental domains:** The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
- **Established Reliability:** Reliability scores of approximately 0.70 or above.
- **Established Findings Regarding Validity:** Validity scores for the tool must be approximately 0.70 or above. Measures of high validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s)
- **Established Sensitivity/Specificity:** Sensitivity and specificity scores of approximate-

ly 0.70 or above.
Current recommended tools that meet these criteria:

- Ages and Stages Questionnaire (ASQ)[™] - 2 months to 5 years
- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)[™]
- Batelle Developmental Inventory Screening Tool (BDI-ST)[™] -- Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS)[™] - 3 months to 2 years
- Brigance Screens - II -- Birth to 90 months
- Child Development Inventory (CDI)[™] - 18 months to 6 years
- Infant Development Inventory[™] -- Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS)[™] - Birth to 8 years
- Parents' Evaluation of Developmental Status - Developmental Milestones[™] (PEDS-DM)

Tools NOT included in This Measure: It is important to note that standardized tools specifically focused on one domain of development [e.g., child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral and social delays." (CMS, 2013)

Record Review Results

Overall, the members whose records were reviewed reflected a global developmental assessment was completed 79.3 percent of the time.

This percentage differs significantly in each of the age-specific categories studied as indicated below:

Ages 0 to 1 year: 96.4 percent

Ages 1 to 2 years: 75.9 percent
Ages 2 to 3 years: 65.7 percent

What Developmental Screening Tools Were Used?

Age 0 to 1 year

For children ages zero to one year, 132 of the 137 charts reviewed indicated a global developmental screening tool was used to assess all four of the required developmental domains, motor, language, cognitive, and social-emotional. The medical records for the five members who did not meet the criterion for this measure failed to include any developmental tool documentation.

Of the 132 developmental screenings completed for this age population, the majority were completed using the Denver II Screening Test. The tests completed for members age zero to one year which were reviewed is as follows:

Screening Tool	Number of Members Screened (ages 0 to 1 year)
Denver II Screening	114
Pediatric Developmental Milestones	8
Ages and Stages Questionnaire (ASQ or ASQ 3rd Edition) [™]	4
0 - 9 months PDQ - II**	3
Infant Development Inventory: Birth to 18 months [™]	2
Bayley Infant Neuro-developmental Screen (BINS) [™]	1
Brigance Screens - II [™]	1
Child Development Inventory (CDI) [™]	1

All of the tools noted above are considered global

assessments.

Ages 1 to 2 years

For children one to two years, 104 of the 137 charts reviewed indicated a global developmental screening tool was used to assess all four of the required developmental domains, motor, language, cognitive, and social-emotional. The medical records for 11 members who did not meet the criterion for this measure failed to include any developmental tool documentation. Additionally, 11 members' records indicated the M-CHAT™ tool was used and six records indicated the ASQ-SE™ was used, both tools are single domain screening tools.

Of the 104 global developmental screenings completed for this age population, the majority were completed using the Ages and Stages Questionnaire™. The tests completed for members ages one to two years which were reviewed is as follows:

Screening Tool	Number of Members Screened (ages 0 to 1 year)
Ages and Stages Questionnaire (ASQ or ASQ 3rd Edition)™	52
Denver II Screening	39
M-CHAT™ *	11
Pediatric Developmental Milestones	10
Ages and Stages Questionnaire (ASQ-SE) *	6
9-24 months PDQ - II**	5
Parent's Evaluation of Development Status (PEDS)™: Birth to 8 years	2
Batelle Developmental Inventory Screening Tool (BDI-ST)™	1
Brigance Screens - Birth to 90 Months™	1

Ages 2 to 3 years

For children two to three, 89 of the 137 charts reviewed indicated a global developmental screening tool was used to assess all four of the required developmental domains, motor, language, cognitive, and social-emotional. The medical records for 15 members who did not meet the criterion for this measure failed to include any developmental tool documentation. Additionally, 26 members' records indicated the M-CHAT™ tool was used and six records indicated the ASQ-SE™ was used, both tools are single domain screening tools.

Of the 89 global developmental screenings completed for this age population, the majority were completed using the Denver II Developmental Screening. The tests completed for members ages two to three years which were reviewed is as follows:

Screening Tool	Number of Members Screened (ages 0 to 1 year)
Ages and Stages Questionnaire (ASQ or ASQ 3rd Edition)™	39
Denver II Screening	41
M-CHAT™ *	26
Pediatric Developmental Milestones	7
Ages and Stages Questionnaire (ASQ-SE) *	6
2-4 year PDQ - II**	1
Brigance Screens - Birth to 90 Months™	2

* Single domain developmental screening tool.

** Used in conjunction with another developmental screening tool for which the results were not provided.

Summary

Across all age categories studied, the ages and stages questionnaire (ASQ)[™] was a common screening tool used. The ASQ[™] and ASQ-3rd edition[™] were both identified by CMS via the CHIPRA technical specifications manual as a recommended screening tool.

Other tools commonly used for Iowa Medicaid members, which met the CMS definition of a global developmental screening tool were the Denver II Screening Tool and the Pediatric Developmental Milestones Screening Tool. Both tools met the requirements for validity and specificity and assessed the four domains--motor, language, cognitive, and social-emotional.

The Denver Prescreening Questionnaire II (PDQ II) is most often the parent questionnaire used with the Denver II screening tools. In some of the records reviewed for Iowa Medicaid, only the results of the PDQ II screening were provided. Narrative documentation which accompanied the PDQ II noted correlating developmental screening tool was used although results of the secondary screening tool were not provided. These records could not be validated to meet the global developmental screening criterion due to incomplete documentation.

The Modified Checklist for Autism in Toddlers (M-CHAT)[™] increased in frequency in use as the age of the child increased for this study. Clinically, this tool is the most commonly used when screening for autism spectrum disorders due to the simplicity and ease of completion. However, as the name implies, this tool is single dimensional with a focus on screening for autism in toddlers and does not assess overall global developmental delays that may be present. For this reason, members whose records indicated only a M-CHAT[™] screening tool was completed were not able to be validated as

meeting the global developmental screening criterion.

Medical records received for members evaluated by the University of Iowa Hospitals and Clinics all contained a global developmental screening tool, identified within the documentation as "Pediatric Developmental Milestones." This screening tool assessed all four domains of motor, language, cognitive, and social-emotional and the content was consistent with other standardized global assessment tools used by other providers. These members' records were validated as meeting the criterion of a global developmental screening tool.

Overall, Iowa Medicaid will report to CMS a rate of 79.3 percent for members who received a global developmental assessment before their first, second or third birthday. Iowa Medicaid will also report that as the age of the child increases, the use of a global developmental assessment tool decreases significantly each year.

- Ages 0 to 1 year: 96.4 percent
- Ages 1 to 2 years: 75.9 percent
- Ages 2 to 3 years: 65.7 percent

Iowa Medicaid does not have a policy requiring use of a global developmental screening tool for a provider to receive reimbursement for CPT code 96110--developmental screening, with interpretation and report, per standardized instrument.

The process for requesting medical records, specifically the developmental screening tool, resulted in some concerns regarding providers maintenance of records. Although the developmental screening tool was requested for the date of service billed for procedure code 96110, several providers' offices indicated the date of service on record for the developmental screening tool differed from the date of service requested. This may have adversely impacted the ability for providers to submit the requested records.

Recommendations

- Continue to monitor annually for CHIPRA reporting and possible intervention opportunities for IME to improve outcomes.
- Provide education and outreach regarding the American Academy of Pediatrics (AAP) recommendations for screening and use of standardized global developmental screening tools.
- In-depth review of developmental screening tools used by pediatricians versus general practitioners to help identify barriers to completion of a global developmental screening.
- Develop a quality improvement project aimed at increasing use of a global developmental screening tool by five percent within 12 months of implementation.
- Implement policy changes requiring completion of a global developmental screening tool prior to submitting a claim for procedure code 96110.
- Audit of physician office visits, specifically related to EPSDT services due to concerns regarding maintenance of records compared to the date of service billed to Iowa Medicaid.

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Medicaid Value Management (MVM)

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Realizing the fiscal value of
quality care.

About MVM

Medicaid Value Management (MVM) analyzes different areas of Iowa Medicaid to gain an understanding of the quality of the services provided to the Medicaid member. MVM analyzes the efficacy of services provided; best practices used and not used in Iowa and the overall impact on our Medicaid population; MVM also looks at individual programs within Iowa Medicaid. Ultimately MVM looks for ways to promote improved health outcomes within the constraints of Medicaid budget limits and with this information, MVM makes recommendations for policy and program changes.



October 2013

Hydroxyprogesterone Caproate Compound Versus Makena®

1st Qtr. SFY14

History

For many years, women have been treated with progesterone to prevent preterm delivery when they have a history of a preterm birth (before 37 weeks gestation). This treatment has been in the form of a vaginal gel or an injection. The vaginal gel is used primarily when the woman's cervix is shortened. The injection is considered for women who had a spontaneous preterm birth of a single baby and are currently pregnant with a single fetus. It is initiated between 16 and 20 weeks of pregnancy and continued until 37 weeks.

On February 4, 2011, the U.S. Food and Drug Administration (FDA) announced that they had approved the brand Makena® (hydroxyprogesterone caproate) for the use of reducing the risk of preterm birth in women who were currently pregnant with a single fetus and had a history of a spontaneous preterm birth of a single baby. This is the first drug to receive FDA approval specifically for this use. (Delalutin® had FDA approval from 1956-2000 and was used off-label for the prevention of pre-term delivery.) Until this date, hydroxyprogesterone caproate had been exclusively provided by compound

pharmacies. Compound pharmacies are not regulated by the FDA to maintain compliance with the current Good Manufacturing Practices, whereas manufacturers of FDA approved drugs must maintain compliance.

The debate over the use of compounded hydroxyprogesterone caproate versus Makena® arose after KV Pharmaceuticals, the owner of Makena®, initially wanted to charge \$1,500 per dose but lowered their price to \$690 per dose. This was still much higher than the cost of the compounded version, which cost \$10 to \$20 per dose.

When KV Pharmaceuticals obtained FDA approval, they also obtained exclusivity for seven years. On March 30, 2011, the FDA released a statement clarifying how they prioritize enforcement of compound pharmacies in their compliance of not mass producing copies of FDA approved drugs. This statement was in response to a letter sent to multiple pharmacies by KV Pharmaceuticals stating the FDA would no longer be exercising enforcement discretion where compounded versions of Makena® was concerned. On November 8, 2011, the FDA released another statement stating they had received analysis and samples of compounded versions of Makena® from KV Pharmaceuticals and would be conducting their own investigation. The FDA reminded physicians and patients that FDA

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approved drugs provide the greatest safety and effectiveness. On June 15, 2012, the FDA released a statement with the results of their investigation. They did not find any significant safety concerns regarding the compounded versions of Makena® and emphasized they are applying their normal enforcement policies for compound pharmacies.

CMS also issued an Informational Bulletin on March 30, 2011, that informed States that they could choose to pay for the compounded versions of hydroxyprogesterone caproate in accordance with their Medicaid State plan. On June 15, 2012, CMS issued another Informational Bulletin in response to the findings published by the FDA that reminded States they are to cover FDA approved products and any prior authorization processes must not be unreasonable.

On July 5, 2012, KV Pharmaceuticals filed a lawsuit in District Court in the District of Columbia against the FDA asking the court to order the FDA to withdraw their statement relating to their enforcement regarding the compound pharmacies and the compound version of Makena® and enforce K-V Pharmaceutical's exclusivity rights for all injectable versions of hydroxyprogesterone caproate. The ruling filed on September 6, 2012, upheld a previous ruling that FDA's enforcement discretion is not reviewable by the courts.

On October 23, 2012, K-V Pharmaceuticals, filed a complaint with the International Trade Commis-

sion (ITC) in an attempt to block compound pharmacies from being able to obtain the necessary components of the drug. They cited the section relating to "unfair methods of competition in the importation of goods" (*K-V Case Tests Limits of ITC Jurisdiction*, Fues and Frederick, 2013).

December 20, 2012, the ITC announced they would not investigate the complaint filed by K-V Pharmaceuticals. Typically the ITC is involved with patent infringement cases where the importation of goods are involved and they questioned whether or not they had the authority to become involved, thus leaving the decision with the FDA to enforce the exclusivity rights for all injectable versions of hydroxyprogesterone caproate.

On November 8, 2012, K-V Pharmaceuticals filed an appeal with the District of Columbia Circuit Court of Appeals. On March 13, 2013, briefing began in the appeal.

Drug compounding has also caught the attention of the U.S. government. H.R.3204, also known as the "Compounding Quality Act," was created in response to safety concerns following a meningitis outbreak, related to compounded steroids. The bill was passed in the U.S. House of Representatives on September 30, 2013, and has been accepted and read twice in the U.S. Senate. If signed into law, the FDA will have greater control over the regulation of compound pharmacies.

This bill proposes to make it illegal for pharmacies to make copies of FDA approved drugs except in certain circumstances for individual patients

with a valid prescription. There would be additional licensing required by pharmacies and third-party logistics providers who ship drugs across state lines. These providers would need to be licensed by the state from which they ship from or by the federal government, if the originating state chooses not to license their providers.

IME Coverage

IME provides coverage of progesterone products through Pharmacy POS and through Medical billing. On October 25, 2013, IME issued Informational Letter Number 1277 informing providers that Makena® would no longer require a prior authorization (PA). Prior to this date, compounded products were the preferred drugs and did not require a PA. Compounded products include:

- Progesterone Powder (for compounded suppositories), available through Pharmacy POS and
- 17 alpha-hydroxyprogesterone ca-

proate (17HP), available through Medical billing.

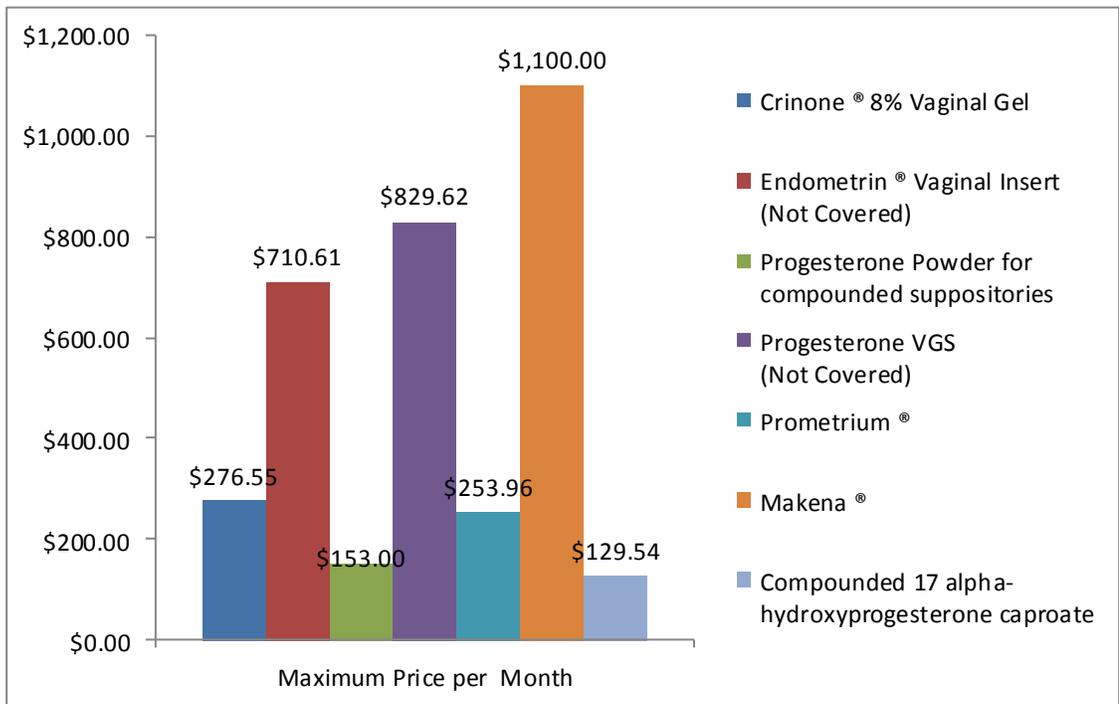
FDA approved drugs include:

- Crinone® 8% Vaginal Gel, considered through Pharmacy PA,
- Prometrium®, considered through Pharmacy PA and
- Makena®, available through medical billing.

The following graph shows the maximum cost per month for each available progesterone product and if it is covered by IME.

IME had previously issued Informational Letter Number 1203 on January 3, 2013, informing providers of the finalization of the PA requirements for Makena®. All of the following criteria needed to have been met for a PA to have been granted by IME

- The member was between 16 weeks and 0 days and 36 weeks 6 days gestation with a singleton pregnancy; and,
- The member had a prior history



- of preterm deliver before 37 weeks gestation; and,
- The member did not have present or prior history of thrombosis or thromboembolic disorder, known or suspected breast cancer, other hormone-sensitive cancer, or history of undiagnosed abnormal vaginal bleeding unrelated to pregnancy, cholestatic jaundice of pregnancy, liver tumors, benign or malignant, or active liver disease or uncontrolled hypertension; and,
- No other form of progesterone, already covered/payable under Pharmacy POS was appropriate as a “preferred” product on the Preferred Drug List (PDL); and,
- There were medical contraindications to the member receiving the compounded version, 17 HP, instead of Makena® or the compounded version of 17HP was not readily available or accessible.

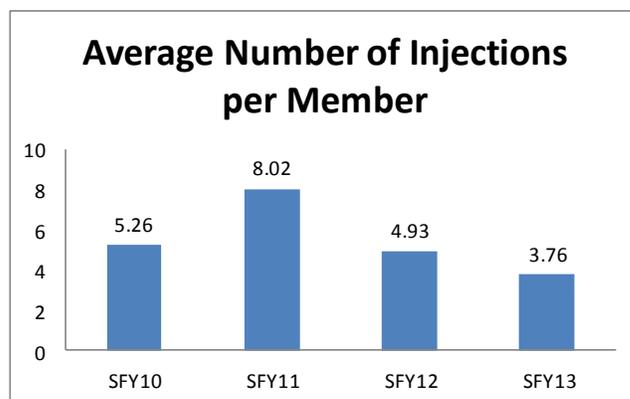
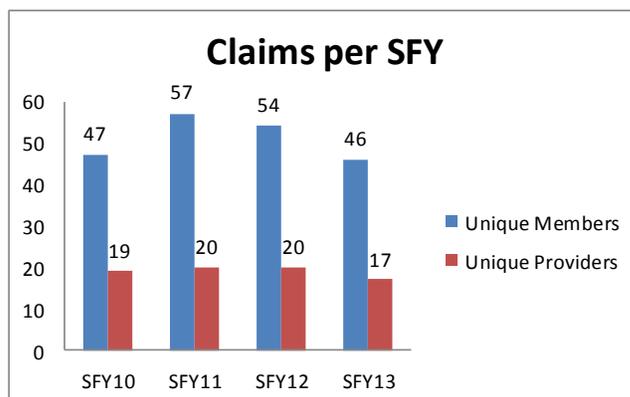
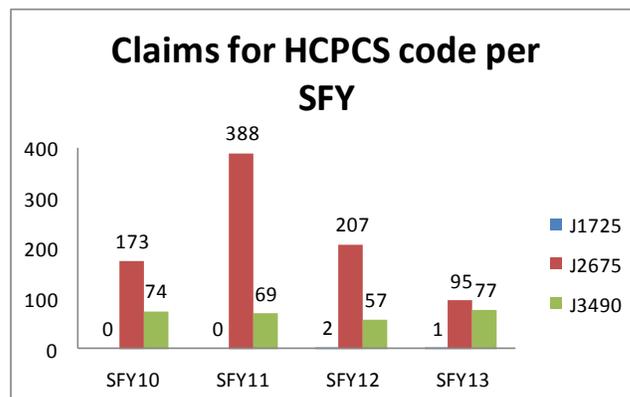
Although the compounded version did not require a PA, the same indications and dosing applied. Both the compounded forms of 17HP and Makena® were covered as physician-administered medications as a medical benefit. The physician office obtained the drug from the compounding pharmacy or the retail pharmacy, administered the drug to the member and billed IME for the drug on each date of administration. The compounded version is billed using HCPCS code J2675 and Makena® is billed using HCPCS code J1725.

Since the release of the PA requirement on October 25, 2013, the indications and dosing of Makena® remains the same and both J2675 and J1725 suspend for review of the same by Medical Services.

IME Claims Analysis

Claims for Makena® and the compounded version were analyzed for SFY10 through SFY13. Claims have been submitted under HCPCS codes J3490 (unclassified drugs), J2675 (progesterone injection, per 50 mg) and J1725 (inj, hydroxyprogesterone caproate, 1 mg).

The following charts show a breakdown of the claims per SFY.



During the analysis, it was noted that in SFY11, four members who received the compounded version of 17HP had exceeded the 20 injections that IME allows per pregnancy.

- The first member received 41 injections from a single provider over a span of 183 days,
- The second member received 37 injections from two providers over a span of 130 days,
- The third member received 49 injections

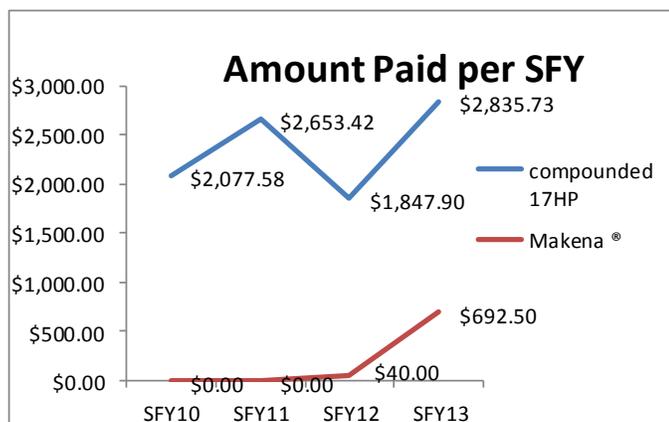
from a single provider over a span of 202 days, and

- The fourth member received 21 injections from a single provider over a span of 74 days.

Claims for the compounded version are set to suspend and are subject to review by Medical Services. Analysis of J2675 found that when it is billed with T1015 (clinic visit, encounter, rural health clinic and FQHC), J2675 did not suspend for review and the claim was paid. This was found to be related to J2675 not being allowed for provider types 13 (rural health clinic) or 49 (FQHC). The following table shows the amount paid for the compounded version of 17HP and Makena ® in each SFY. Please note that when T1015 was billed, the amount reported for 17HP was \$0.00, as all monies were paid under T1015 and could not be separated into the different services provided.

The average cost per injection for the compounded 17HP, when not provided in a rural health clinic or FQHC, was:

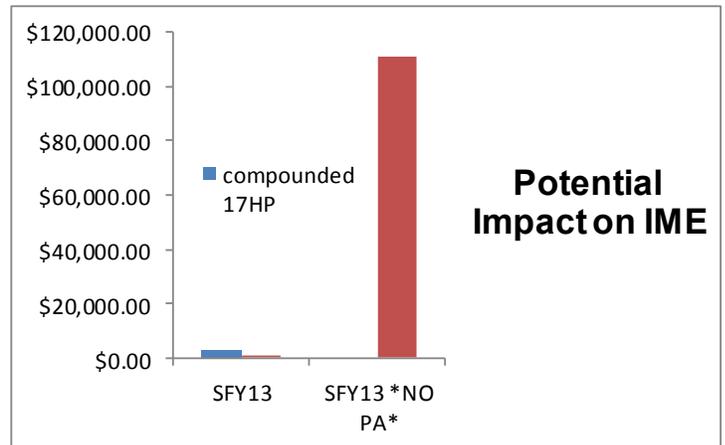
- \$9.36 in SFY10,
- \$9.76 in SFY11,
- \$9.10 in SFY12, and
- \$17.83 in SFY13.



Potential Impact on IME

The recent decision to no longer require a PA

for Makena ® has the potential for significant increases in cost for IME. For SFY13, 13 injections were provided in FQHCs and reimbursement was included in the encounter code fee. That leaves 159 compounded injections that were paid at varying rates. If these injections had all been Makena ®, the difference in the cost for IME would have been \$107,271.77.



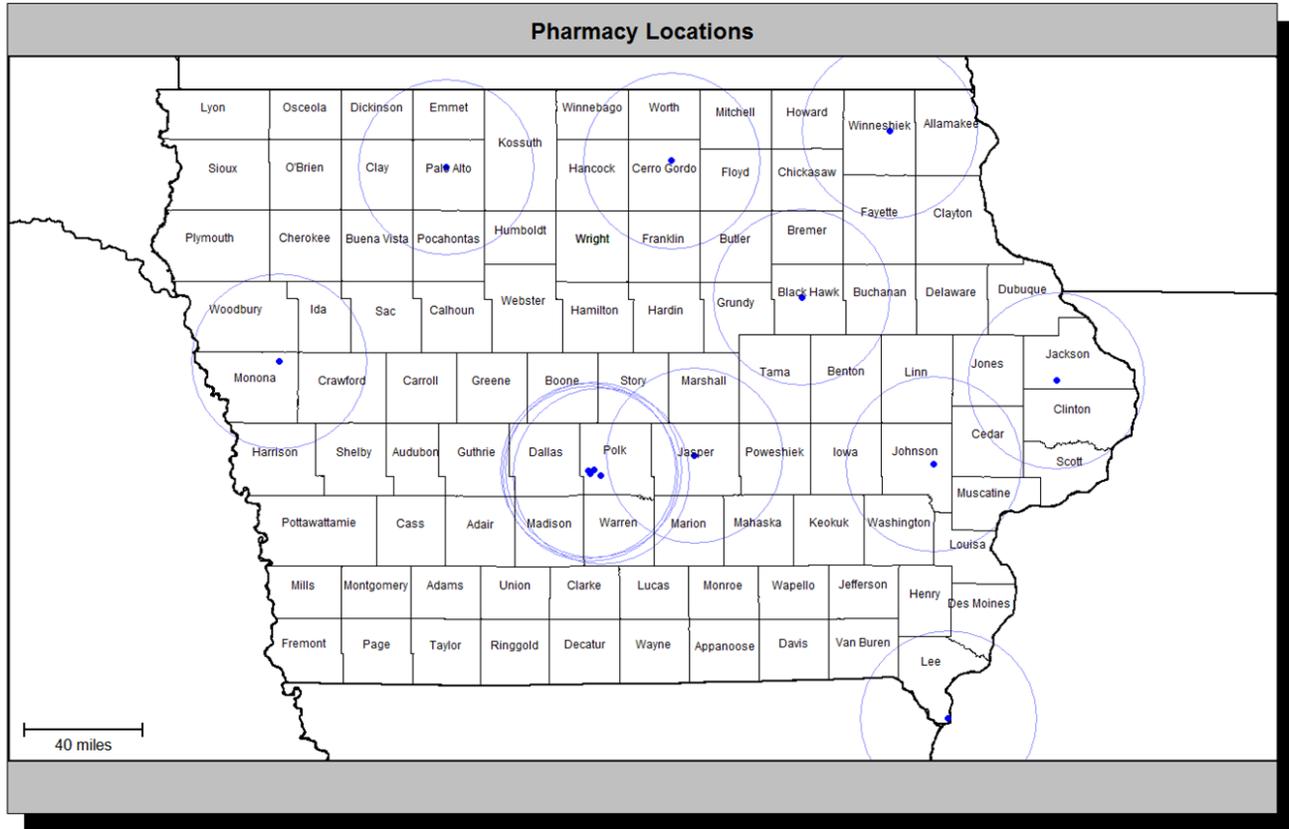
Pharmacy Availability

There are 13 compounding pharmacies located in Iowa. The map on the following page shows where these pharmacies are located and reflects a 30-mile radius where providers have access to the pharmacies. There are 10 additional compound pharmacies in cities that border Iowa and could fill some of the gaps in access for our members. Two of these pharmacies are located in the Illinois side of the Quad Cities area, one is located in La Crosse, Wisconsin, one is located in Austin, Minnesota, two are located in Sioux Falls, South Dakota and four are located in Omaha, Nebraska.

Makena ® can only be obtained from a retail pharmacy and must be shipped. CuraScript and TheraCom are the only retail pharmacies.

- CuraScript ships from Ohio and
- TheraCom ships from Maryland.

Both pharmacies offer a standard second day shipping. CuraScript charges \$15.00 for overnight shipping and TheraCom provides overnight shipping at no additional charge.



● Provider locations (13)

○ 30 mile radius

Recommendations

- Update MMIS to include UR criteria.
- Update MMIS to add provider types 13 and 49 as valid provider types for J2675 and J1725 and set these provider types to suspend for review for medical necessity.
- Consider Makena ® a non-preferred product and resume the previously established PA criteria.

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Medicaid Value Management (MVM)

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Realizing the fiscal value of quality care.

About MVM

Medicaid Value Management (MVM) analyzes different areas of Iowa Medicaid to gain an understanding of the quality of the services provided to the Medicaid member. MVM analyzes the efficacy of services provided; best practices used and not used in Iowa and the overall impact on our Medicaid population; MVM also looks at individual programs within Iowa Medicaid. Ultimately MVM looks for ways to promote improved health outcomes within the constraints of Medicaid budget limits and with this information, MVM makes recommendations for policy and program changes.

Query Facts

Iowa Medicaid claims data.



October 2013

Home and Vehicle Modifications

1st Qtr, SFY14

Points of interest:

- Between SFY03 and SFY12, 6,805 unique members accessed HVM services under the various waivers.
- The total cost across all waivers for SFY03 through SFY12, was \$15,947.094.96.
- Despite having significantly fewer unique members accessing HVM services, the BI waiver reports the highest average cost per member for total HVM costs.
- Average HVM cost for BI waiver members was \$4,657.12.

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What are home and vehicle modifications (HVMs)?

Home and/or vehicle modifications (HVM) are physical modifications to the member's home or vehicle that directly addresses the member's medical or remedial need.

For Iowa Medicaid members, HVMs are covered benefits under five of the state's seven Home and Community Based Services (HCBS) waivers. The five waivers which provide some coverage of HVMs are:

- Health and Disability Waiver (formerly known as the Ill and Handicapped Waiver)
- Elderly Waiver
- Intellectual Disability Waiver
- Brain Injury Waiver
- Physical Disability Waiver

The definition and modifications identified as covered are the same across all five waivers; the monthly and annual maximum dollar amount to fund these services differs from waiver to waiver.

The Iowa Administrative Code (IAC) stipulates that covered modifications must be necessary to provide for the health, welfare, or safety of the member and ena-

ble the member to function with greater independence in the home or vehicle.

Exclusions to the HVM policy regarding covered benefits include "...modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing or added square footage to the residence." (IAC, 2013)

Why are HVMs a covered benefit?

The short answer to why HVMs are a covered benefit is because they allow members to continue to reside safely in their home.

There are other factors that further support the coverage of home and vehicle modifications. One pivotal contributor to the HCBS waiver services, which includes HVMs, and every other benefit covered by Medicaid is the Olmstead Plan, also referred to as the Olmstead Act.

The significant difference in the cost of providing services and supports to allow members to reside in their home compared to the expense of placement in a facility also supports coverage of HVM services.

Understanding Olmstead

The premise of the Olmstead Plan is to deinstitutionalize individuals who could, with appropriate resources and treatments, be successfully integrated into society. The landmark Supreme Court decision, for which the plan's namesake was a defendant, contended that failure to provide community resources to allow individuals to be transitioned into the community was in violation of the 1990 Americans with Disabilities Act, citing that individuals who could be active members of society were unfairly isolated in institutions based on their disability or diagnosis.

The 1999 Supreme Court decision, *Olmstead, Commissioner, Georgia Department of Human Resources, et al. v. L.C., By Zimring, Guardian ad litem and next Friend, et al.*, ruled

“We affirm the Court of Appeals’ decision in substantial part. Unjustified isolation, we hold, is properly regarded as discrimination based on disability. But we recognize, as well, the States’ need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States’ obligation to administer services with an even hand....” (U.S. Supreme Court, 1999).

The Court of Appeals’ 1995 decision ruled that

“When a disabled individual’s treating professionals find that a community-based placement is appropriate for that individual, the ADA [Americans with Disabilities Act] imposes a duty to provide treatment in a community setting—the most integrated setting appropriate to meet the patient’s needs....” (Eleventh Circuit, Court of Appeals, 1995)

One of the ways Iowa helps to enforce the Olmstead Plan is by use of HCBS waiver services.

HCBS Waiver Services

The preamble of chapter 83 in the IAC relating to Medicaid Waiver Services states

“Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.” (IAC, 2013)

To establish which Medicaid members qualify to receive HCBS waiver ser-

Medicaid HCBS waivers provide coverage for services to maintain members in their homes or communities who would otherwise be institutionalized.

vices, the member or designated representative for the member, must first apply for the desired waiver. A level of care review is conducted by Medicaid based on the medical documentation made available addressing the assistance needs of the individual. If the member’s assistance needs are determined to be at a level that without the use of additional waiver support services the member is at risk of institutional placement, the member is determined to be eligible for the waiver program.

Other factors such as diagnoses, age, and income may also impact a member’s eligibility for a HCBS waiver.

Once a member has been determined eligible for waiver benefits, the service worker (SW), case manager (CM) or targeted case manager (TCM) develops a service plan identifying the type and amount of services required to meet the member’s needs. These services should fall within the allotted budget for the waiver and may be subject to additional review.

Service plan review of some provider rates as well as prior authorization of some waiver services are required; HVMS require a waiver prior authorization (WPA) review to be conducted prior to payment being approved for the service.

The IAC, HCBS and HVMS

As previously stated, HVMS are a covered benefit for five of the state’s seven HCBS waiver programs. The HVM

benefit across all five of these waivers are the same, but the funds available for HVMS differ for each waiver.

Health and Disability Waiver

The Health and Disability (HD) Waiver, formerly known as the Ill and Handicapped Waiver, is available for members who are under the age of 65 and meet all other eligibility requirements; specifically members who are not eligible for supplemental security income (SSI) benefits. Members who are SSI eligible may only be enrolled in the HD waiver until age 21. (IAC, Chapter 83)

Within the HD waiver there are three different level of care determinations that may be made based on the member’s medical and/or remedial need. A maximum monthly allowed amount is established for each level of care based on the aggregate cost of services for members with similar level of care needs.

IAC 441--83.2(2)b, notes the following:

“Except as provided below, the total monthly cost of the ill and handicapped [health and disability] waiver services shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,765	\$950	\$3,365”

(IAC, Chapter 83, 2013)

Members who are SSI eligible may only be enrolled in the HD waiver until age 21.

IAC 441--79.1(2), notes effective July 1, 2013, the upper limit for HVMs increased to \$6,366.64, per year.

Elderly Waiver

The Elderly Waiver (EW) is available for members age 65 and older who meet all other eligibility requirements.

The EW waiver has two different level of care determinations that may be made based on the member's medical and/or remedial need. A maximum monthly allowed amount is established for each level of care based on the aggregate cost of services for members with similar level of care needs. (IAC, Chapter 83, 2013)

IAC 441--83.22(2)c(2), notes the following:

“Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs are limited as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>
\$2,765	\$1,339

IAC 441--79.1(2), notes effective July 1, 2013, the upper limit for HVMs increased to \$1,061.11; lifetime maximum.

Intellectual Disability Waiver

The Intellectual Disability (ID) waiver is available for members with a mental retardation (MR) diagnosis who meet all other eligibility requirements. (IAC, Chapter 83, 2013)

IAC 441--83.61(1)a, identifies the rules for establishing and recertifying the MR diagnosis.

Unlike the HD and EW waivers, the ID waiver does not specify a monthly maximum allowable cost of services. The ID waiver also has only one level of care; intermediate care facility for persons with an intellectual disability (ICF/ID). (IAC, Chapter 83, 2013)

IAC 441--79.1(2), notes effective July 1, 2013, the upper limit for HVMs increased to \$5,305.53; lifetime maximum.

Brain Injury Waiver

The Brain Injury (BI) waiver is available for members aged one month to 64 years with a brain injury diagnosis who meet all other eligibility requirements. (IAC, Chapter 83)

The BI waiver has three level of care categories; ICF/ID, skilled nursing and intermediate care facility (ICF). IAC 441--83.82(2)d, stipulates that “the total cost of brain injury waiver services shall not exceed \$2,954 per month. If more than \$520 is paid for home and vehicle modification services, the service worker shall encumber up to \$520 per month within the monthly cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.”

IAC 441--79.1(2), notes effective July 1, 2013, the upper limit for HVMs increased to \$6,366.64, per year.

Physical Disability Waiver

The Physical Disability (PD) waiver is available for members aged 18 to 64 years with a diagnoses of a physical disability. 441--83.101(249A) notes the following definition of physical disability “...a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-

sufficiency.” (IAC, Chapter 83, 2013)

The PD waiver has two level of care categories; skilled nursing and intermediate care facility.

IAC 441--83.102(2)b, stipulates “the total cost of physical disability waiver services shall not exceed \$692 per month. If more than \$520 is paid for home and vehicle modification services, the service worker shall encumber up to \$520 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.” (IAC, Chapter 83, 2013)

IAC 441--79.1(2), notes effective July 1, 2013, the upper limit for HVMs increased to \$6,366.64, per year.

Updated IME HVM Rates

Effective January 1, 2013, the maximum amount allowable for waiver services was increased by two percent. The updated rates were identified in [Informational Letter \(IL\) 1200](#), dated December 28, 2012.

The monthly budget maximum for services provided under the waivers, including HVMs when applicable, were increased again by three percent on July 1, 2013. This was communicated via [IL 1265](#), dated July 18, 2013.

The current HVM rates are as follows:

- BI, PD and HD waivers: \$6,366.64 (annually)
- ID waiver: \$5,305.53 (lifetime)
- EW: \$1,061.11 (lifetime)

The HVM workgroup

Due to concerns regarding the cost of HVMs and consistent application of policy across all

HCBS waivers that include this benefit, a HVM workgroup was convened in April 2013.

The workgroup, comprised of representation from Policy as well as the Medical Services Unit’s exception to policy and waiver prior authorization teams, identified the following goals:

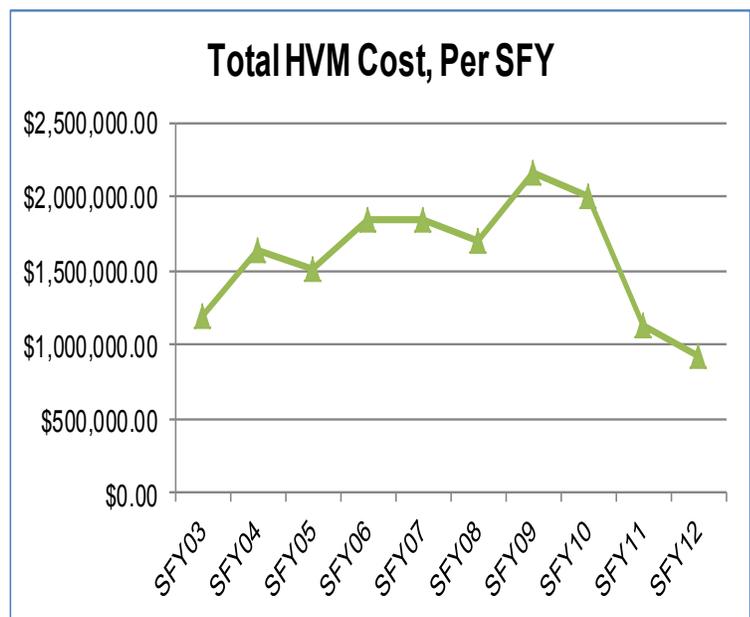
- Determine what should and should not be approved for home and vehicle modifications.
- Consistency in HVM policy application across waivers and members.
- Recommended rule changes (consider other states).

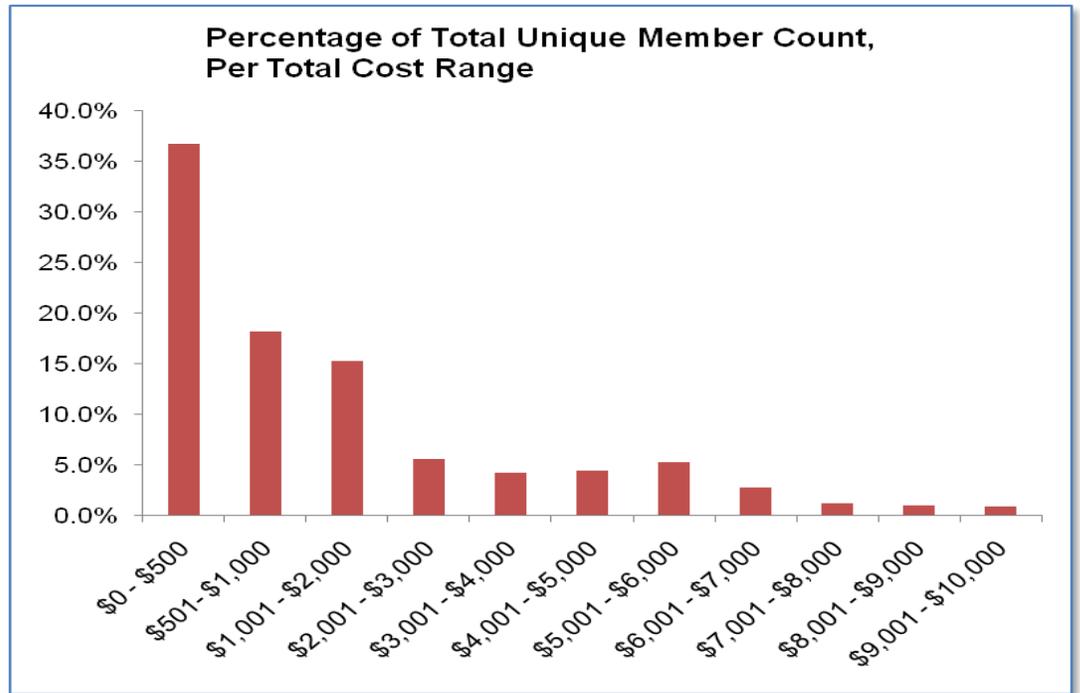
HVM historical cost analysis

To gain an understanding of the trends for HVM use, claims data was queried for state fiscal years (SFY) 2003 through 2012.

HVM Costs

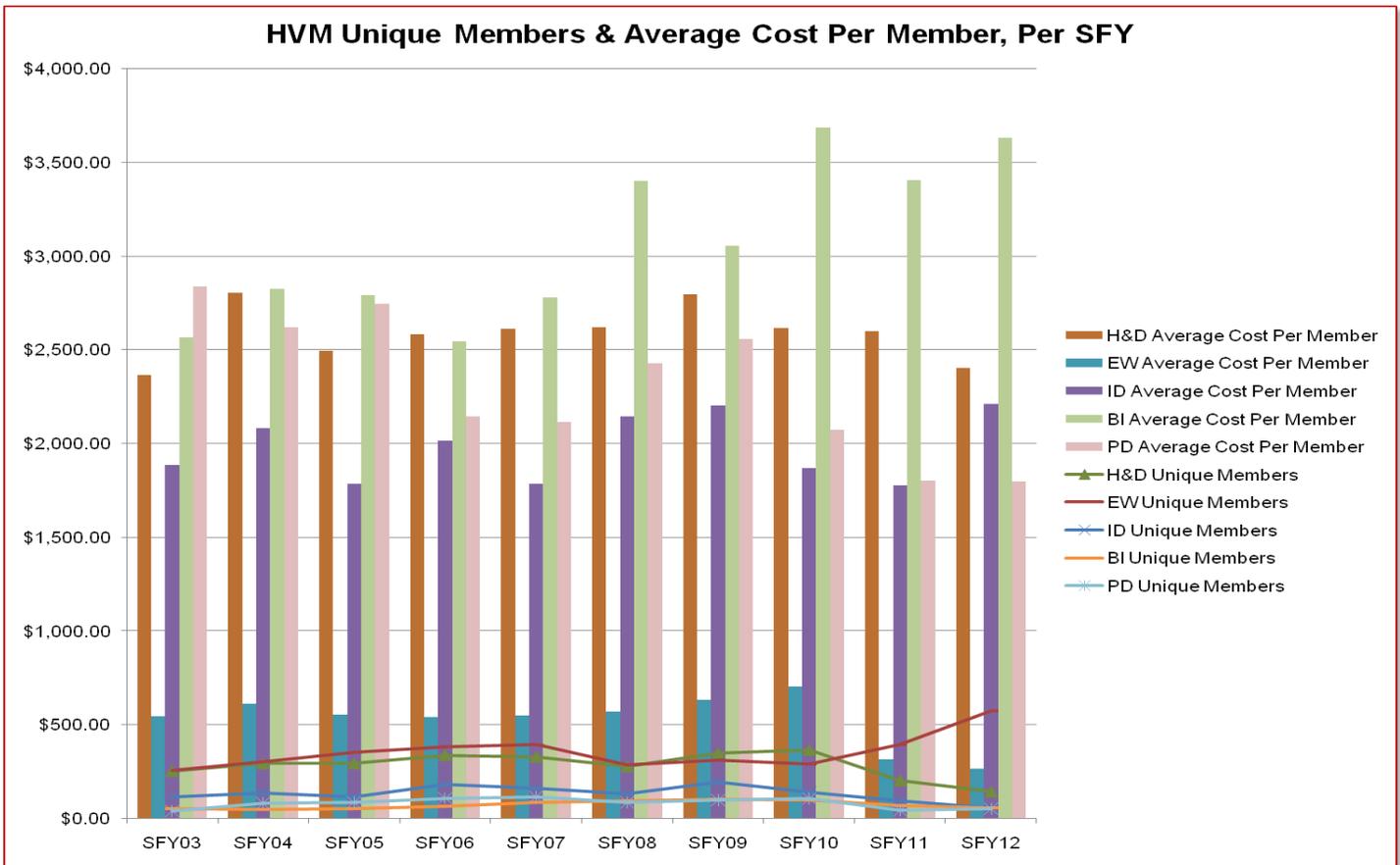
The following chart reflects the cost of HVM per SFY. Although the number of HVMs requested have remained relatively stable, the overall cost associated have decreased steadily since SFY10; this coincides with the implementation of the waiver prior authorization program.





The chart to the right reflects the percentage of unique members in each dollar range.

The majority of members' HVM costs were less than \$3,000 (75.5 percent). HVM costs totaling less than \$500, per unique member, accounted for 36.7 percent of the unique members.



Anecdotally, it had been reported that some members were accessing the HVM annually utilizing the entire benefit amount available each year. This led to concern of possible abuse of the benefit. Analysis of the data queried does not support this statement to be an area of concern. Between SFY09 and SFY12, 2,795 unique members accessed the HVM benefit; only nine members accessed the HVM benefit every year.

The following chart represents a total cost of HVM services averaged across unique members for the respective waivers between SFY03 and SFY12.

Waiver	Average HVM Cost, Per Member, Across SFYS 03-12	No. of Unique Members
Health and Disability Waiver	\$3,815.25	1,941
Elderly Waiver	\$534.79	3,315
Intellectual Disability Waiver	\$2,316.16	1,124
Brain Injury Waiver	\$4,657.12	493
Money Follows the Person	\$3,487.92	2
Physical Disability Waiver	\$3,189.34	584

Despite having significantly fewer unique members accessing HVM services, the BI waiver reports the highest average cost per member for total HVM costs. The total cost across all waivers

for SFY03 through SFY12, was \$15,947,094.96.

Between SFY03 and SFY12, 6,805 unique members accessed HVM services under the various waivers.

Total cost of HVMs ranged from \$1.00 to \$45,442.98 for individual members from SFY03 to SFY12.

Money Follows the Person (MFP) was used for two HVMs during the timeframe studied. MVP is not a stand-alone waiver and therefore was excluded from average cost calculations.

Bid and Estimate Software

The HVM workgroup researched commercially available software which may aid the Department in determining appropriateness of bids, specifically for home modifications for which only a portion of the requested modifications are authorized. The group hypothesized such software may provide a method to validate bids submitted for HVM requests.

Several products were found available that were marketed to provide both bids, or estimates, for work as well as a final invoice for the completed work. Although a trial of some products was available, the current bid information received for HVM requests is not sufficient enough to allow for accurate analysis of comparing software results with current bids submitted. The workgroup determined the inability to validate the current bids with the software coupled with software costs did not support this as a viable option for use at this time.

However, the alternatives to IME validation of bid accuracy were identified:

- Consider outreach to home builders and contractors associations in an effort to recruit additional providers and enhance the

- opportunity for competitive bids.
- Consider use of a general contractor as a consultant to the HVM waiver prior authorization (WPA) program.
- Continue to use the bid expectations and estimate example document developed in 2012 by Medical Services in collaboration with policy staff to provide education to case managers and providers.

What types of modifications are covered under the HVM benefit?

The IAC provides a list of covered modifications. Specifically, IACs 441--78.34(9)b; 78.37(9)b; 78.41(4)b; 78.43(5)b; and 78.46(2)b, identifies the following:

1. Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
2. Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible shower and sink areas.
3. Grab bars and handrails.
4. Turnaround space adaptations.
5. Ramps, lifts, and door, hall and window widening.
6. Fire safety alarm equipment specific for disability.
7. Voice-activated, sound activated, light activated, motion activated, and electronic devices directly related to the member's disability.
8. Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
9. Keyless entry systems.
10. Automatic opening device for home or vehicle door.
11. Special door and window locks.
12. Specialized doorknobs and handles.
13. Plexiglas replacement for glass windows.
14. Modification of existing stairs to widen, lower or raise enclosed stairs.
15. Motion detectors.
16. Low-pile carpeting or slip-resistant flooring.
17. Telecommunications device for the deaf.
18. Exterior hard-surface pathways.
19. New door opening.
20. Pocket doors.
21. Installation or relocation of controls, outlets, switches.
22. Air conditioning and air filtering if medically necessary.
23. Heightening of existing garage door opening to accommodate modified van.
24. Bath chairs.

IACs 441--78.34(9)a; 78.37(9)a; 78.41(4)a; 78.43(5)a; and 78.46(2)a, also specifies "modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing or adding square footage to a residence, are excluded....Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded."

Iowa Medicaid HVM Nuances

The table on the next page analyzes some of the nuances presented to Iowa Medicaid related to the HVM benefit. Although a medical need may be present for a specific HVM, additional items are often necessary to allow the HVM to be completed or there are additional items requested which are primarily aesthetic in nature and do not serve to meet a medical or remedial need.

Unique circumstances often accompany a HVM request which requires additional consideration regarding the HVM benefit.

Rental Properties

When an HVM is requested for a rental property, the Department must consider whether or

not the member and/or provider has permission from the owner of the property to complete the requested HVM.

Also, consideration is given as to whether or not the owner of the property would be willing to fund the requested HVM; in specific cases when inquiry into this option has been sought there has not been any rental property owners who have accepted financial responsibility for the HVM.

Building Code

City, state and federal building requirements required for home modifications also present challenges for the Iowa Medicaid HVM benefit. Iowa code specifies “all modifications and adaptations shall be provided in accordance with applicable federal, state and local building and vehicle codes.” (IACs 441--78.34(9)d; 78.37(9)d; 78.41(4)d; 78.43(5)d; and 78.46(2)d)

The nuance in this scenario for the Iowa Medicaid HVM, is in order for a specific HVM to be completed additional maintenance or upgrades are often required to an existing dwelling to bring the dwelling up to city, state or federal code. These requirements are not part of the specific HVM, however are required to be done to obtain the necessary permit(s) to complete an HVM that has been deemed medically necessary.

An example of this often occurs when a bathroom modification is requested in an existing dwelling that was not previously equipped with an exhaust fan. Many city or state building codes require the installation of an exhaust fan in a bathroom for the modification to be permitted, especially if removal of a window is required to accommodate the bathroom modification. The exhaust fan is not required to meet a medical or remedial need, however is required to allow for the modification of a bathroom that has been deemed medically necessary.

Other Items Requested: Medical Necessity versus Appearance; Non-Covered HVMs

When a family is considering modifying their home, it is natural to consider how the modification will fit into the overall style and appearance of the home. However to remain fiscally responsible the Department must consider the least costly modifications that will safely, and adequately, meet the member’s medical and/or remedial needs. There are often variances in what is requested versus what is found to be medically necessary.

Some specific examples of this nuance can be found when modifications are requested for kitchens, bathrooms, flooring, etc. Often the materials requested are chosen to match other areas of the home or to enhance the overall appearance of the modification. Materials such as granite counter tops and laminate flooring are often requested but are not the least costly material to complete a modification. Similarly, a walk-in shower may be requested when a less costly tub-cut may be adequate to meet the member’s needs.

Similarly, decorative railings for ramps or ramps made of materials other than standard pre-treated wood are often requested to complement the home exterior and may not be medically necessary or cost effective for the state to allow.

Based on consultation with the waiver prior authorization and exception to policy programs in Medical Services, the tables on the following pages were completed to identify in more detail some of the HVM nuances for Iowa Medicaid. Specifically, what component of the request is medically necessary, any associated requests received relating to city, state or federal building code and what additional materials or supplies are at times requested but deemed not medically necessary.

Home Modifications		
Medically Necessary HVM	Associated City, State, or Federal Building Code Requirements	Other Items or Materials Requested
Alarm Systems (when less costly items are contraindicated)	N/A	Telephone monitoring; multiple exits; video monitoring systems
Bathroom Modification; Shower; Roll-In (when less costly alternatives are contraindicated; e.g., tub cut, walk-in, etc.)	Required exhaust fan; plumbing upgrade.	Ceramic tile; name brand faucets, removing window, removing plumbing, replacing flooring; drywall; painting; moving light switches and/or electrical outlets; moving or building wall(s); moving closets; moving additional bathroom fixtures (e.g., vanity, toilet, heating/cooling vents); remove and/or replace concrete.
Bathroom Modification; Shower; Tub Cut	N/A	Walk-in tub
Bathroom Modification; Shower; Walk-In (when less costly alternatives are contraindicated; e.g., tub-cut)	Required exhaust fan; plumbing upgrade.	Ceramic tile; name brand faucets, removing window, removing plumbing, replacing flooring; drywall; painting; moving light switches and/or electrical outlets; moving or building wall(s); moving closets; moving additional bathroom fixtures (e.g., vanity, toilet, heating/cooling vents); remove and/or replace concrete.
Bathroom Modification; Sink; Lowering Existing Sink	Plumbing Upgrade	N/A
Bathroom Modification; Sink; Pedestal	Plumbing Upgrade	Name brand faucets; granite countertop and/or sink.
Bathroom Modification; Toilet--ADA (when less costly alternatives are contraindicated; e.g., toilet riser, toilet safety frame, etc.)	Plumbing Upgrade	Duplicate ADA toilet for multiple bathrooms in the home.
Concrete (for shower subflooring, ramp landings, etc.)	City/Town building permit requirements	Driveways, walkways (sidewalks), landings, stairs.
Deck/Landing	60 inch turn-around radius	N/A
Door Widening; Bathroom (when swing clear hinges are contraindicated)	32 inches or greater (tolerance of 1/4 to 3/8 inch are considered an acceptable range for usable doors)	Pocket doors (unless determined to be less expensive; i.e., replacing an existing pocket door); multiple entries; alternative entry; create new entry.
Door Widening; Garage	N/A	To accommodate a vehicle; see IAC coverage for heightening garage door to accommodate a modified van.
Door Widening; House Entry (when swing clear hinges are contraindicated)	32 inches or greater (tolerance of 1/4 to 3/8 inch are considered an acceptable range for usable doors)	Multiple entries; alternative entry; create new entry

Home Modifications (Continued)		
Medically Necessary HVM	Associated City, State, or Federal Building Code Requirements	Other Items or Materials Requested
Fencing; Standard Chain Link (covered under Exception to Policy Only--120ft, linear, plus 4ft gate)	City/Town building permit requirements	Covenant rule requirements; privacy fence; decorative fencing; fence repair and/or replacement.
Fencing; Wood (when standard chain link is contraindicated; covered under Exception to Policy Only--120ft, linear, plus 4ft gate)	City/Town Building permit requirements	Covenant rule requirements; cedar wood; decorative fencing; fence repair and/or replacement.
Flooring; low pile carpeting or slip resistant flooring	N/A	Hardwood; laminate; tile; non-slip resistant linoleum; sub-flooring, removal of existing flooring; refinishing existing hardwood; flooring for rooms not accessible by the member; flooring for rooms unrelated to ADL/IADL needs.
Ramp; Aluminum (when treated wood is contraindicated)	ADA rise requirements	Decorative railings; decks; composite material; stairs attached to ramp landing; sidewalk from ramp to driveway; duplicate ramp (multiple entry); waiver or provider owned homes; replacing landscape removed for ramp installation; removal and replacement of windows, faucets, and other fixtures for ramp installation. Duplicate ramp for multiple entries to the home.
Ramp; Portable (when stationary ramp is contraindicated)	ADA rise requirements	N/A
Ramp; Treated Wood	ADA rise requirements	Decorative railings; decks; composite material; stairs attached to ramp landing; sidewalk from ramp to driveway; duplicate ramp (multiple entry); waiver or provider owned homes; replacing landscape removed for ramp installation; removal and replacement of windows, faucets, and other fixtures for ramp installation. Duplicate ramp for multiple entries to the home.
Stair Glide	N/A	Platform stair glides; request for access to floor other than main living area for shelter from inclement weather, to access to therapy/hydrotherapy, for family time, for alternate showering facilities, for mental health and wellbeing; access to rooms unrelated to ADL/IADL needs. *Elevators have been requested in lieu of use of a stair glide.
Window and/or Door Locks	N/A	N/A

Vehicle Modifications		
Medically Necessary HVM	Associated Training or Other Requirements	Other Items or Materials Requested
Vehicle; Controls; Accelerator and Break Pedals (change in accessibility; e.g., change from right foot access to left foot access)	Adaptive equipment rehabilitation training.	N/A
Vehicle; Controls; Hand	Adaptive equipment rehabilitation training.	N/A
Vehicle; Modification; Repair or Replacement of Existing Modification	N/A	N/A
Vehicle; Lift (when less costly alternatives are contraindicated; e.g., vehicle ramp; manual lift)	Vehicle make/model does not support use of standard lift without additional modifications	Additional modifications to vehicle, such as raising roof and/or lowering floor to accommodate lift mechanism. Removal and/or replacement of seating in vehicle.
Vehicle; Ramp	N/A	N/A
Vehicle; Seat; Valet Turn Seat (when less costly alternatives are contraindicated)	Vehicle make/model does not support use of standard lift options.	N/A

The majority of HVM requests are for home modifications for which the options and needs for modifications can vary greatly based on the medical needs of the member and the design of the home. Home modifications greatly consist of ramps for entry and exit of the home and bathroom modifications to facilitate greater independence in ADLs; flooring to accommodate mobility needs also comprise a significant amount of home modification requests. Vehicle modification requests primarily focus on lifts and vehicle controls with some requests for ramps and seating.

Resources available through the Department of Justice such as the [2010 ADA Standards for Accessible Design](#) and the U.S. Department of Housing and Urban Development (HUD) [Fair Housing Act Design Manual](#) provide guidance to builders, consumers and policy makers regarding ADA design specifics. Specific dimensions, such as door widths, degree of incline for ramps and walkways, turn-around space for landings, etc. are provided in the above-mentioned manuals. The table below highlights a few of the specifications for commonly requested home (environmental) modifications.

Modification	Specifications	Resource
Door or Entryway Width	Provide a clear opening of 32 inches <u>minimum</u> .	2010 ADA Standards HUD Fair Housing Act
Wheelchair Accessible, Turn-around Radius	The space required for a person using a wheelchair to make a 180-degree turn; a turn radius of 60 inches required.	HUD Fair Housing Act Design Manual
Ramp/Walkway; Degree of Incline/Slope	"To be practical the slope must be less than 10%" (HUD, 1998)	HUD Fair Housing Act Design Manual
Ramp; Clear Width	"...the clear width between handrails shall be 36 inches (915mm) minimum."	2010 ADA Standards

Although the minimum door or entry clearance identified by both HUD and ADA is 32 inches, 36 inches is fairly standard to support wheelchair accessibility.

Beginning below, some of the research from other state Medicaid programs will be highlighted. An appendix to this report will contain additional information from other state Medicaid programs.

Other State Research

Colorado

Home Modifications: Home modifications are covered under six waiver programs within Colorado Medicaid.

HCBS--Elderly, Blind and Disabled (EBD) Waiver
 Community Mental Health Supports Waiver,
 Brain Injury Waiver
 Spinal Cord Injury Waiver
 HCBS--Supported Living Services Waiver
 Children's Extensive Support Waiver

Home modifications are defined as:

“Those physical adaptations to the home, required by the individual's plan of care, which are necessary to assure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State and local building codes.” (Colorado Medicaid)

Some specifications unique to Colorado Medicaid for HVM services are as follows:

- Prior authorization required for home modifications estimated to cost between \$1,000.00 and \$10,000.00.
- The case manager may approve Home Modifications projects estimated at less than \$1,000.00 without prior authorization.
- The Department may conduct on-site visits or any other investigations
- An occupational therapist shall assess the client's needs and the therapeutic value of the requested Home Modification.
 - If qualified occupational therapist, with experience in home modification, is not available a Department-Approved physical therapist may be substituted.
- A report specifying how the home modification would contribute to the client's ability to remain or return to his/her home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited.
 - This Evaluation shall be submitted with the prior authorization request.
- Claims may be submitted proactively for up to 50 percent of the project cost for materials, permits and initial labor cost. The remaining will be reimbursed when modification is completed and documented in client's file.
- One year written warranty on parts and labor.

- Final inspection documentation verified by case manager and documented in the client's file that the Home Modification has been completed.

In addition to the benefit description noted previously for other HCBS waivers in Colorado, the Supported Living Services Waiver and the Children's Extensive Support Waiver includes the following added verbiage:

"...Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Prior Authorization is required for any adaptation adding square footage to the home...." (Colorado Medicaid)

Vehicle Modification: Vehicle modifications are covered under two waiver programs within Colorado Medicaid.

HCBS-Supported Living Services Waiver Children's Extensive Support Waiver

Vehicle modifications are defined as: "Adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the Service Plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded:

- (1) Adaptations or improvements to the vehicle that are general utility, and are not of direct or remedial benefit to the participant;
- (2) Purchase or lease of a vehicle; and
- (3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modification."

The following service limitations are identified: "The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed \$10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or if it decreases the need for paid assistance in another waiver service on a long-term basis." (Colorado Medicaid)

Florida

Florida covers assistive devices and home and vehicle adaptations under eight of the nine HCBS waiver programs.

MR/DD waiver

Frail Elders waiver

Elderly and Disabled waiver

AIDS waiver

Nursing Home Diversion waiver

Family and Supported Living Waiver (Disabilities Waiver)

Traumatic Brain Injury and Spinal Cord Injuries Waiver

Alzheimer's Disease Program

Home modifications which are covered include: Installation of ramps
Environmental controls, and adaptive switches

Excluded home (environmental) modifications under Florida's HCBS waivers include:

"those adaptations or improvements to the home, which are of general utility, and are not of direct or medical or remedial benefit to the recipient, such as carpeting, roof repair, central air conditioning, etc." (Florida Medicaid, 2010)

Florida Medicaid, like many other states, has varying benefits and limitations that are waiver

specific.

For home (environmental) modifications, under the MR/DD waiver, Florida stipulates:

- Minor adaptations are considered modifications costing less than \$3,500;
- Major modifications are those costing \$3,500 or more.
- “Total environmental accessibility adaptations cannot exceed \$20,000 during a five-year period.” (Florida Medicaid, 2010)

Funding limits for the Frail Elders waiver and the Family and Supported Living Waiver (Disabilities Waiver) have been specified as \$2,000 per calendar year, per recipient. (Florida Medicaid, 2010)

Funding limits for the Elderly and Disabled waiver and the Alzheimer's Disease Program have been specified as “five jobs per year at \$1,000, per job or \$5,000 per year.” (Florida Medicaid, 2010)

Funding limits for the Traumatic Brain Injury and Spinal Cord Injuries Waiver have been specified as a maximum reimbursement for adaptations of \$5,000 per year. (Florida Medicaid, 2010)

Vehicle Modification: Vehicle modifications are only covered under the MR/DD waiver.

“Vehicle adaptations, including lifts, tie downs, and raised roof or doors in a family owned or individually owned full-size van.” (Florida Medicaid, 2010)

Indiana

Environmental modifications are covered HCBS waiver benefits for the Indiana Medicaid program.

Indiana Medicaid defines environmental modifi-

cations as:

“Environmental modifications are minor physical adaptations to the home, as required by the individual’s service plan which are necessary to ensure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.” (Indiana, DOA, 2013)

Covered environmental modifications include:

- Adaptive door openers and locks.
- “Limited to one per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.” (Indiana, DOA, 2013)
- Bathroom Modification
 - “Limited to one existing bathroom per individual primary residence when no other accessible bathroom is available.
 - Bathroom modifications may include:
 - Removal of existing bathtub, toilet or sink
 - Installation of roll-in shower, grab bars, ADA toilet, and wall mounted sink
 - Installation of replacement flooring, if necessary due to bath modification.” (Indiana, DOA, 2013)
- Environmental controls
 - Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.
 - Environmental safety devices are limited to:
 - Door alarms
 - Anti-scald devices
 - Hand-held shower head

- Grab bars for the bathroom
- Fence
 - Limited to 200 linear feet
 - Individual must have a documented history of elopement
- Ramp
 - Limited to one per individual primary residence and only when no other accessible ramp exists:
 - In accordance with ADA or ADAAG, unless this is not in the best interest of the client
 - Portable
 - Considered for rental property only
 - Permanent
 - Vertical lift
 - May be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used
- Stair lift
 - If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service plan.
- Single room air conditioners/single room air purifiers
 - If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service plan:
 - There is a documented medical reason for the individual's need to maintain a constant external temperature.
 - The documentation necessary for this equipment includes a prescription from the primary care physician.
 - The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.

- Widen doorway
 - To allow safe egress:
 - Exterior--Modification limited to one per individual primary residence when no other accessible door exists
 - Interior--Modification of bedroom, bathroom, or kitchen door/doorway as needed to allow for access.
 - A pocket door may be appropriate when there is insufficient room to allow for the door swing.
- Windows
 - Replacement of glass with Plexiglas® or other shatterproof material when there is a documented medical/behavioral reason.

Prior authorization is required for all environmental modifications.

Unique to the Indiana Medicaid program is an annual allotment of \$500 per year for maintenance, repair and service, of environmental modifications that have been provided through the HCBS Waiver. (Indiana, DOA, 2013)

Louisiana

Louisiana Medicaid requires a final inspection for environmental accessibility adaptations (EAA). The EAA assessor schedules a final inspection with the member and/or their representative, the support coordinator and the provider. A final inspection form is completed and signed by the member or their representative, the support coordinator and the provider indicating satisfactory completion of the job.

“This form is to be used for all requests for Environmental Accessibility Adaptations included in the OCDD approved Plan of Care (POC) or Revision Request. Support Coordinator (SC) completes **Section 1**, obtain proper signatures and a written itemized detailed bid, which in-

cludes the drawing with the dimensions of the existing and proposed plans related to the modification, from the service provider/contractor, and send along with the POC or Revision to OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District. **Section 2** will be completed by the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District and if approved, forwarded to SRI with the POC budget pages if it is requested an initial or annual or revision request for PA and then send back to the SC who will forward it to the service provider/contractor. **Section 3** will be completed by the service provider/contractor and returned to SC as soon as the job is completed. **Section 4** will be completed by the SC, signed by the recipient/family/guardian and the support coordinator to indicate that they have accepted the job, and submitted to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District for their signature and final approval, who will forward the approval to SRI for issuance of the Post Authorization (payment). All signatures are mandatory. ***All work is to be performed and completed in the current approved POC year. Enough time should be allowed for completion of job before the end of the POC year.*** (Louisiana Department of Health and Hospitals, 2010)

New York

New York Medicaid offers **home and vehicle modification** benefits under the **Care At Home (CAH)** Medicaid Waiver programs.

Some items covered under the CAH waivers include:

- Purchase of backup generator for medical equipment
- Installation of wheelchair ramps

- Widening of doorways
- Modifications to permit independent use of bathroom or modifications to facilitate bathroom use with assistance
- Stair-glides
- Modification to a parent-owned vehicle to accommodate the CAH child
 - **“NOTE:** The structure of the vehicle must be able to support the requested modification.” (New York DOH, 2000)

Similar to other state Medicaid programs, New York has identified exclusions to covered home modification.

“...Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are also excluded.” (New York, DOH, 2000)

Additional, specific, home modification items outlined for exclusion by the New York Medicaid program include:

- Build any portion of new housing construction
- Build room extensions or build additional rooms or spaces beyond the existing structure or dwelling
- Renovate or build rooms for the use of physical therapy equipment
- Purchase equipment such as any therapeutic equipment or supplies, exercise equipment, televisions, video cassette recorders, personal computers, etc.
- Purchase swimming pools, hot tubs, whirlpools, steam baths or saunas for either indoor or outdoor use
- Pave driveways
- Purchase central air conditioning, freestanding air conditioners, or humidifiers
- Purchase and install elevators
- Purchase items that primarily benefit members of the household other than the CAH

participant

- Purchase service or maintenance contracts

New York Medicaid also provides additional guidance regarding materials, child(ren) primary residences and new home selection; noting the following:

“Home adaptation expenses should be based on contractor grade materials in all instances. Medicaid will not pay for add-ons or upgrades. Medicaid will only pay for work that is necessary to reasonably accommodate the medical needs of the recipient and to finish the alterations (e.g., molding, trim, primer, and finish coat of paint).

Home adaptations to accommodate the CAH child shall only be approved for the child's primary residence. Vehicle modifications to accommodate the CAH child shall only be approved for one parent-owned vehicle.

When looking for a new home, it is the family's responsibility to take the child's needs into account and choose a home that requires the least amount of modification. Whenever possible the child should be placed on the first floor with access to a bathroom and an exit. In cases of new construction, or where existing structures are gutted, adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies essential to the welfare of the child.” (New York, DOH, 2000)

Prior authorization is required for HVMs to be covered under the New York Medicaid CAH waivers.

Oregon

Oregon Medicaid has six HCBS waivers to provide additional support to seniors and people with disabilities.

Aged and Physically Disabled Waiver
Comprehensive Waiver
Support Services Waiver
Behavioral Model Waiver
Hospital Model Waiver
Medically Involved Waiver

Home (environmental) modifications or adaptations covered under Oregon's HCBS waivers include, but are not limited to, the installation of ramps and grab-bars, removing or widening of doorways, handrails, electric door openers, adaptations of kitchen cabinets/sinks, modification of bathroom facilities, individual room air conditioners to maintain stable temperature required by the individual's medical condition, installation of non-skid surfaces, overhead track systems to assist with lifting or transferring, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

“Environmental modification consultation necessary to evaluate the family home and make plans to modify the home to ensure the health, welfare and safety of child is included....

Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. For home adaptations that exceed \$5,000 the Department will protect its interest through liens or other legally available means. Home adaptations that are provided in a rental structure must be authorized in writing by the owner of the struc-

Examples of HISA exclusions include:

- Walkways to exterior buildings
- Widening of driveways (in excess of a 7ft x 6ft area)
- Spa, hot tub, or Jacuzzi
- Exterior decking (in excess of 8ft x 8ft)

In addition to the HISA grant, Veterans may be eligible for a Special Home Adaptation (SHA) grant or a Specially Adapted Housing (SAH) grant. (Veterans Administration, 2012)

Special Home Adaptation (SHA) Grant

“The SHA grant is for modifying an existing home to meet adaptive needs, such as assistance with mobility throughout the home. Veterans and service members with specific service-connected disabilities may be entitled to this type of grant.” (Veterans Administration 2008) The grant is currently limited to \$12,756. A temporary grant may be available to veterans and service members who are/will be temporarily residing in a home owned by a family member.

The SHA grant is available to veterans who are and service members who will be entitled to disability compensation for permanent and total disability due to:

- Blindness in both eyes with 5/200 visual acuity or less or,
- The anatomical loss or loss of use of both hands or extremities below the elbow, or
- A severe burn injury (as so determined).” (Veterans Administration 2008)

Specially Adapted Housing (SAH) Grant

“The SAH Grant is designed to help provide a barrier-free living environment that affords the individual a level of independent living they may not otherwise enjoy, such as creating a wheelchair accessible home. Veterans and

service members with specific service-connected disabilities may be entitled to a grant for the purpose of constructing or modifying a home to meet their adaptive needs.” (Veterans Administration 2008)

This grant is currently limited to \$63,780.

The SAH grant is available to veterans who are and service members who will be entitled to disability compensation for permanent and total disability due to:

- Loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair, or
- Blindness in both eyes, having only light perception, plus loss or loss of use of one lower extremity, or
- Loss or loss of use of one lower extremity together with (1) residuals of organic disease or injury, or (2) the loss or loss of use of one upper extremity, which so affects the functions of balance or propulsion as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair or,
- Loss or loss of use of both upper extremities such as to preclude use of the arms at or above the elbow, or
- A severe burn injury (as so determined)” (Veterans Administration, 2008)

Veterans may also receive funding assistance for vehicle modifications.

Automobile Adaptive Equipment (AAE)

“The Automobile Adaptive Equipment (AAE) program permits physically challenged persons to enter, exit, and/or operate a motor vehicle or other conveyance.

Veterans are trained, through the [Veterans Administration] VA Driver’s Rehabilitation Program, how to safely oper-

ate their vehicle on our nation's roadways." (Veterans Administration, 2012)

Additional coverage may be provided for the following vehicle modification equipment::

- Platform wheelchair lifts
- Under Vehicle Lifts (UVLs)
- Power door openers
- Lowered floors/raised roofs
- Raised doors
- Hand controls
- Left foot gas pedals
- Reduced effort and zero effort steering and braking
- Digital driving systems

This list is not all inclusive of items that may be covered under this VA benefit. (Veterans Administration, 2012)

The VA provides the following guidance for vehicle conversion.

Mini-Van

- Reimbursement will be made in an amount equal to or less than the average cost of a conventional van modification, plus 25 percent (only for persons with a service-connected disability)
- Reimbursement for the cost of transporting/delivery of the vehicle

Full Size Van

- This type of conversion is considered comfort; exceeds space required for transportation
- The reimbursed amount should not exceed that of conventional van conversion

Pick-Up Trucks

- The space modified is about half of a mini-van
- The dollar amount should not exceed that of a mini-van conversion

Motor Homes

- All modifications must be prior authorized
- Only VA approved equipment may be authorized
- Maximum reimbursed amounts established for automobile adapted equipment will not be exceeded for similar items installed in a motor home
- Amount authorized for purchase and installation of a lift will not exceed the average amount authorized for similar lifts installed in vans.
- VA is not responsible for the removal, modification or reinstallation of any convenience items contained in the motor home (e.g., cabinets, stoves, showers, refrigerators, etc.) (Veterans Administration, 2012)

The U.S. Department of Veterans Affairs further defines what is considered "repairs" for purpose of the AAE benefit..

"Repairs

- Routine service to items is not considered a repair e.g., brake shoes, drums and pads or other adjustments (only the power booster). Power Steering and Automatic Transmission service or fluid fills are not authorized (only the transmission itself, or the power steering components).
- Maximum reimbursement is for the total amount of the certified invoice
- Repairs, cost of parts, and labor, are listed in the current Mitchell's Mechanical Parts and labor Estimating Guide for Domestic Cars
- Towing is not normally an authorized repair

Used Vehicles

- Prorated by reducing the standard equipment reimbursable amount for like items by 10% per year (this includes any add-on adaptive equipment previously installed)
- Maximum deduction of 90% of the new reimbursement rate will be allowed for vehicles 10 years or older (vehicles will have a residual value of 10%) (Veterans Administration, 2012)

Other Resources

“The Iowa Program for Assistive Technology (IPAT) helps lowans find out about and get the assistive technology (AT) they need as part of their daily lives to learn, work, play, and participate in community life safely and independently.

IPAT serves lowans of all ages with all types of disabilities, including persons who are aging....” (IPAT n.d.)

“...The Iowa Program for Assistive Technology supports two programs that get used assistive technology (AT) devices into the hands of lowans who need them:

[Iowa Compass](#) – maintains a list of local and state programs that loan out used assistive technology devices, sometimes called loan closets. They also have the [Used Equipment Referral Service or UERS](#) which is a free on-line listing of used devices that people are selling and looking to buy....” (IPAT, n.d.)

Searchable categories within the Iowa Compass program include:

- Adapted Equipment and Accessibility
- Education and Information
- Employment
- Financial Assistance/Services
- Health and Medical Services
- In-Home and Community Based Services
- Legal Services, Advocacy and Rights Protection
- Recreation and Sports
- Residential Facilities & Housing Services
- Social and Emotional Support
- Transportation and Travel

Searchable categories within the UERS program include:

- Ambulation Aids

- Architectural/Home Adaptations
- Augmentative/Alternative Communication
- Classroom/Office Equipment
- Clothing
- Computers
- Environmental Control
- Ergonomics
- Farm Adaptations
- Furniture/Home Management
- Hearing Technology
- Mobility
- Orthotics/Helmets
- Personal Care
- Prosthetics
- Recreation
- Scooters
- Switches
- Therapy Aids
- Travelchairs/Strollers/Car Seats
- Vehicle Accessories
- Vehicles with Lifts/Ramps
- Visual Aids
- Wheelchair Accessories
- Wheelchairs, Manual
- Wheelchairs, Power
- Easter Seals Equipment Loan

“The [Easter Seals Iowa Assistive Technology Center](#) takes in donated used devices and medical equipment. The cleaned and fixed devices are provided to lowans with disabilities for a small service fee for as long as needed....” (IPAT, n.d.)

“For those in need of medical equipment, but cannot afford it or might not have ready access to it, Easter Seals Iowa provides a valuable resource. We loan refurbished medical equipment at a nominal fee to individuals with disabilities or illness. Having the proper medical equipment can often mean the difference between simply existing with a long-term or short-term disability or being cared for at home and functioning independently....

....Easter Seals offers a wide variety of

equipment for loan (based on current inventory), including:

- Wheelchairs (manual and electric, adult and pediatric)
- Walkers (adult and pediatric)
- Shower benches
- Hoyer lifts
- Hospital beds” (Easter Seals, n.d.)

The table on the next page reflects the fees associated with the equipment loan program through Easter Seals of Iowa.



EASTER SEALS EQUIPMENT LOAN FEES (Effective February 1, 2012)

http://ia.easterseals.com/site/DocServer/Equipment_Loan_Pricing_Feb_1_2012.pdf?docID=148939

Type of Equipment	One Time Fee
Bathtub/aqua lift – water controlled	\$40
Bathtub/aqua lift – electric/battery	\$75
Bathtub/shower chair – non-transfer	\$20
Bathtub/shower chair – transfer	\$35
Bed Rails	\$10
Cane	\$10
Commode	\$20
Crutches	\$10
Daily Living Devices	\$5
Elevated Toilet Seat	\$10
Exercycle	\$20
Geriatric Chair	\$35
Grab Bars	\$10
Hospital Bed (electric)	\$130
Hospital Bed (manual)	\$65
Hoyer Lift (with sling) hydraulic	\$65
Hoyer Lift (with sling) battery	\$130
Hoyer Lift sling only	\$10
Lift Chair	\$75
Overbed Table	\$25
Ramp	\$50
Stair Lift	\$100
Standing Aid	\$50
Toilet Safety Arms	\$15
Transfer Board	\$10
Transport Chair	\$35
Trapeze	\$25
Walker-standard	\$10
Walker with fold down seat/Rollator	\$25
Walker with forearm supports	\$20
Wheelchair/electric / electric scooter	\$130 (plus batteries)
Wheelchair (manual)	\$35
Wheelchair cushion – standard	\$10
Wheelchair cushion – Roho/gel, etc.	\$40

Summary

In summary, home and vehicle modifications are an important component of the HCBS waivers and provide funding to support members' independence within the home and community. Advancing technologies and the evolution of the design for assistive equipment has over the years increased the cost to the Medicaid program for these modifications. Although rules are currently in place for inclusions, and exclusions, to the HVM policies changes are needed to ensure the benefit is fiscally sustainable for Medicaid program to offer to the members in need.

- The majority of members' HVM costs were less than \$3,000 (75.5 percent). HVM costs totaling less than \$500, per unique member, accounted for 36.7 percent of the unique members.
- Despite having significantly fewer unique members accessing HVM services, the BI waiver reports the highest average cost per member for total HVM costs.
- Average HVM cost for BI waiver members was \$4,657.12.
- The total cost across all waivers for SFY03 through SFY12, was \$15,947,094.96.
- Between SFY03 and SFY12, 6,805 unique members accessed HVM services under the various waivers.
- Total cost of HVMs ranged from \$1.00 to \$45,442.98 for individual members from SFY03 to SFY12.
- Unique circumstances often accompany a HVM request which requires additional consideration regarding the HVM benefit such as modifications to a rental property or city, state or federal building code requirement changes needed to update a property before a modification can be completed.
- The majority of HVM requests are for home modifications for which the options and needs for modifications can vary greatly based on the medical needs of the member and the de-

sign of the home.

- Home modifications greatly consist of ramps for entry and exit of the home and bathroom modifications to facilitate greater independence in ADLs; flooring to accommodate mobility needs also comprise a significant amount of home modification requests.
- Vehicle modification requests primarily focus on lifts and vehicle controls with some requests for ramps and seating.

Several states have incorporated verbiage referencing "general utility" to describe home owner's responsibility for home repairs. For example "Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc...." It is felt similar wording within the IAC would help clarify the exclusions not specifically listed that would fall within the "etc." category.

The following information from **Colorado** Medicaid may aid in rule making for Iowa Medicaid.

- An occupational therapist shall assess the client's needs and the therapeutic value of the requested Home Modification.
- A report specifying how the home modification would contribute to the client's ability to remain or return to his/her home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited.
- One year written warranty on parts and labor.

The following information from **Florida** Medicaid may be helpful in rule making for Iowa Medicaid:

- For home (environmental) modifications, under the MR/DD waiver, Florida stipulates minor adaptations are considered modifications costing less than \$3,500; major modifi-

cations are those costing \$3,500 or more.

- “Total environmental accessibility adaptations cannot exceed \$20,000 during a five-year period.” (Florida Medicaid, 2010)
- For multiple waivers Florida has stipulated benefit limits of “five jobs per year at \$1,000, per job or \$5,000 per year.” (Florida Medicaid, 2010)
- Other waivers may have an annual limit of \$2,000 specified.

The following information from [Indiana’s](#) Medicaid program may assist in rule making for Iowa Medicaid.

- “Limited to one per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.” (Indiana, DOA, 2013)
- Also Unique to the Indiana Medicaid program is an annual allotment of \$500 per year for maintenance, repair and service, of environmental modifications that have been provided through the HCBS Waiver.

[Louisiana](#) Medicaid requires a final inspection for environmental accessibility adaptations (EAA). The EAA assessor schedules a final inspection with the member and/or their representative, the support coordinator and the provider. A final inspection form is completed and signed by the member or their representative, the support coordinator and the provider indicating satisfactory completion of the job.

The following information from [New York’s](#) Medicaid program which identifies specific exclusions may be useful in clarifying items in the rule making process for Iowa Medicaid.

- Build any portion of new housing construction
- Build room extensions or build additional rooms or spaces beyond the existing structure or dwelling
- Renovate or build rooms for the use of physi-

cal therapy equipment

- Purchase equipment such as any therapeutic equipment or supplies, exercise equipment, televisions, video cassette recorders, personal computers, etc.
- Purchase swimming pools, hot tubs, whirlpools, steam baths or saunas for either indoor or outdoor use
- Pave driveways
- Purchase central air conditioning, free-standing air conditioners, or humidifiers
- Purchase and install elevators
- Purchase items that primarily benefit members of the household other than the CAH participant
- Purchase service or maintenance contracts

In addition to providing detail for exclusions to the benefit, New York Medicaid provides additional guidance regarding materials, child(ren) primary residences and new home selection; noting the following:

“Home adaptation expenses should be based on contractor grade materials in all instances. Medicaid will not pay for add-ons or upgrades. Medicaid will only pay for work that is necessary to reasonably accommodate the medical needs of the recipient and to finish the alterations (e.g., molding, trim, primer, and finish coat of paint).

Home adaptations to accommodate the CAH child shall only be approved for the child's primary residence. Vehicle modifications to accommodate the CAH child shall only be approved for one parent-owned vehicle.

When looking for a new home, it is the family's responsibility to take the child's needs into account and choose a home that requires the least amount of modification. Whenever possible the child should be placed on the first floor with access to a bathroom and an exit. In cases of new construction, or where existing structures are

guted, adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies essential to the welfare of the child.” (New York, DOH, 2000)

Oregon's Medicaid program requires an evaluation to be completed to assess that the modification requested will meet the member's needs. “Environmental modification consultation necessary to evaluate the family home and make plans to modify the home to ensure the health, welfare and safety of child is included....” (Oregon Medicaid, 2009)

As another government entity, benefits provided and the policy language used by the **U.S. Department of Veterans Affairs** may provide not only verbiage to assist in rule writing for Iowa Medicaid, but also lend support to the policy changes being carried out by another governmental agency.

Through the Home Improvements and Structural Alterations (HISA) Grant, veterans “...may receive assistance for home improvement necessary for the continuation of treatment or for disability access to the home and essential lavatory and sanitary facilities.” (Veterans Administration, 2012)

Examples of what may be funded under HISA include:

- Allowing entrance or exit from the home
- Improving access for use of essential restroom and bathing facilities (lavatory and sanitary facilities)
- Improving access to kitchen and bathroom counters
- Handrails
- Lowered electrical outlets and switches
- Improving paths or driveways

- Improving plumbing/electrical work for dialysis patients

The Special Home Adaptation (SHA) Grant “is for modifying an existing home to meet adaptive needs, such as assistance with mobility throughout the home. Veterans and service members with specific service-connected disabilities may be entitled to this

type of grant.” (Veterans Administration 2008) The grant is currently limited to \$12,756. A temporary grant may be available to veterans and service members who are/will be temporarily residing in a home owned by a family member.

The SHA grant is available to veterans who are and service members who will be entitled to disability compensation for permanent and total disability due to:

- Blindness in both eyes with 5/200 visual acuity or less or,
- The anatomical loss or loss of use of both hands or extremities below the elbow, or
- A severe burn injury (as so determined).” (Veterans Administration 2008)

The Specially Adapted Housing (SAH) Grant “is designed to help provide a barrier-free living environment that affords the individual a level of independent living they may not otherwise enjoy, such as creating a wheelchair accessible home. Veterans and service members with specific service-connected disabilities may be entitled to a grant for the purpose of constructing or modifying a home to meet their adaptive needs.” (Veterans Administration 2008) This grant is currently limited to \$63,780.

The SAH grant is available to veterans who are and service members who will be entitled to disability compensation for permanent and total disability due to:

- Loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair, or
- Blindness in both eyes, having only light perception, plus loss or loss of use of one lower extremity, or
- Loss or loss of use of one lower extremity together with (1) residuals of organic disease or injury, or (2) the loss or loss of use of one upper extremity, which so affects the functions of balance or propulsion as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair or,
- Loss or loss of use of both upper extremities such as to preclude use of the arms at or above the elbow, or
- A severe burn injury (as so determined)” (Veterans Administration, 2008)

Veterans may also receive funding assistance for vehicle modifications.

The Automobile Adaptive Equipment (AAE) program permits physically challenged persons to enter, exit, and/or operate a motor vehicle or other conveyance.

Veterans are trained, through the [Veterans Administration] VA Driver’s Rehabilitation Program, how to safely operate their vehicle on our nation’s roadways.” (Veterans Administration, 2012)

Additional coverage may be provided for the following vehicle modification equipment:

- Platform wheelchair lifts
- Under Vehicle Lifts (UVLs)
- Power door openers
- Lowered floors/raised roofs
- Raised doors
- Hand controls
- Left foot gas pedals
- Reduced effort and zero effort steering and braking

- Digital driving systems

This list is not all inclusive of items that may be covered under this VA benefit. (Veterans Administration, 2012)

The VA provides the following guidance for vehicle conversion coverage.

As payer of last resort, and confirmed by the Revenue Collections Unit of IME, Iowa Medicaid should be the second payer to members receiving benefits through the U.S. Veterans Administration if the member meets criteria for home or vehicle modifications covered through the HISA

“[The Iowa Program for Assistive Technology \(IPAT\)](#) helps lowans find out about and get the assistive technology (AT) they need as part of their daily lives to learn, work, play, and participate in community life safely and independently.

IPAT serves lowans of all ages with all types of disabilities, including persons who are aging....” (IPAT n.d.)

“The [Easter Seals Iowa Assistive Technology Center](#) takes in donated used devices and medical equipment. The cleaned and fixed devices are provided to lowans with disabilities for a small service fee for as long as needed....” (IPAT, n.d.)

HVM services or equipment may be available through the VA benefit for veterans, IPAT and Easter Seals of Iowa. As the payer of last resort, when appropriate these services should be accessed prior to submitting to Iowa Medicaid.

The recommendations on the following pages have been developed under the Program Integrity Unit’s MVM program in collaboration with the Medical Services Unit’s exception to

policy and waiver prior authorization programs with feedback provided by the two designated IME Policy Unit, Program Managers.

Recommendations

The recommendations identified as part of the HVM workgroup can be broken down into three primary categories--rule changes, benefit changes and service definitions or clarification.

On the next several pages the recommendations will be explained with reference, when applicable, to Iowa Medicaid, other state Medicaid or other payers for which a current policy is in place to support the recommendation.

1. As payer of last resort, **when appropriate other resources** such as the VA benefit for veterans or IPAT **should be consulted prior to submitting a request to Iowa Medicaid.**
2. **Remove language within the IAC allowing coverage for “heightening of existing garage door opening to accommodate modified van.”** Historically few modification requests have been received for this structural change. This coincides with recent HVM authorizations which have excluded coverage for raising the roof and lowering the floor to accommodate a lift which due to the cost associated with the vehicle modification. Without raising the roof on a van, any need to heighten an existing garage door is reduced significantly.
3. **Remove language within the IAC which excludes repairs** to existing HVMs; **and**
 - a. **Add language within the IAC to allow repair to HVMs which are proportionately appropriate** to the value of the cost of a new modification. Consider similar to state plan DME repair coverage which is allowed providing the cost of repairs do not exceed two-thirds (2/3) the cost of a new modification; **and**
 - b. **Add language to IAC defining repairs.** Repairs can be defined as “to restore to a good or sound condition after decay or damage.” (dictionary.com and previously sited in an affirmed appeal decision from the Director’s office--appeal MED 11003788); **and**
 - c. **Add language to IAC specifying repairs only covered for adaptive equipment**, including but not limited to ramps and vehicle lifts. Excluded are modifications to the home or vehicle which are of general utility, which include but are not limited to, the repair or replacement of stairs due to shifting soil, replacement of worn flooring and routine vehicle maintenance; **and**
 - d. **Add language to IAC specifying repairs for services and/or supplies covered under warranty are not covered.** Require warranty coverage to be exhausted prior to submission for HVM repair.
4. **Change language within IAC clarifying exclusions as modifications to the home or vehicle that which are of general utility and are not of direct medical or remedial benefit to the individual**, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. This is consistent with other state Medicaid programs.
5. **Add language to IAC defining general utility.** General utility can be defined as a service that is generally available to the public and/or standard responsibilities of any home or vehicle owner.
6. **Add language within the IAC which requires a physician order (MD, DO, PA, ARNP) for all HVMs.** This will further support care coordination by ensuring the primary care provider is aware of any adaptive needs for the member. Several state Medicaid programs require a physician or-

der for HVM services. State specific information is available in the Compendium of Home Modification and Assistive Technology Policy and Practice.

7. **Add language within the IAC specifying HVMs duplicative in nature** (e.g., multiple ramps, multiple ADA toilets, vehicle lifts for multiple vehicles, etc.) **are not covered**. This is consistent with coverage language provided by Indiana Medicaid.
8. **Add language within the IAC allowing Consumer Choices Option (CCO) fees to be included in the authorized amount for HVMs when the HVM is the only CCO service**. Allowing these fees to be included in the CCO HVM bid will allow for a greater provider base for HVMs and enhance the competitive bidding process for HVMs to allow for fiscal responsibility for the program; this would eliminate the current need for ETP and enhance member choice. Changes to the IAC have already been drafted for this recommendation.
9. **Explore use of an environmental consultation, by an occupational therapist, prior to submission of a request for a HVM**. Such consultation will allow for a professional assessment of the member's needs and feasibility of the environment (either home or vehicle) to be adequately modified to meet the members medical and/or remedial needs. This is consistent with Oregon Medicaid.
10. **Require a minimum of one (1) year warranty on all parts and labor for HVMs funded by Iowa Medicaid**. This will ensure the quality of the workmanship and allow provision for faulty equipment. Misuse or damage beyond repair found not to be a direct fault of the workmanship for the HVM may be excluded from the warranty. This is consistent with a benefit requirement by Colorado Medicaid.
11. **Define home (environmental) modifications within the IAC** independent from vehicle modifications. This would support program integrity oversight through transparency in the program coupled with changes implemented with the atypical code in July 2013, allowing for distinct coding of claims for home modification versus vehicle modification. This is consistent with multiple state Medicaid programs; **and**
 - a. **Define coverage of home (environmental) modification specifically addressing new construction versus modification of an existing dwelling**. The table below and on the next page provides recommendations for specific home modifications for both new construction and existing dwelling.

Medically Necessary Home Modification	Recommended Coverage		Comments
	Existing Dwelling	New Construction	
Alarm Systems (when less costly items are contraindicated)	Yes with limitations	Yes with limitations	Existing Dwelling and New Construction: Recommend <u>only</u> when a documented history of elopement is present <u>and</u> less costly alternatives are available and feasible for homeowners to utilize (e.g., battery operated alarm) which have when appropriately installed and maintained have failed to meet the member's needs.
Bathroom Modification; Shower; Roll-In (when less costly alternatives are contraindicated; e.g., tub cut, walk-in, etc.)	Yes	Yes with limitations	New Construction: Bathing facilities would be installed in a new construction, therefore recommendation is to allow difference between cost of standard shower and roll-in shower.
Bathroom Modification; Shower; Tub Cut	Yes	No	New Construction: Bathing facilities would be installed in a new construction; appropriate shower should be installed at the time of construction.

Medically Necessary Home Modification	Recommended Coverage		Comments
	Existing Dwelling	New Construction	
Bathroom Modification; Shower; Walk-In (when less costly alternatives are contraindicated; e.g., tub-cut)	Yes	No	New Construction: Bathing facilities would be installed in a new construction; appropriate shower should be installed at the time of construction.
Bathroom Modification; Sink; Lowering Existing Sink	Yes	No	New Construction: A sink would be installed in a new construction, and therefore height can be adjusted at the time of installation; consider wall mounted sink.
Bathroom Modification; Sink; Pedestal	Yes	No	New Construction: A sink would be installed in a new construction, and therefore height may be adjusted at the time of installation; consider wall mounted sink.
Bathroom Modification; Toilet--ADA (when less costly alternatives are contraindicated; e.g., toilet riser or safety frame, etc.)	Yes	No	New Construction: Toileting facilities would be installed in a new construction. Due to the nominal difference in the price of a standard toilet and one which meets ADA standards, coverage of this modification is not recommended for new construction.
Concrete (for shower subflooring, ramp landings, etc.)	Yes with limitations	Yes with limitations	Existing Dwelling: Allow only if it is associated with a ramp (footings and landings) or required for a bathroom modification. New Construction: Allow only if it is associated with a ramp (footings and landings) or exterior lift.
Concrete; Exterior hard surface pathways	Yes with limitations	No	Existing Dwelling: Recommendation to allow only when attached to a ramp or required for direct access to home entry. Exclude walkways to exterior buildings and walkways that extend beyond residential property. New Construction: Entry to the home would be required for new construction; appropriate entry, including needed walkways, should be considered in the new construction design.
Deck/Landing	Yes with limitations	Yes with limitations	Existing Dwelling and New Construction: Allow only when attached to a ramp; reimbursement for deck or landing with a turn radius of 60 inches. New Construction: See recommendations for ramp coverage.
Door Widening; Bathroom (when swing clear hinges are contraindicated)	Yes	No	New Construction: Doors and doorways would be installed in a new construction; appropriate entry width should be considered in the new construction design.

Medically Necessary Home Modification	Recommended Coverage		Comments
	Existing Dwelling	New Construction	
Door Widening; Garage	Yes with limitations	No	Existing Dwelling: Recommendation to allow door widening only for access to attached garage and home. New Construction: Doors and doorways would be installed in a new construction; appropriate entry width should be considered in the new construction design.
Door Widening; House Entry (when swing clear hinges are contraindicated)	Yes	No	New Construction: Doors and doorways would be installed in a new construction; appropriate entry width should be considered in the new construction design.
Fencing; Standard Chain Link (covered under Exception to Policy. Only an enclosed area of 30ft x 30ft (or 120ft, linear) plus 4ft gate)	Yes with limitations	Yes with limitations	Recommend <u>only</u> when a documented history of elopement and only when the area to be enclosed does not exceed 30ft x 30ft. If request is a portion of a plan to enclose an area in excess of 30ft x 30ft, fencing will not be covered.
Fencing; Wood (when standard chain link is contraindicated; (covered under Exception to Policy. Only an enclosed area of 30ft x 30ft (or 120ft, linear) plus 4ft gate)	Yes	Yes	Recommend <u>only</u> when a documented history of elopement and only when the area to be enclosed does not exceed 30ft x 30ft. If request is a portion of a plan to enclose an area in excess of 30ft x 30ft, fencing will not be covered.
Flooring; low pile carpeting or slip resistant flooring	Yes with limitations	No	Existing Dwelling: Only cover for cost of low pile carpeting or slip resistant flooring and installation and removal when existing flooring poses a health or safety risk; exclude cost for aesthetic maintenance (e.g., refinish flooring under removed carpeting or wallboards). New Construction: Flooring would be required for new construction therefore appropriate flooring should be considered in the new construction design.
Ramp; Aluminum (when treated wood is contraindicated)	Yes	No	New Construction: Entry to the home would be required for a new construction; appropriate entry needs should be considered in the new construction design.
Ramp; Portable (when stationary ramp is contraindicated)	Yes	No	New Construction: Entry to the home would be required for a new construction; appropriate entry needs should be considered in the new construction design.
Ramp; Portable (when stationary ramp is contraindicated)	Yes	No	New Construction: Entry to the home would be required for a new construction; appropriate entry needs should be considered in the new construction design.

Medically Necessary Home Modification	Recommended Coverage		Comments
	Existing Dwelling	New Construction	
Ramp; Treated Wood	Yes	No	New Construction: Entry to the home would be required for a new construction; appropriate entry needs should be considered in the new construction design.
Stair Glide	Yes with limitations	Yes with limitations	Allowed only if required for access to rooms required to complete activities of daily living. Not covered for caregiver convenience or when the room access is only required for social interaction.
Window and/or Door Locks	Yes with limitations	Yes with limitations	Existing and New Construction: Recommend reimbursement only for specialized lock components not provided with standard windows <u>and</u> only when a documented history of elopement is present.

12. **Contact associations** for general contractors and home builders **regarding the potential of enrolling as a lowa Medicaid provider for waiver HVM services** in an effort to expand the provider base for home modifications.
13. **Add a general contractor to the list of available consultants**, through Medical Services, available for use by IME to assist with questions regarding home modifications.
14. **Add language to code specifying “Home adaptation expenses should be based on contractor grade materials in all instances.”** This will provide support in appeals when the material(s) approved is adequate to meet the member’s needs and is less costly than what was requested. Language has been established by New York Medicaid.
15. **Add language to IAC limiting coverage for home (environmental modifications) to only two different residences in a seven (7) year timeframe** for the same member with the following **exclusions: fire, natural disaster, court or other legal actions.**
16. **Add language within the IAC specifying home (environmental) modifications are only covered for the member’s primary residence.** Exclude modifications to shared or secondary residences.
17. **Add language within the IAC specifying the family’s responsibility to take into account the child’s needs** and choose a home that requires the least amount of modification. Whenever possible the child should be placed on the first floor with access to a bathroom and an exit. This language has been established by the New York Medicaid program.
18. **Remove language within the IAC allowing for HVM coverage for bath chairs and transfer benches.** Recent rule changes for durable medical equipment (DME) has allowed for greater coverage of bath chairs and transfer benches under the Medicaid state plan when medically necessary thus rendering coverage under waiver duplicative and unnecessary.
19. **Add language to IAC clarifying coverage of “enclosed open stairs.”** Specifically, what is intended to be covered under this modification (e.g., enclosing the backing between stairs or installing walls surrounding the staircase).
20. **Add language to IAC clarifying “air conditioning” coverage to specify coverage for only a window (or room specific) air conditioning unit and air filtering system.** This is consistent with multiple states’ Medicaid programs; **and**

- a. **Remove “medically necessary” from this bullet point within the IAC** due to medical necessity being a requirement for all HVMs.
21. **Add language to IAC defining “exterior hard surface pathways” and provide examples within the IAC for reference.** Several other state Medicaid programs as well as the U.S. Department of Veteran Affairs has adopted exclusions, such as walkways to exterior buildings, from being a covered benefit. (see home modification recommendation table for recommendations for existing dwelling and new construction)
22. **Add language to IAC requiring new home modifications be completed in accordance with ADA and/or HUD housing specifications for persons with disabilities (e.g., degree of incline for ramps, doorway clearance width, etc.) as required to meet the member’s current medical need. Replacement of an existing home modification (e.g., ramp) are not covered unless there has been a change in the member’s medical condition necessitating a new modification.** If modification is not able to meet ADA and/or HUD specifications documentation explaining how the modification to be completed will be adequate to meet the members needs as well as explanation of why the ADA and/or HUD specifications are not able to be met will be required before authorization will be approved. Non-ADA standard modifications may not be covered.
23. **Add language to the IAC specifying that for home modifications in excess of \$5,000 the Department will protect it’s interest through liens or other legally available means.** This is consistent with Oregon’s Medicaid program. This would allow the Department to recover funding for HVMs completed on homes that are sold prior to becoming part of the estate recovery. Rental properties should be excluded.
24. **Add language to the IAC specifying all home modifications completed on rental properties must have written consent from the property owner** allowing the modification to be completed and acknowledging that as the property owner, they are unable or unwilling to assume the financial costs associated with the modification. This will provide a documented paper trail of the communication between tenant and landlord prior to costly completion of work. This is consistent with Oregon Medicaid.
25. **Add language to IAC specifying home modifications will not be covered for HCBS provider owned homes**, or homes affiliated with a HCBS provider, for which the occupancy is directed at members who receive services funded by the HCBS program.
26. **Add language to IAC to allow up to \$500 annually for necessary maintenance of previously approved HVMs; up to \$100 maintenance may be allowed without prior authorization. A prior authorization shall be required with supporting documentation of services and/or supplies to be provided for maintenance fees in excess of \$100 and may be granted for no more than \$500.** Allowing these costs may improve the usable life to the HVM and reduce the need for costly repair or replacement of the HVM. This is a benefit of the Indiana Medicaid program.
27. **Add language to the IAC requiring written acknowledgement of job completion** for home (environmental) adaptations. This written documentation should be signed by the member or their representative, the provider and DHS case manager, targeted case manager, service worker or other DHS designated representative and kept in the member’s file. Payment for services will be provided upon satisfactory completion of the job. This will ensure appropriate completion of the work to adequately meet the members needs. A process for remediation of differences will need to be developed for situations when there is disagreement regarding job completion. Louisiana Medicaid has a process in place and has developed a form to be completed and signed off by all parties prior to reimbursement for the completed project.
28. **Define vehicle modifications within IAC separate from home (environmental) modifica-**

- tions.** The coding changes coupled with distinct differences in modification requests for home and vehicle supports this as an opportune time to clarify the intended benefits for each type of modifications that may not be applicable to both home and vehicle.
29. **Define coverage of a vehicle modification specifically addressing adaptive equipment previously installed in a vehicle when purchased.** Consider assigning a **depreciation of 10 percent, per year**, to modifications previously installed in a vehicle. This would be consistent with coverage provided by the U.S. Department of Veterans Affairs.
 30. **Add language to IAC limiting coverage for vehicle modifications to only one (1) vehicle within in a five year timeframe** with the following **exclusions: theft, fire, accident, court or other legal actions, costly repairs** (repairs exceed 2/3 cost of new), **changes in the driver's medical condition which requires a change in adaptive equipment or a different vehicle, mileage in excess of 150,000 miles from the date of the previous modification.**
 31. **Add language to IAC clarifying coverage of vehicle lift to include the lift component(s) only.** Specify exclusion of raising the roof and lowering the floor to accommodate a lift installed in a mini-van; **or**
 - a. **Adopt the U.S. Department of Veterans Affairs definitions and/or policy for van conversion.** This policy would address cost associated with conversion of a full-size or mini-van to accommodate the member's needs.
 32. **Add language within the IAC allowing coverage for "remote start systems" only when the vehicle has been modified with adaptive equipment and the member is the registered driver.** Historically few modification requests have been received for this adaptation. In addition to the minimal number of requests received, there are very few occasions when a vehicle remote start system is found to be medically necessary; most often this adaptation is found to be a convenience item.
 33. **Remove the language within the IAC (441--78.34(9) "Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.";** and
 - a. **Add language to the IAC stating "Covered modifications are structural alterations which are medically necessary for the effective treatment of the member's disability and which enable the member to function with greater independence in the home or vehicle."** The current language is broad and does not directly relate to the medical necessity of the HVM requested. Removing or changing the language within the IAC, which is also applicable to other waiver services, will assist with appeals being affirmed by the administrative law judge. Historically waiver prior authorization decisions have been reversed based on the argument by the appellant and at times the case manager representing the appellant that the request is for safety or emotional well-being that is not directly related to the member's disability (e.g., request for a stair lift to access the basement for inclement weather for "emotional well-being" when an interior room is accessible to provide shelter from a storm and all other rooms required to meet IADL needs are accessible without the use of a stair lift). Appeals have been reversed based on the interpretation of this wording to include coverage for services that address emotional needs regardless of if it is tied to the member's disability.
 34. Based on the informative analysis of the HVM benefit and in addition to the recommendations previously noted, **the MVM team also recommends a snapshot analysis be completed of the five largest waiver programs, BI, EW, H&D, and ID, to gain an understanding of the population served and the services accessed under each of these waivers.** The analysis would include demographics of the members served and services utilized including the number of units and cost. This analysis, to be completed by the MVM team, is anticipated to provide insight into

the amount of services needed to serve each population subset to assist with program management and any additional rule recommendations needed.

Appendix

1. Comparison of Home and Vehicle Modifications Across States: Compilation of research completed by Sue Stairs, Iowa Medicaid Program Manager
2. U.S. Department of Justice such as the [2010 ADA Standards for Accessible Design](#)
3. U.S. Department of Housing and Urban Development (HUD) [Fair Housing Act Design Manual](#)
4. Louisiana
5. BID Expectations for HVM, Assistive Devices, Environmental Modifications and Specialized Medical Equipment.
6. Home and Vehicle Modification (HVM) Reversed Appeals, SFY13

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Medicaid Value Management (MVM)

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Realizing the fiscal value of quality care.

About MVM

Medicaid Value Management (MVM) analyzes different areas of Iowa Medicaid to gain an understanding of the quality of the services provided to the Medicaid member. MVM analyzes the efficacy of services provided; best practices used and not used in Iowa and the overall impact on our Medicaid population; MVM also looks at individual programs within Iowa Medicaid. Ultimately MVM looks for ways to promote improved health outcomes within the constraints of Medicaid budget limits and with this information, MVM makes recommendations for policy and program changes.

Query Facts

Iowa Medicaid Claims and ISIS data

Comparison of Home and Vehicle Modification Across States

State	Home Motif.	Vehicle Motif.	Items Covered	Bids	Limitations	Documentation required
Alaska		Yes	Hand controls (\$1,400 limit), wheelchair lift systems (capped at \$8,900), and wheelchair tie-downs			
Arizona			Items covered when they are medically necessary and when it deters the risk of an increase in exiting HCBS services or institutionalization.		They require verification from the recipient if there are any plans for them to move in the next two years and will general decline a request if a modification has been made with in the past two years in a different setting. Individual cases considered. Modifications are not made when it is for the convenience of the recipient or caregiver.	They have a Home modification request/justification form that I have on record.
Florida	Yes	Yes		3 bids	Least costly, Adaptations or improvements to the home that are general utility and are not direct medical or remedial need. Adaptations to only existing structures. The modification enables the recipient to function with great independence. Items not covered are carpeting, floor coverings, roof repair, driveways, decks, patios, fences, swimming pools, spas and hot tubs, sheds, sidewalks, central air and heating, raised garage doors, standard home fixtures such as sinks, commodes, tub, stove, fridge, washer, dryer, window and door coverings, furniture, etc.	Copy of claims submitted for payment, copy of service log, and original prescription for medical equipment.

Comparison of Home and Vehicle Modification Across States

Georgia						They have a home consultant service that pays for home inspector to go to the home prior to the HVM is created and then afterward to make sure it was done right. The pay \$250 per visit.
Idaho	Yes		Adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems	3 Bids for items over \$500	Services must: a. Be done under a permit, if required; and b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes.	
Indiana	Yes					
Louisiana	Yes	Yes	Ramps, grab-bars, widening of doors, bathrooms, installing special electric for med. Equip., vehicle lifts or adaptations to vehicle.		Exclude <ul style="list-style-type: none"> •Flooring (carpet, wood, vinyl, tile, stone, etc.), •Interior/exterior walling not directly affected by a modification, •Lighting or light fixtures, which are for non-medical use, •Furniture, •Roofing, installation or repairs, this also includes covered ramps, walkways, parking areas, etc., •Air conditioning or heating (solar, electric, or gas; central, floor, wall, or window units, heat pump-type devices, furnaces, etc.), 	Itemized, detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted to the State for prior authorization. Upon completion of the work and prior to payment, the provider shall give the

Comparison of Home and Vehicle Modification Across States

				<ul style="list-style-type: none"> •Exterior fences or repairs made to any such structures, •Motion detector or alarm systems for fire, security, etc., •Fire sprinklers, extinguishers, hoses, etc., •Pools, •Smoke and carbon monoxide detectors, •Interior/exterior non-portable oxygen sites, •Replacement of toilets, septic system, cabinets, sinks, counter tops, faucets, windows, electrical or telephone wiring, or fixtures when not affected by a modification, not part of the installation process, or not one of the pieces of medical equipment being installed, •Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc), •Adaptations, which add to the total square footage or add total living area under the roof of the residence, •Repairs to the home or adaptations to the vehicle provided under the NOW, or •Repairs or modifications provided to previously installed home or vehicle modifications not provided under the NOW. <p>Home modification funds are not intended to cover basic construction</p>	<p>recipient a certificate of warranty for all labor and installation, and all warranty certificates from the manufactures. Labor and installation must cover a period of at least 6 months. <u>There is a copy of their completion form, which could be valuable to Iowa.</u></p> <p>The support coordinators must contact the State before approving modifications for a recipient leaving an ICF/DD.</p>
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Comparison of Home and Vehicle Modification Across States

					<p>cost. For example, in a new facility a bathroom is already part of the building cost, waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom, but in any situation must pay for a specific approved adaptation. Modifications to the home shall meet all applicable state and local building or housing code standards.</p> <p>Car seats are not considered as a vehicle adaptation.</p> <p>Also excluded are any items covered under the Medicaid State Plan. A cap of \$7,000 per recipient per a 3 year period.</p>	
Maine	Yes	Yes	<p>Ramps, grab bars, widening of doorways and hallways, bathrooms, lifts, specialized electrical equipment and plumbing, automatic door openers, door and window alarms, air filtering and cooling devices, non-breakable windows, and flooring. Van lifts, tie downs, ramp, specialized seating, and safety</p>	3 bids	<p>\$15,000 in a 3 year period. All expenditures are paid through their fiscal intermediary. Items excluded are general utility, that are not direct medical or remedial benefit to the individual such as carpeting and central air, and the addition of square footage unless necessary to make an adaptation.</p>	

Comparison of Home and Vehicle Modification Across States

			restraints.			
Massachusetts			This state has a Home Modification Loan Program. The applicant must be the owner of the property. Adding footage to the home is allowed in situations where the bathroom is enlarged to allow for the needs of the member. They cover ramps, lifts, bathroom & kitchen accessibility, widening doorways, door hardware.	Yes	The state saw a savings by using this program.	
Montana	Yes	Yes	Ramps, grab bars, widening of doorways and hallways, bathrooms, lifts. Repairs and training are also covered.		Limits are based on \$7,800 yearly for all waivers.	Prior authorization, assessment by other health professional and medical necessity required.
Nebraska	Yes		Construction of an accessible entrance into the home, widening of doorways, roll-in showers, roll under sinks, raised toilets, wheelchair lifts, star glides, door levers, ramps, door openers, signaling devises. Training and repairs allowed.	Yes	There is a \$5,000 limit per year.	Prior authorization, assessment by other health professional, and medical necessity required.

Comparison of Home and Vehicle Modification Across States

New Hampshire	Yes		Ramps, grab bars, widening of doorways, bathrooms, specialized electric and plumbing and repairs.	Yes	None	Prior authorization, assessment by other health professional, and MD order required.
New Jersey	Yes	Yes	Entrances (includes ramps, door widening, Bathrooms, Kitchens, floor basis, toilet and tub rails, Stairs (includes elevators & stair guides	Yes 2-3	Cost of modifications would go under the member's dollar cap per month of \$7,790 (under BI waiver)	Medical necessity and MD order required.
New Mexico	Yes		Ramps, automatic door openers, modified switches, voice activated electronic devices, roll in showers, sink, bathtub, and toilet mods, grab bars, widening of doorways, and lowering of counters. Repairs are covered.		\$7,500 per lifetime. After this is reached there is a \$300 a month maintenance fee that is included in their service plan. (Elderly and Disabled Waiver) Training on use and repairs are allowed.	Prior authorization required.
New York	Yes	Yes	Back-up generator, ramps, widening doorways, accessible bathrooms, stair glides, vehicle mod, Physical adaptations to the member's home and vehicle to ensure member's health, safety, and welfare and	3 bids when cost is over \$1,000	New construction, room extensions, renovation of rooms for physical therapy, pave driveways, air conditioners, humidifiers, elevators, maintenance contracts, mod for the benefit of the caregiver and not the member, maintenance of home and vehicle are not covered. \$15,000 annual cost	They require a physician's statement, plan of care, permission of building owner, evaluation such as safety, of adaptation, does it benefit the member, most cost effective, home or vehicle must be

Comparison of Home and Vehicle Modification Across States

			increases their independence in the home and community.			structurally sound. Bids must be broken down. A form is required to be completed.
North Carolina	Yes	Yes	Ramps, safety rails, grab bars, non-skid surfaces, hand-held showers, widening of doorways,		Modification can only be done on a home that the family owns. Limited to \$15,000 over three years. (Under the MR/DD Waiver). \$1,500 per year under the Elderly/Disabled Waiver.	Prior authorization and MD order required.
North Dakota	Yes		Considered environmental mod. Safety rails, ramps, widening of doorways, bathroom/kitchen modifications. The label this under environmental mod.	Yes	None listed	Prior authorization required.
Ohio	Yes	Yes	Van lifts; vehicle interior modifications; driver control modifications. Bathroom modifications; kitchen modifications; wheelchair accessible interior doorways; ramps; guard rails	Yes	Project must be medically necessary, authorized in ISP, completed within waiver span for which it was authorized, within assigned funding range unless waiver prior authorization approved, not otherwise available under Medicaid state plan. Limited to home only not property. Home Mod Up to \$7,500 per job Vehicle Mod Up to \$10,000 per period	Prior authorization, assessment by other health professional, MD order, and medical necessity required.
Oklahoma	Yes	Yes	Grab bars, door	3 bids	Does not cover construction or	Assessment by other

Comparison of Home and Vehicle Modification Across States

			widening, FRP board for hallways, handicapped toilets, anti-scalding devises, ramps, roll in showers, turney seats, tie down systems for wheelchairs, side lifts, training and repairs included.		remodels, no addition of square footage, subfloors, foundation work, roofs, major plumbing, installation of heating or air conditioning units, humidifiers, water softeners, fences, sun rooms, porches, decks, canopies, covered walkways, driveways, septic tanks, room additions. They will only modify two different residences in a 7 year period for the same member. All modifications are permanent. For vehicle adaptations are limited to one vehicle in a 10-year period per member.	health professional and prior approval required.
Oregon	Yes		Ramps, grab bars, widening doors, handrails, electronic door openers, adaptations to kitchen and bathrooms, individual room air conditioners, electronic and plumbing to accommodate medical equipment.	Yes	Environmental consultation required to evaluate the home and make plans to modify the home is included. Repairs are not covered. The cost of waiver services cannot exceed \$20,000 per plan year unless prior authorized. <u>If the cost of environmental adaption exceeds \$5,000, the state will gain a security interest in the home.</u>	Prior authorization is required.
Pennsylvania	Yes	Yes	Vehicle lifts, alteration to seat in van, certain adaptations to vehicle to make it safe, ramps, grab bars, widening doors, handrails, electronic door		Limits \$20,000 per household. If the individual moves a new \$20,000 limit applies. (Under the MR Waiver)	Assessment by other health professional and prior authorization is required.

Comparison of Home and Vehicle Modification Across States

			openers, adaptations to kitchen and bathrooms, electronic and plumbing to accommodate medical equipment, adaptations for smoke/fire alarms for the sensory impaired, sidewalks, elevating systems, major appliances and furnishing.			
Rhode Island	Yes	Yes	Ramps, lifts, doorway widening, accessible door hardware, handrails, assessable bathroom and kitchen features, remote control lightening, emergency calling systems		Repairs are not covered under the MR waiver but they are covered under the IH, Habilitation, Assisted Living waivers.	Assessment by other health professional, medical necessity, and prior authorization is required.
South Carolina	Yes	Yes	Vehicle lifts, tie downs, adaptations, devices, controls, household appliances.		None listed.	Prior authorization required.
South Dakota	Yes	Yes	Housing and vehicle modifications, such as lifts, ramps, fences, bathroom modifications, door widening, electronic and plumbing to accommodate medical equipment. Repairs are		Monthly caps exist, but there are not lifetime benefit caps.	MD order required

Comparison of Home and Vehicle Modification Across States

			covered.			
Tennessee	Yes	Yes	Wheelchair ramps, widening of doorways, modification of bathroom and kitchen facilities, electronic and plumbing to accommodate medical equipment, vehicle lifts, roof modifications, tie downs, grab bars, head/leg rests, safety belts. Training and repairs are covered.	Yes	They allow training for and repairs on vehicles. There is a \$20,000 per enrollee per 5-year period.	Prior authorization, assessment by other health professional, MD order, prior authorization, and medical necessity required.
Texas	Yes	Yes	Vehicle mod is paid for through the Division for Rehabilitation Services. The list of coverage for this is very extensive.	Yes	Under the ICF/MR Waiver there is a lifetime limit of \$7,500 per individual. After the \$7,500 limit has been reached, an individual is eligible for an additional \$300 per ICP year for additional modifications or maintenance of minor home repair.	Prior authorization, assessment by other health professional, MD order, prior authorization, and medical necessity required.
Utah	Yes	Yes	Ramps, grab bars, widening of doorways and hallways, mod of bathrooms and kitchen facilities, and mod of electric and plumbing systems that are necessary to accommodate medical equipment, care and supplies.		Cost cap of \$10,000 per service.	Medical necessity required.
Vermont	Yes		Adaptive sinks and faucets; telephones	Yes	\$4,000 lifetime per individual (under Global Commitment Waiver)	Assessment by other health professional

Comparison of Home and Vehicle Modification Across States

			with large numbers; air conditioner, bath/shower chair, widening of doorways, grab bars, hand held shower, medication reminder units, raise toilet seats, repairs and training are covered.		\$750 per year per individual per calendar year (under Choices for Care Waiver)	and prior authorization.
Virginia	Yes	Yes	Ramps, grab bars, widening of doorways and hallways, mod of bathrooms and kitchen facilities, and mod of electric and plumbing systems that are necessary to accommodate medical equipment, care and supplies, mod to primary vehicle. Training and repairs are covered. This is all listed under environmental mod.		Under the MR waiver there is a limit of \$5,000 per year.	Prior authorization, assessment by other health professional, prior authorization, and medical necessity required.
Washington	Yes	Yes	Ramps, grab bars, widening of doorways, mod of bathrooms, mod of electric and plumbing systems that are necessary to accommodate medical equipment, training and repairs are	Yes	\$1,425 per year for any combination of services under their Basic Waiver. Under the Basic Plus Waiver the limit is \$6,070 per year for any combination of services.	Prior authorization, assessment by other health professional, prior authorization, and medical necessity required.

Comparison of Home and Vehicle Modification Across States

			covered.			
West Virginia	Yes	Yes	Ramps, grab bars, widening of doorways, mod of bathrooms, mod of electric and plumbing systems that are necessary to accommodate medical equipment, training is covered.		\$1,000 per calendar year. Repairs are not covered.	Medical necessity required.
Wisconsin	Yes	Yes	Ramps, porch/stair lifts, doors/doorways, door handles or opening devices, locks, door bells, security items or devices, plumbing and electrical mod, medically necessary heating, cooling or ventilation systems; shower, sink, tub, and toilet mods, accessible cabinetry, counter tops, grab bars and rails. Training and repairs are covered.	Yes	None listed.	It depends on the waiver as to what is required for documentation such as MD order, medical necessity, prior authorization.
Wyoming	Yes	Yes	Ramps, grab bars, widening of doorways, mod of bathrooms, mod of electric and plumbing systems that are necessary to accommodate medical equipment, porch/stair	3 bids	They sometimes research the item and limit the markup by 20%. Items cannot be of general use, primarily used by other people in the home, has to be cost effective for similar services provided.	MD order, assessment by other health professional, medical necessity, and prior authorization are required.

Comparison of Home and Vehicle Modification Across States

			lifts			
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Through Florida-- If a recipient builds a home while major or structural changes not covered. Coverage for this situation are the difference between a handicapped-accessible bathroom and a standard bathroom. However, the cost difference for each item and adaption must be documented, with total cost not exceeding \$3,500.

Bid Expectations for HVM, Assistive Devices, Environmental Modifications and Specialized Medical Equipment

Medical Services has been tasked by the State to ensure that all plans for modifications and supports meet the specific identified needs of the member, are the most cost effective approach that meets member need and are appropriate for long term member support. In order to support the expense decision to meet Federal audit requirements, a number of elements must be provided.

Components of contractors bid for a modification should include, IAC 79.9(2):

- 1.) Description of the scope of work performed;
- 2.) Contractor grade or lower cost materials;
- 3.) An itemized price list of all materials and/or equipment;
- 4.) Cost of labor w/number of hours X rate of pay;
- 5.) Separate cost of each component of the modification;
- 6.) Diagrams of the project, whenever applicable, and
- 7.) Compliance with Federal, State and local municipality codes.

All estimates should identify the costs of each component; i.e. each part of the proposed modification should be listed separately. For example, if the requested modification is for modification to the bathtub and modification to widen the doorway, the bid should list separately the costs involved with modifying the tub from the cost associated with widening the doorway.

The following information is requested:

- Certification of Medical Necessity
- Case manager or service worker service plan
- Documented description of the item that includes the medical, remedial or safety benefit to the member
- Three independent itemized estimates (if over \$50)
- Denial for state plan durable medical equipment, if applicable, per IAC 78.10(2) and CMS State Medicaid Manual 4442.3
- If existing item, need repair versus replacement cost estimate (HVM only)
- Mental health professional recommendation (Environmental Modifications only)

Whenever possible, three competitive bids shall be presented for the modification, per IL 1039. Please reference IL 1035 for items \$50.00 and under.

Invoice

ABC Construction Company Address City, State & Zip Fax number: 000 000 000 Phone number: 000 000 000 Email: email@domain.com	Invoice Number: Ref: Date:
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To	Member's information should go here- address, name etc.	Billing period	
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Description	Material	Quantity	Amount
This is where the contractor should describe the item or service. For example: laminate flooring for a 12' x 12' room, 150 sq ft of materials needed for overlap/ waste. Product used is lowest cost available in compliance with IAC 79.9(2), which states that Medicaid will pay for the most cost effective service.	laminate flooring	150 sq feet of material	\$.99 per sq ft x 150 sq feet= \$148.50
This is where the contractor should break down the amount of labor required for installing the flooring above. The labor should include the hourly wage for the laborer, as well as the amount of time needed for the task.	Labor	3 hours	\$11 per hour x 3 hours= \$33.00
Each item should be clearly separated. For example, if requesting multiple changes to a bathroom (sink, toilet, flooring, shower, etc), each should be broken out by cost of the materials, cost of the labor. This way, should the physician reviewer determine that a lowered sink is needed, but a walk in shower is not necessary, Medical Services can approve the portion determined to be medically necessary for the member. Faucet with single handle to turn water off and on, to replace separate knobs that are difficult for the member to turn independently.	Delta faucet style, helps to put in a part ID number	1	\$50.00 for faucet
Labor to install faucet	Labor	30 minutes	\$5.50 for labor at \$11 per hour.

	Sub total		
	Profit and overheads		
	Total taxable amount		
	Sales Tax (@ 0.0725%)		
	Other levies		
	Total		

Authorized Signature & Seal	Notes / Comments:
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SAMPLE

Department of Health and Hospitals
Office for Citizens with Developmental Disabilities
ENVIRONMENTAL ACCESSIBILITY ADAPTATION JOB COMPLETION FORM

Instructions: This form is to be used for all requests for Environmental Accessibility Adaptations. The Support Coordinator will complete **Section 1** and submit with the Plan of Care or Revision Request to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District. **Section 2** will be completed by the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District. **Section 3** will be completed by the enrolled service provider/contractor. **Section 4** will be completed by the Support Coordinator and signed by the recipient/family/guardian. All signatures are mandatory.

SECTION 1 – COMPLETED BY SUPPORT COORDINATOR			
Recipient's Name:	SSN #:		
Address:			
Support Coordination Agency:	Phone #: ()	Fax #: ()	
Provider Agency:	Phone #: ()		
Address:	Provider #:		
Description of Requested Services:	Requested Amount: \$		
Anticipation Completion Date:	Date Modification Needs to be Completed by:		
Funds Available? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has this equipment been requested through the Medicaid DME Program or Medicaid State Plan?			
<input type="checkbox"/> NO Why? _____			
<input type="checkbox"/> YES Was request denied? <input type="checkbox"/> NO <input type="checkbox"/> YES (Notice of denial must be attached)			
Provider Agency Agreement Signature: _____		Date: _____	
Providers/contractors are NOT to complete the purchase without having received the Prior Authorization for the purchase			
Support Coordination Agency Agreement Signature:		Date:	
Recipient/Family Agreement Signature:		Date:	
SECTION 2 - WAIVER OFFICE - AGREEMENT AND PRIOR APPROVAL DETAILS (To be completed by OCDD Regional/Authority/District Waiver Staff and forwarded to SRI for PA)			
Description of Approved Service:			
Procedure Code:	Approved Amount:\$		
Waiver Office Prior Approval Signature:	Date of Prior Approval:		
SECTION 3 – ENROLLED SERVICE PROVIDER/CONTRACTOR - VERIFICATION OF JOB COMPLETION (To be completed by the provider and contractor then forwarded to the Support Coordinator)			
Description of Completed Job:	Does Job Meet All State and Local Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date Job Began:	Date Job Completed:		
Has Recipient Received A Certificate of Warranty For All Labor and Installation and All Manufacturers' Warranties? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Provider Agency Signature:	Date:	Contractor's Signature:	Date:
Recipient/Family Signature:	Date:		
SECTION 4 – FINAL VERIFICATION OF JOB COMPLETION (To be completed by the support coordinator and forwarded to OCDD Regional/Authority/District Waiver Staff)			
Date Completed Job Verified:	Job Acceptable? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments:			
Support Coordinator's Signature:	Date:		
Recipient/Family Acceptance Signature:	Date:		
Waiver Staff Final Approval Signature:	Date of Final Approval:		

Environmental Accessibility Adaptation Job Completion Form Instructions

This form is to be used for all requests for Environmental Accessibility Adaptations included in the OCDD approved Plan of Care (POC) or Revision Request. Support Coordinator (SC) completes **Section 1**, obtain proper signatures and a written itemized detailed bid, which includes the drawing with the dimensions of the existing and proposed plans related to the modification, from the service provider/contractor, and send along with the POC or Revision to OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District. **Section 2** will be completed by the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District and if approved, forwarded to SRI with the POC budget pages if it is requested an initial or annual or revision request for PA and then send back to the SC who will forward it to the service provider/contractor. **Section 3** will be completed by the service provider/contractor and returned to SC as soon as the job is completed. **Section 4** will be completed by the SC, signed by the recipient/family/guardian and the support coordinator to indicate that they have accepted the job, and submitted to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District for their signature and final approval, who will forward the approval to SRI for issuance of the Post Authorization (payment). All signatures are mandatory. **All work is to be performed and completed in the current approved POC year. Enough time should be allowed for completion of job before the end of the POC year.**

Section 1: After the POC or revision request is approved and the family has agreed upon a service provider/contractor for the job, this information shall be completed by the SC. The SC will then obtain signatures of service provider/contractors and recipient/family member to indicate agreement of all parties involved. The SC will ensure that the service provider/contractor is aware of any applicable vendor standards and/or requirement for delivery and installation of environmental accessibility adaptations. The service provider/contractor will bear the burden of liability with all applicable local and state building codes and licensing/certification requirements in effect for the area of the state in which the work is being performed.

Recipient’s identifying information:	The recipient’s full legal name, SSN, and address.
SC Agency’s identifying information:	The SC agency’s name, phone and fax #.
Provider Agency’s identifying information:	The provider agency’s name, address, phone # and the provider number.
Description of Requested Service:	SC will describe the requested environmental accessibility adaptation.
Anticipated Completion Date:	SC will enter the anticipated completion date of job as indicated by service provider/contractor.
Date Job Must be Completed By:	The job must be within the POC year.
Requested Amount:	SC will enter the amount requested for the environmental accessibility adaptation.
Funds Available:	Shows that the recipient does have available funds. SC will contact appropriate OCDD personnel to verify whether or not the recipient has funds available. The SC should also check their records to determine if anything has been previously requested, as not all services may have been billed/paid. It is the SC’s responsibility to track this, and the family’s responsibility to know if they have utilized their funding.
Procedure Code:	SC will indicate appropriate procedure code for the environmental accessibility adaptation.
Denial from Medicaid/State Plan:	Indicate whether this equipment has been requested through Medicaid DME or Medicaid State Plan and provide documentation of this.

Agreement Signatures:	Signatures in this section validate that the environmental accessibility adaptation is a new need of the recipient and that the environmental accessibility adaptation has not already been completed or in the process of completion.
Provider Agreement Signature:	Presence of a signature of service provider/contractor indicates agreement to provide the service, cost, and anticipated completion date.
Support Coordination Agency Agreement Signature:	Presence of a signature of SC Agency representative indicates agreement with the need of the service, cost, and anticipated completion date.
Recipient/Family Agreement Signature:	Presence of a signature indicates approval of the service provider/contractor, and agreement with the cost and anticipated completion date.

After Section 1 has been completed by SC, the job completion form with the revision request or budget pages if at annual or initial certification, will be forwarded to OCDD Regional/Authority/District Waiver Office for review and completion of Section 2.

Section 2: OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District staff will enter the approved environmental accessibility adaptation, procedure code of the approved service, and the dollar amount approved. Presence of signature in section labeled “Waiver Office Agreement and Prior Approval” indicates authorization of the requested service and dollar amount payable to contractor for environmental accessibility adaptation job completion. OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District staff will enter the date of the approval for the environmental accessibility adaptation and then forwards approved Environmental Accessibility Adaptation form and Revision Request form to Statistical Resources, Inc., for issuance of Prior Authorization (PA). The approval of the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District does not override any limits the participant has already met.

Description of Approved Service:	Waiver Office/Authority/District staff will describe the waiver service that has been approved.
Procedure Code:	Waiver Office/Authority/District staff will indicate appropriate procedure code for the environmental accessibility adaptation.
Approved Amount:	Waiver Office/Authority/District staff will enter the approved amount for the environmental accessibility adaptation.
Waiver Office/Authority/District Prior Approval Signature:	Signature of the waiver staff that authorized prior approval.
Date of Prior Approval:	Waiver Office/Authority/District staff will indicate the date that prior approval was given.

After Section 2 has been completed by the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District, the form will be returned to the Support Coordinator. The SC notifies the service provider/contractor by forwarding the prior authorization form along with the revision request/budget pages if an annual or initial, to the service provider/contractor for completion of Section 3.

Section 3: The selected service provider/contractor will complete the following after the environmental accessibility adaptation is completed:

Description of Completed Job:	Description of environmental accessibility adaptation completed.
Does Job Meet all State and Local Requirements:	Check yes or no.

Date Job Began: Actual date environmental accessibility adaptation job began.

Date Job Completed: Actual date environmental accessibility adaptation job completed.

Provider Agency and Contractor's Signature: Presence of signature(s) indicates the environmental accessibility adaptation has been completed by service provider agency and contractor as agreed upon.

Recipient/Family Signature: Presence of a signature verifies that the environmental accessibility adaptation was completed.

After Section 3 has been completed by the service provider, the form will be forwarded to the SC Agency for final approval. This form can be faxed to the Support Coordinator to expedite the process, but the original needs to be mailed immediately to the S.C.

Section 4: Upon receipt of this form the Support Coordinator shall complete this section, with the SC's signature and obtain signature of recipient/family member indicating approval/agreement, and send a copy of the form to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District via fax or mail, who will sign this once final approval is given for payment. The completed form must be mailed or faxed to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District within ten (10) working days of the date of the actual environmental accessibility adaptation completion.

Date Completed Job Verified: Enter the date the S.C viewed the completed job with the recipient/family.

Job Acceptable: Indicate whether or not the completed job is acceptable to recipient/family. If not considered acceptable the SC shall negotiate with the provider/contactor in accordance with established policy.

Comments: Enter any comments made by the recipient/family/SC.

Signatures: Obtain signatures of the SC and the recipient/family.
(SC and recipient/family)

The completed form must be mailed or faxed by the SC to the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District within ten (10) working days of the date of the actual job completion.

Waiver Office/Authority/District Staff Signature: Waiver Office/Authority/District staff must sign the job completion form indicating final approval of the job for issuance of post authorization (release of payment).

Once a final determination is made the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District will submit the job completion form to the SC and data contractor (i.e. SRI).

Reimbursement for this service shall require prior and final approval by the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District staff.

Reimbursement shall not be authorized until verification has been received that the job has been completed in accordance with the prior approved agreement and the family is satisfied with the adaptation.

After the completed form is received in the OCDD Regional Waiver Supports and Services Office or the Human Services Authority or District, it is then forwarded to Statistical Resources, Inc., for issuance of Post Authorization allowing for release of payment.

Home and Vehicle Modification (HVM) Reversed Appeals, SFY13

The following are summaries of the three HVM appeals which were reversed in SFY13.

Appeal No. 13000334

Summary: Appeal was filed for a 55 year-old paraplegia requesting a ceiling track lift system to be installed under HVM. Medical Services' WPA review denied the HVM request because the appellant currently had a Hoyer lift which was meeting her needs based on the documentation provided. In addition to the member owned Hoyer lift, the case plan noted a safety plan of having someone with the member for supervision at all times.

Administrative Law Judge (ALJ, Anne E. Brendon) noted in the proposed decision:

“With respect to IME’s reliance on the case plan, the undersigned notes that it is apparently not up to date. It makes reference to the Appellant’s husband being laid off from work, which is not currently the case. This obviously makes a difference, and explains the statement, regarding the representation that Ms.... “is always with someone to supervise her.” Mr. and Mrs....testimony indicates that this is not true.”

Medical Services’ Analysis: Rule changes for Durable Medical Equipment (DME) to be implemented September, 1, 2013, may provide coverage under state plan for the ceiling track lift system when a medical prior authorization is approved.

Appeal No. 13006673

Summary: Appeal was filed for a 2 year-old with a diagnosis of a grade III brain bleed, heart defect and delays in all areas of development. A HVM request was submitted to remove carpet from the home, then to sand, stain, and seal the existing hardwood floor beneath the carpet. The request was to enable use of walker in her bedroom, the room used for her therapy and the hallway between the two rooms; inclusion of hallway also provided access to the bathroom.

Medical Services approved payment for removal of the carpet but denied payment for the sanding, staining and sealing of the existing hardwood flooring as homeowners repair responsibility.

Administrative Law Judge (ALJ, Emily Kimes-Schwiesow) noted in the proposed decision:

“The Department’s argument that refinishing the existing hardwood to a safe condition is an excluded repair and not a modification is not convincing. IME

Home and Vehicle Modification (HVM) Reversed Appeals, SFY13

does not dispute that... needs hard surface flooring, and is willing to pay for the carpet removal to allow her to function with greater independence within her home. It is unreasonable to expect her to do so on a hard surface that is unsafe. The fact that the current condition of the hardwood is unsafe for anyone absent refinishing does not end the analysis. The requested modification is not one that would be necessary for anyone to use the floor in its current carpeted condition. This modification is needed because...cannot walk on carpet. ...needs a hard surface floor. The requested modification is clearly necessary to meet her needs and is in fact the least costly option for supplying her with hard surface flooring. The Department's denial of the request for prior authorization is reversed."

Medical Services' Analysis: The difference in interpretation of a repair and homeowner responsibility resulted in this reversal. Further clarification, definition, in rule of repair may resolve this issue.

Also of note, Medical Services' discussed with two different program managers the desire to submit this decision for Director review; one program manager supported the Director review petition and the second program manager did not, therefore this decision was not forwarded for Director review.

Appeal No. 130006727

Summary: Appeal was filed for a nine year-old with a diagnosis of Duchenne Muscular Dystrophy (DMD). A request was submitted for a HVM, to be funded through the Consumer Choice Option (CCO), to install a stair lift in a new construction to provide access to the basement for family time and shelter in case of severe weather. The majority of living space in the new construction is on the main floor.

Medical Services denied the requested stair lift due to it not being required to meet a medical or remedial need for the member. The member would have access to the bedrooms, bathroom and kitchen and dining areas on the main floor. Medical Services noted family time could be provided on the main level.

Administrative Law Judge (ALJ, John M. Priester) noted in the proposed decision the following:

"The Department denied the request on the basis that the stair lift did not meet a medical need of.... Also, the Department does not approve stair lifts solely for safety from severe weather.

The undersigned finds that the Department's interpretation of 441 IAC 78.34(9) is too narrow. The administrative rules states modification "must be necessary to

Home and Vehicle Modification (HVM) Reversed Appeals, SFY13

provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.” 441 IAC 78.34(9)

The above administrative rule looks to the “health, welfare, or safety” of the consumer. This is not solely limited to the health of the consumer. The undersigned finds that the stair lift is necessary for the welfare and safety of.... The psychological welfare of a consumer must be as important as the physical/medical health. Also, the safety of...is not limited to protection during severe storms. If...tries to navigate the steps without any assistance and falls it may well result in his not being able to walk ever again. This certainly must be considered when determining whether the stair lift is necessary for the safety of....”

Medical Services’ Analysis: This was a request to access the basement of the home for shelter from weather and family time. The requested stair glide to the basement was part of a new home construction. The member, who is a child, had their bedroom and bathroom on the main floor along with the living room and kitchen. Clarifying rules regarding modifications to new constructions versus existing dwellings as well as further defining or removal of the verbiage “health, welfare, or safety” from rule may solidify the Department’s position for covered benefits.

Also of note, Medical Services’ discussed with two different program managers the desire to submit this decision for Director review; one program manager supported the Director review petition and the second program manager did not, therefore this decision was not forwarded for Director review.



October 2013

Prevention Quality Indicators

1st Qtr, SFY14

Points of interest:

- In CY12, Iowa Medicaid showed a decrease in PQI #1, Short-term Complications of Diabetes for the first time since CY09.
- Iowa Medicaid performed better than the comparison rate in 12 PQI measures

In this report:

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Recommendations	13

AHRQ Quality Indicator Overview

The Agency for Healthcare Research and Quality (AHRQ) is the health services research arm of the US Department of Health and Human Services (HHS). AHRQ specializes in major areas of health care research such as quality improvement, patient safety, outcomes and effectiveness of care. AHRQ Quality Indicators (QIs) are a set of quality indicators organized into four "modules," each of which measures quality associated with processes of care that occurred in an outpatient or an inpatient setting. All four modules rely on hospital inpatient data:

1. Prevention Quality Indicators (PQIs)--or ambulatory care sensitive conditions--identify hospital admissions that evidence suggests could have been avoided, at least in part, through high-quality outpatient care.
2. Inpatient Quality Indicators (IQIs) reflect quality of care inside hospitals and include:
 - Inpatient mortality for medical conditions.
 - Inpatient mortality for surgical procedures.
 - Utilization of procedures for which there are questions of overuse, underuse, or misuse.
 - Volume of procedures for which there is evidence that a higher volume of procedures may be associated with lower mortality.
3. Patient Safety Indicators (PSIs) also reflect quality of care inside hospitals, but focus on potentially

avoidable complications and iatrogenic events.

4. Pediatric Quality Indicators (PDIs) both reflect quality of care inside hospitals and identify potentially avoidable hospitalizations among children.

Prevention Quality Indicators (PQIs) were chosen for this study as they represent the areas of ability to intervene in Iowa Medicaid health care management approaches. These indicators measure the outcomes of preventive care for both acute illness and chronic conditions, reflecting two important components of the quality of preventive care: effectiveness and timeliness. These ambulatory care sensitive conditions (ACSCs) are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. According to the AHRQ PQI Fact Sheet, PQIs assess the quality of the health care system as a whole and the ability of ambulatory care to prevent medical complications. The measures are best used at the population level such as public health groups like Iowa Medicaid.

The PQIs serve as a screening tool as opposed to being a definite indicator of a quality concern. They provide initial infor-

mation about potential problems that may require more in-depth analysis. This is the analysis of Iowa Medicaid claims data from state calendar year 2012.

Prevention Quality Indicators (PQIs)

Indicator		Iowa Medicaid Numerator	Iowa Medicaid Denominator	Iowa Medicaid Rate per 100,000	Iowa Medicaid 95% CI Indicator	Observed (comparison) Rate per 100,000
# 1	Diabetes Short -term Complication Admission Rate	361	251,088	143.77	128.95 - 158.60	69.06
# 2	Perforated Appendix Admission Rate	42	131	32.06 *	24.06 - 40.05	28.70 *
# 3	Diabetes Long-term Complication Admission Rate	237	251,088	94.39	82.38 - 106.40	116.24
# 5	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate	510	251,088	203.12	185.51 - 220.73	534.00
# 7	Hypertension Admission Rate	84	251,088	33.45	26.30 - 40.61	61.76
# 8	Congestive Heart Failure Admission Rate	302	251,088	120.28	106.72 - 133.83	332.26
# 9	Low Birth-weight Rate	1,158	17,249	6.71 *	6.34 - 7.08	6.10 *
# 10	Dehydration Admission Rate	199	251,088	79.26	68.25 - 90.26	73.49
# 11	Bacterial Pneumonia Admission Rate	482	251,088	191.96	174.84 - 209.09	295.84
# 12	Urinary Tract Infection Admission Rate	309	251,088	123.06	109.35 - 136.78	193.64
# 13	Angina Without Procedure Admission Rate	9	251,088	3.58	1.24 - 5.93	18.58

All rates are reported per 100,000 except for those noted with an “*” which are reported per 100 populous.

Indicator		Iowa Medicaid Numerator	Iowa Medicaid Denominator	Iowa Medicaid Rate per 100,000	Iowa Medicaid 95% CI Indicator	Observed (comparison) Rate per 100,000
# 14	Uncontrolled Diabetes Admission Rate	27	251,088	10.75	6.70 - 14.81	21.92
# 15	Asthma In Younger Adults Admission Rate	119	251,088	47.39	38.88 - 55.91	119.34
# 16	Rate of Lower-Extremity Amputation among Patients with Diabetes	33	251,088	13.14	8.66 - 17.63	32.99
# 90	Composite: Overall	2,657	251,088	1,058.19	1,018.17 - 1,098.22	1,526.08
# 91	Composite: Acute Conditions	990	251,088	394.28	369.77 - 418.80	562.97
# 92	Composite: Chronic Conditions	1,667	251,088	663.91	632.15 - 695.68	663.91

Although PQIs are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions have not received appropriate patient education needed for self-management of their disease.

“With high-quality, community-based primary care, hospitalization for these illnesses often can be avoided. Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community. Because the PQIs are calculated using readily available hospital administrative data, they are an easy-to-use and inexpensive screening tool. They can be used to provide a window into the community — to identify unmet community health care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.” (AHRQ, 2013)

The rates are calculated based on claims data submitted to Iowa Medicaid with a purpose of reimbursement for inpatient hospitalizations, not specifically for quality indicator measurements. As such, there may be slight variances in the actual rates based on individual provider billing practices. Persons who were dually eligible for Medicare and Medicaid during calendar 2012 were excluded.

Based on the sample size, we can calculate a value and a 95 percent Confidence Interval (CI). This

interval is a range. It represents that we can be 95 percent confident that the “true value” is within the range. This basically accounts for the inherent possible error in any statistical analysis and calculation. If the comparison value is within this range, we cannot state with 95 percent confidence that the “true value” is really different than the comparison, because that true value is at least 95 percent likely to be somewhere in the range that also includes the comparison.

The graphs on the next several pages reflect the Iowa Medicaid rate for each individual measure as well as the Iowa Medicaid and national benchmark “comparison” rates when available. When the comparison rate fell within the 95 percent confidence interval, it will be noted for the respective measure.

Comparison rates included are as provided by AHRQ, H-CUPnet: National information on measures of health care quality based on the NIS, using the AHRQ Quality Indicators.

PQI #1 Diabetes Short-term Complication Admission Rate

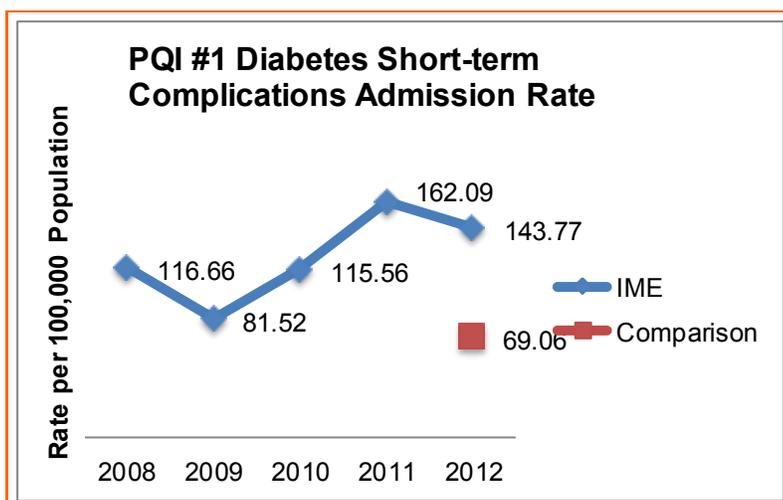
This measure identifies the admissions for a principle diagnosis of diabetes with short-term complications for persons aged 18 years and older. Obstetric admissions and transfers from other institutions were excluded. Complications include ketoacidosis, hyperosmolarity and coma (AHRQ, 2012).

These life-threatening emergencies may arise from the imbalance of glucose and insulin resulting from misadministration of insulin, failure to follow a proper diet, errors in taking insulin or simply not taking it.

Although Iowa Medicaid performed worse than the comparison for this measure, it is important to note the IME rate decreased in CY12 for the first time since CY09. This may be due to increased education and outreach to both providers and members regarding diabetic care.

It is anticipated the rate for short-term complications of diabetes will continue to decline with the implementation of medical health homes which include performance measures focusing on diabetes management.

* IME CI for this indicator is 128.95 - 158.60 per 100,000 population.



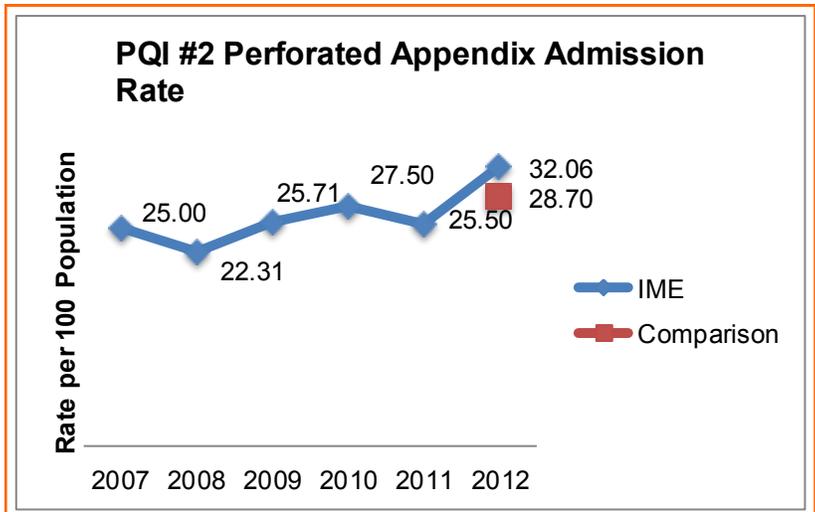
PQI #2 Perforated Appendix Admission Rate

This measure identifies admissions for diagnosis of perforations of the appendix with a diagnosis of appendicitis for persons aged 18 years and older. Obstetric admissions and transfers from other institutions were excluded. (AHRQ, 2012)

Perforated appendix may occur when appropriate treatment for acute appendicitis is delayed due to lack of access to care, patient failure to interpret symptoms as important, or a diagnosis of appendicitis not being made in a timely manner.

The comparison rate fell within the 95 percent CI for this measure indicating there may not be any difference in the Iowa Medicaid rate and the comparison.

* IME CI for this indicator is 24.06 - 40.05 per 100 population.



PQI #3 Diabetes Long-term Complications Admission Rate

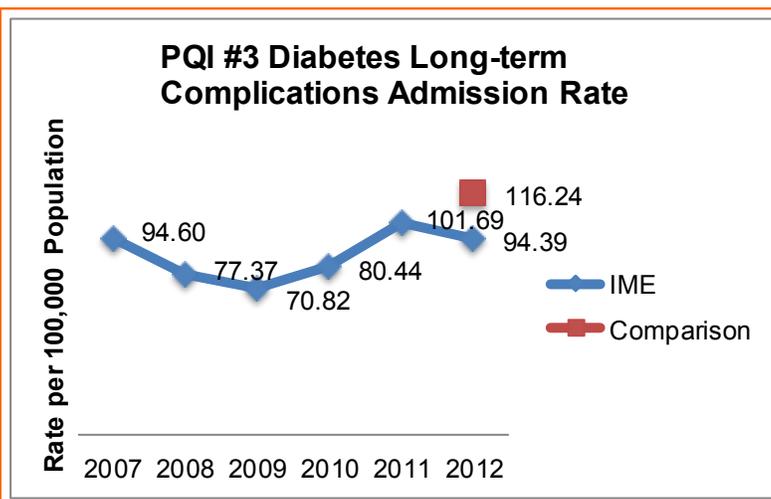
This measure identifies admissions for a principle diagnosis of diabetes with an associated long-term complication for persons aged 18 years and older. Obstetric admissions and transfers from other institutions were excluded.

Complications include renal, eye, neurological and circulatory disorders (AHRQ, 2012); these complications occur at some time in the majority of patients with diabetes to varying degrees. They are thought to arise from

sustained long-term poor control of diabetes and are best prevented by adherence to therapy and consistent monitoring.

IME performed better than the comparison for this measure.

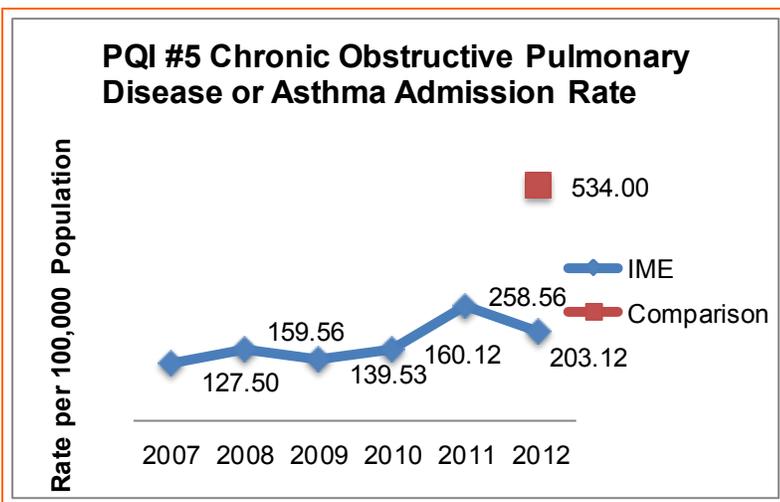
* IME CI for this indicator is 82.38 - 106.40 per 100,000 population.



PQI #5 Chronic Obstructive Pulmonary Disease or Asthma Rate in

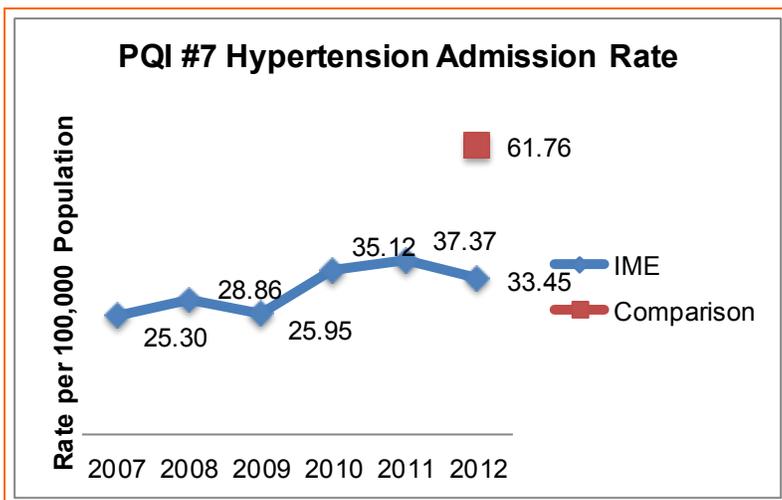
This measure identifies admissions with a principle diagnosis of chronic obstructive pulmonary disease (COPD) or asthma in persons aged 40 years and older. Obstetric admissions and transfers from other institutions were excluded. (AHRQ, 20112)

Comprised of three diseases causing respiratory dysfunction (asthma, emphysema, chronic bronchitis), COPD may be characterized by sudden worsening symptoms such as dyspnea, or shortness of breath, cough and fatigue.



IME performed better than the comparison for this measure.

* IME CI for this indicator is 185.51 - 220.73 per 100,000 population.



PQI #7 Hypertension Admission Rate

This measure identifies admissions with a principal diagnosis of hypertension for persons aged 18 years and older. Persons with diagnoses of kidney disease combined with dialysis access procedure admissions, cardiac procedure admissions, obstetric admissions, and transfers from other institutions were excluded. (AHRQ, 2012)

IME performed better than the comparison for this measure.

* IME CI for this indicator is 26.30 - 40.61 per 100,000 population.

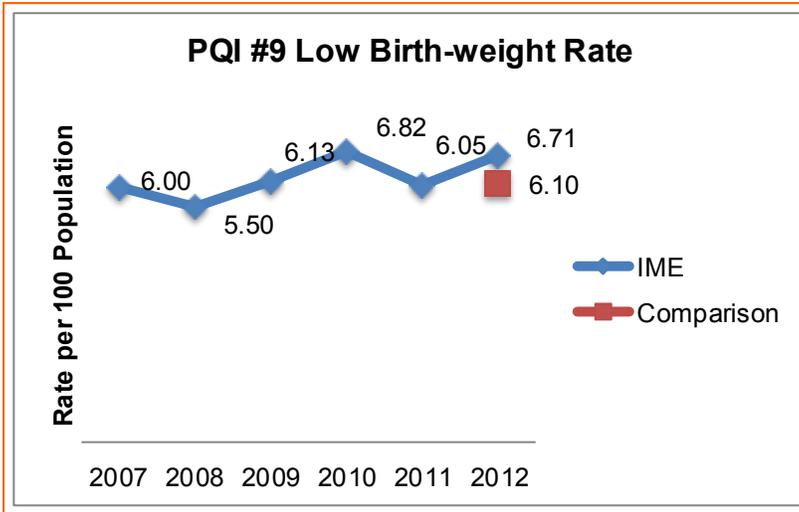
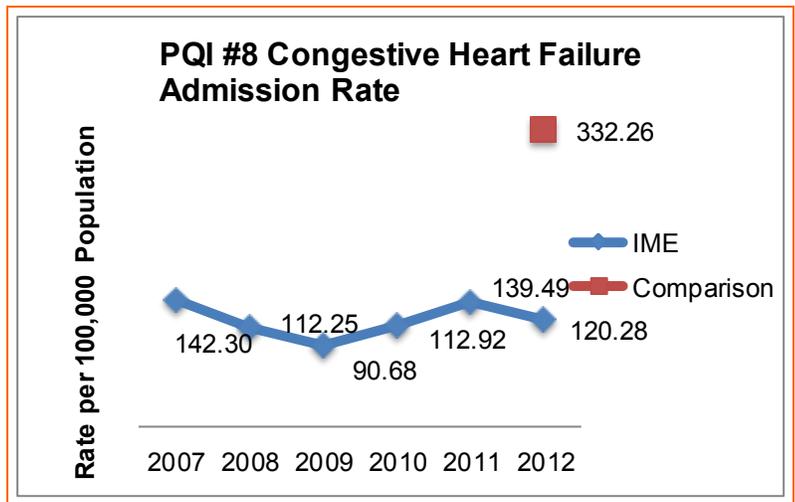
PQI #8 Congestive Heart Failure Admission Rate

This measure identifies admissions with a principal diagnosis of heart failure for persons aged 18 years and older. Cardiac procedure admissions, obstetric admissions, and transfers from other institutions were excluded. (AHRQ, 2012)

Congestive Heart Failure (CHF) is a chronic progressive disorder and hospital admissions can be caused by lack of patient compliance, problems accessing care or poor quality care.

IME performed better than the comparison for this measure.

* IME CI for this indicator is 106.72 - 133.83 per 100,000 population.



PQI #9 Low Birth-weight Rate

This measure identifies infants born with a low birth-weight, defined as a birth-weight of less than 2,500 grams. Transfers from other institutions were excluded. (AHRQ, 2012)

This concern may occur due to inadequate intrauterine growth or premature birth. Risk factors include low income and tobacco use during pregnancy.

Low birth-weight infants are at a higher risk developing cardiovascular disease and obesity as adults which are contributing factors to cesarean section deliveries. (Barker, et al, 1993)

IME performed worse than the comparison for this measure and was noted to have increased in rate from CY11. A statewide OB strategy, recently approved by the OB Taskforce, working with the Iowa Health Information Network (IHIN) addresses it and here at Medicaid we are working with the MHTF and a QI project around maternal tobacco cessation.

* IME CI for this indicator is 6.34 - 7.08 per 100 population.

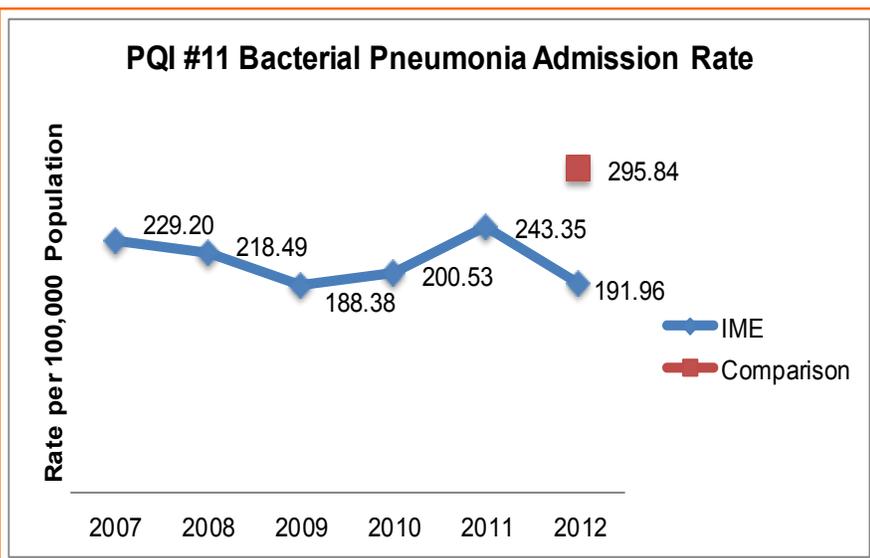
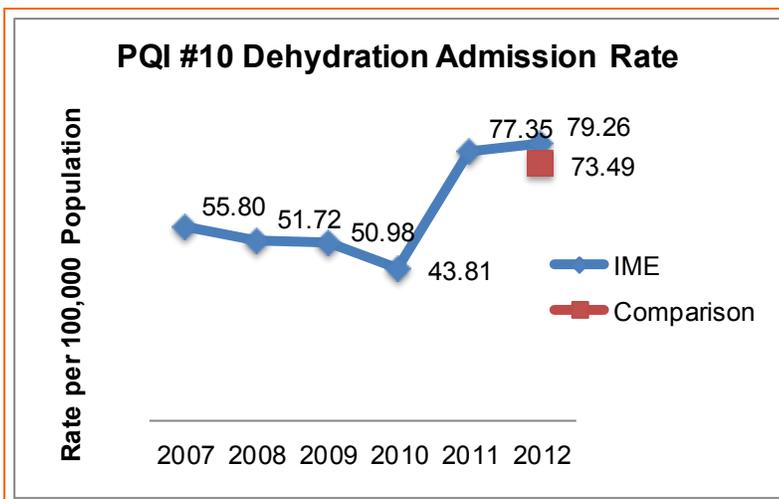
PQI #10 Dehydration Admission Rate

This measure identifies admissions with a principal diagnosis of dehydration for persons aged 18 years and older. Obstetric admissions and transfers from other institutions are excluded. (AHRQ, 2012)

Dehydration is a serious acute condition that occurs in frail patients and patients with underlying illnesses following insufficient attention and support for fluid intake. It is potentially fatal for the elderly, young children, frail patients and patients with serious co-morbid conditions.

The comparison rate fell within the 95 percent CI for this measure indicating there may not be any difference in the Iowa Medicaid rate and the comparison.

* IME CI for this indicator is 68.25 - 90.26 per 100,000 population.



PQI #11 Bacterial Pneumonia Admission Rate

This measure identifies admissions with a principal diagnosis of bacterial pneumonia for persons aged 18 years and older. Sickle cell or hemoglobin-S admissions, other indications of immunocompromised state admissions, obstetric admissions, and transfers from other institutions were excluded. (AHRQ, 2012)

Bacterial pneumonia is a relatively common acute condition, but left untreated can lead to death, particularly

among the elderly. Vaccination for pneumococcal pneumonia for the elderly and early management of bacterial respiratory infections can reduce admissions.

IME performed better than the comparison for this measure.

* IME CI for this indicator is 174.84 - 209.09 per 100,000 population.

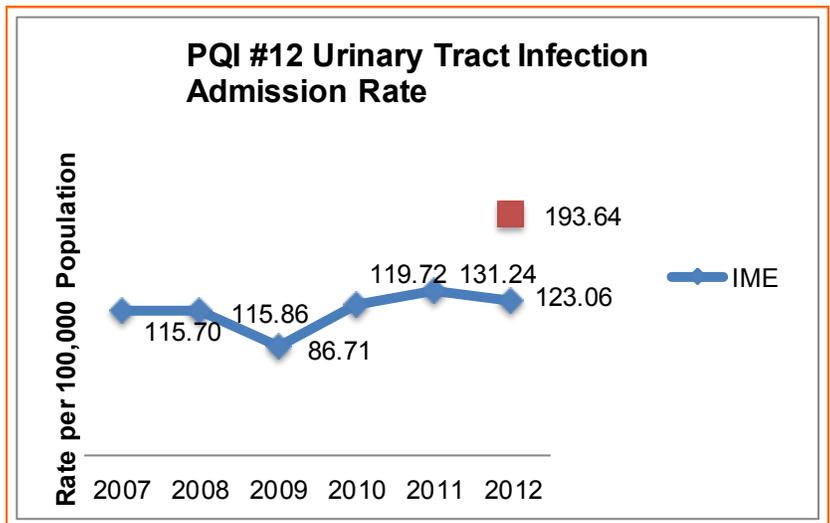
PQI #12 Urinary Tract Infection Admission Rate

This measure identifies admissions with a principal diagnosis of urinary tract infection in persons aged 18 years and older. Kidney or urinary tract disorder admissions, other indications of immunocompromised state admissions, obstetric admissions, and transfers from other institutions were excluded. (AHRQ, 2012)

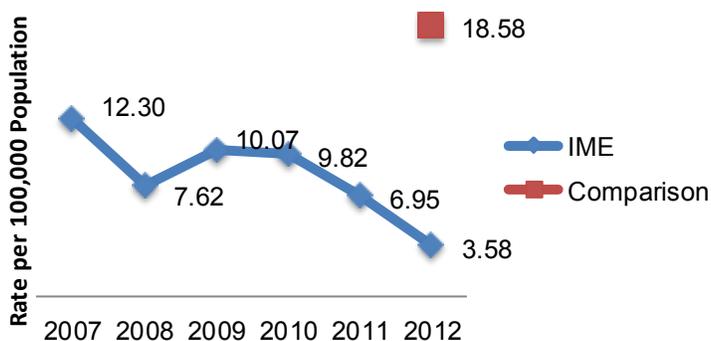
This is a common condition that can progress to clinically significant infections in vulnerable individuals with inadequate treatment.

IME performed better than the comparison for this measure.

* IME CI for this indicator is 109.35 - 136.78 per 100,000 population.



PQI #13 Angina Without Procedure Admission Rate



PQI #13 Angina without Procedure Admission Rate

This measure identifies admissions with a principal diagnosis of angina without cardiac procedure for persons aged 18 years and older. Cardiac procedure admissions, obstetric admissions and transfers from other institutions are excluded. (AHRQ, 2012)

Angina is a symptom of potential coronary artery disease. Effective management of coronary artery disease reduces occurrence of heart attacks and angina related admissions. Risk factors are smoking, hyperlipidemia, hypertension and elderly age.

IME performed better than the comparison for this measure.

IME performed better than the comparison for this measure.

* IME CI for this indicator is 1.24 - 5.93 per 100,000 population.

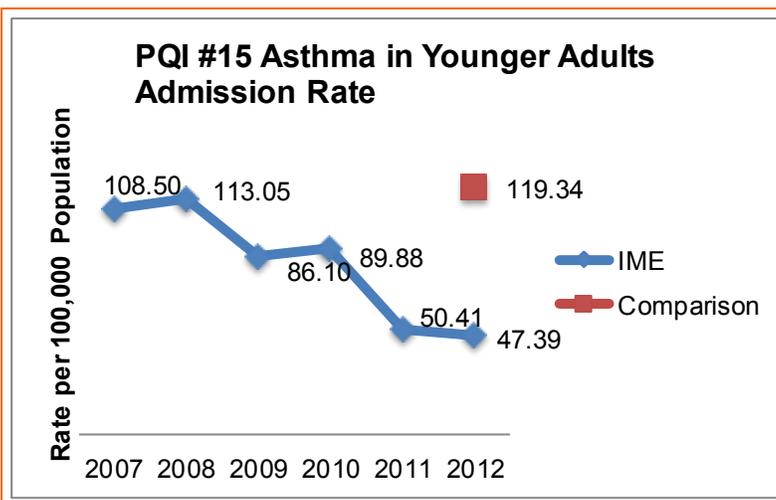
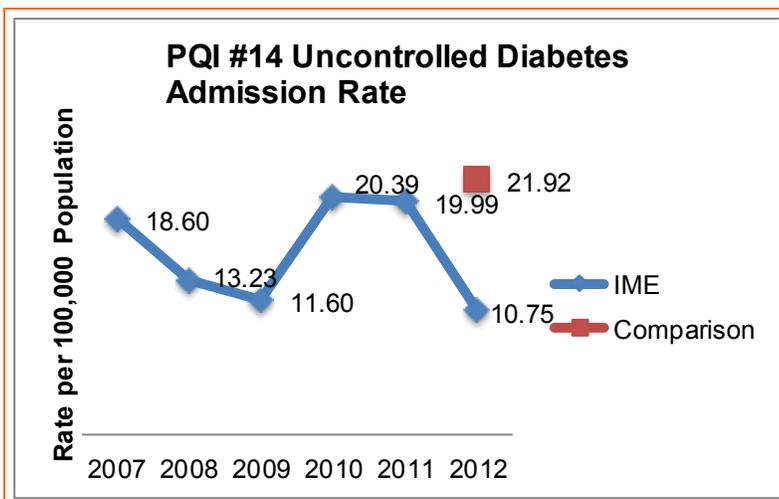
PQI #14 Uncontrolled Diabetes Admission Rate

This measure identifies admissions for a principal diagnosis of diabetes without mention of short-term complications or long-term complications for persons aged 18 years and older. Obstetric admissions and transfers from other institutions were excluded. (AHRQ, 2012)

This measure should be used in conjunction with short-term complications of diabetes (PQI #1). Diabetic emergencies are potentially life-threatening and include ketoacidosis, hyperosmolarity and coma. Long-term complications of diabetes are addressed in PQI #4.

IME performed better than the comparison for this measure with a significant decrease from the previous year.

* IME CI for this indicator is 6.70 - 14.81 per 100,000 population.



PQI #15 Asthma in Younger Adults Admission Rate

This measure identifies admissions with a principal diagnosis of asthma for persons aged 18 to 39 years. Admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions were excluded. (AHRQ, 2012)

Asthma is one of the most common reasons for hospital admission and emergency room care. Environmental factors may have an

impact as well as inadequate access to care. (AHRQ, 2004)

IME performed better than the comparison for this measure.

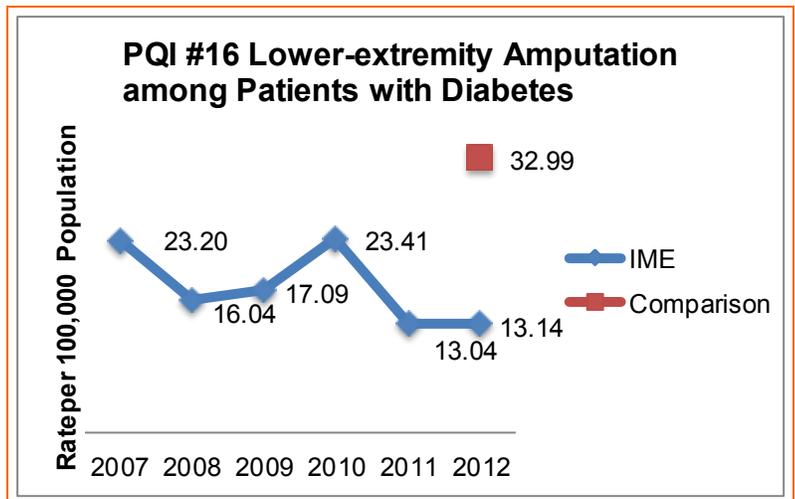
* IME CI for this indicator is 38.88 - 55.91 per 100,000 population.

PQI #16 Rate of Lower-Extremity Amputation among Patients with Diabetes

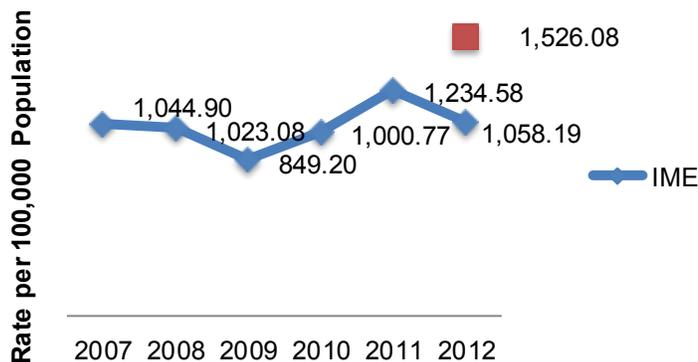
This measure identifies admissions for a diagnosis of diabetes and a procedure of lower extremity amputation for persons aged 18 years and older. Diagnoses of traumatic lower-extremity amputation admissions, toe amputation admissions (likely to be traumatic), obstetric admissions, and transfers from other institutions were excluded. (AHRQ, 2012)

IME performed better than the comparison for this measure.

* IME CI for this indicator is 8.66 - 17.63 per 100,000 population.



PQI #90 Composite: Overall



PQI #90 Composite: Overall

The overall composite includes admissions for persons aged 18 years and older for diabetes with short-term and long-term complications, uncontrolled diabetes without complications, diabetes with lower extremity amputation, COPD, asthma, hypertension, heart failure, angina without cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection. (AHRQ, 2012)

Composite measures have been constructed for overall, acute and chronic conditions. They help summarize quality across multiple indicators and help identify drivers of quality.

The numerators of all the measures except PQI 2 (Perforated Appendix) and PQI 9 (Low Birth Rate) were combined to obtain an overall composite score for Iowa Medicaid. Those two measures were excluded as their denominators were different.

IME performed better than the comparison for this measure.

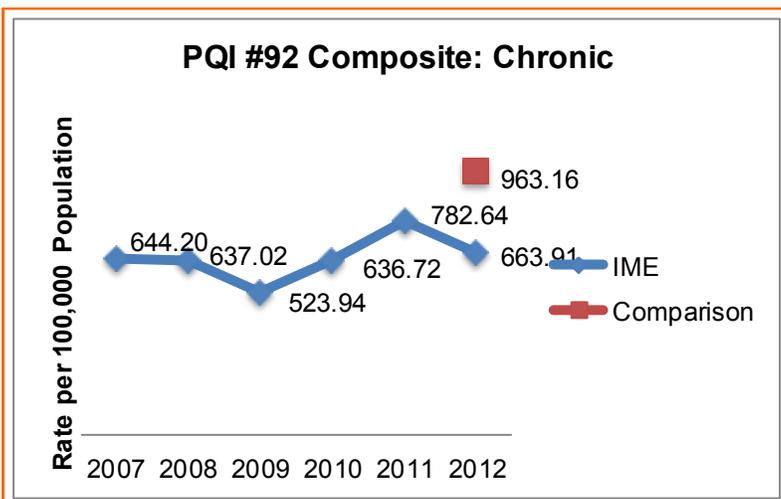
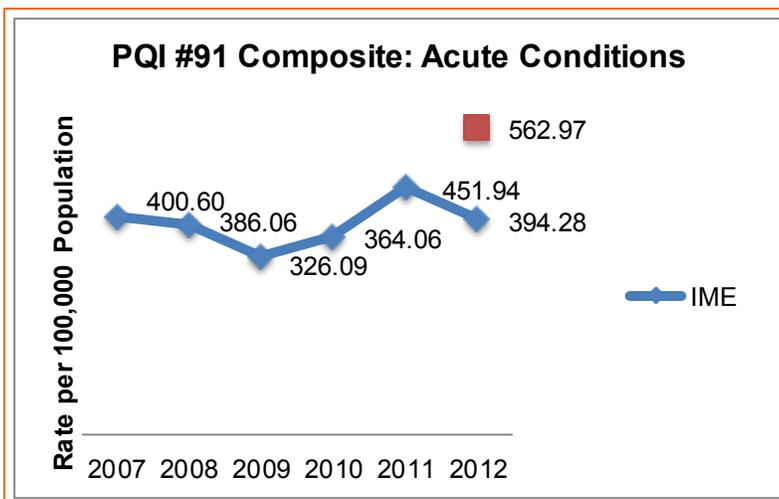
* IME CI for this indicator is 1,018.17 - 1,098.22 per 100,000 population.

PQI #91 Composite: Acute Conditions

The acute-only composite includes three PQI conditions: Dehydration (PQI 10), Bacterial Pneumonia (PQI 11) and Urinary Tract infection (PQI 12) to provide a picture of outpatient care for these acute conditions.

IME performed better than the comparison for this measure.

* IME CI for this indicator is 369.77 - 418.80 per 100,000 population.



PQI #92 Composite: Chronic Conditions

The chronic-only composite includes nine indicators that measure chronic conditions: Diabetes (PQI 1, 3, 14 and 16), COPD (PQI 5), Hypertension (PQI 7), CHF (PQI 8), Angina (PQI 13) and Asthma (PQI 15). The combination of these nine measures presents an overall score for outpatient care for typical chronic conditions.

The comparison rate fell within the 95 percent CI for this measure indicating there may not be any difference in the Iowa Medicaid rate and the comparison.

IME performed better than the comparison for this measure.

* IME CI for this indicator is 632.15 - 695.68 per 100,000 population.

Summary

In summary, Iowa Medicaid performed worse than the national comparison in the following PQIs:

- PQI #1 Diabetes Short-term Complications
- PQI #9 Low Birth-weight Rate

Although Iowa Medicaid noted changes in these PQI measures, the amount of change does not necessarily indicate a change in the quality of care in the state.

Iowa Medicaid performed better than the national benchmark in the following PQIs:

- PQI #4 Diabetes Long-term Complications Admission Rate
- PQI #5 Chronic Obstructive Pulmonary Disease or Asthma Admission Rate
- PQI #7 Hypertension Admission Rate
- PQI #8 Congestion Heart Failure Admission Rate
- PQI #11 Bacterial Pneumonia Admission Rate
- PQI #12 Urinary Tract Infection Admission Rate
- PQI #13 Angina Without Procedure Admission Rate
- PQI #14 Uncontrolled Diabetes Admission Rate
- PQI #15 Asthma in Younger Adults Admission Rate
- PQI #16 Lower-extremity Amputation among Patients with Diabetes
- PQI #90 Composite: Overall
- PQI #91 Composite: Acute Conditions

In the following PQIs, Iowa Medicaid the comparison rate fell within the 95 percent confidence interval indicating there may not be any difference in the Iowa Medicaid rate and the comparison rate.

- PQI #2 Perforated Appendix Admission Rate
- PQI #10 Dehydration Admission Rate
- PQI #92 Composite: Chronic Conditions

Also of note, with exception of PQI 10, dehydration, the IME rates for all admission PQIs have shown small decreases.

Recommendations

- Complete an in-depth analysis of individual members' claims to identify treatment patterns.
 - PQI measure 9, further evaluation of the members who comprised this rate increase to determine the populations affected; is enrollment in the health homes or managed care program making a difference?
 - PQI measure 14, further evaluation of the members who comprised this rate to determine actual cause of admission. Uncontrolled diabetes is not routinely the primary reason for admission and is generally treated outpatient. Although Iowa performed better than the comparison, this may be an area to review further for other interventions that may benefit these members.
- Continue to participate in the MMDN and the projects that are applicable to the Iowa Medicaid population.
- Continue Iowa Medicaid's quality improvement project for diabetes in conjunction with the CMS adult quality measures grant.
- Continue to monitor the AHRQ PQIs annually for trends to encourage a dialogue among healthcare providers, consumers and the Medicaid program to promote optimal health outcomes.

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Medicaid Value Management (MVM)

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Realizing the fiscal value of quality care.

About MVM

Medicaid Value Management (MVM) analyzes different areas of Iowa Medicaid to gain an understanding of the quality of the services provided to the Medicaid member. MVM analyzes the efficacy of services provided; best practices used and not used in Iowa and the overall impact on our Medicaid population; MVM also looks at individual programs within Iowa Medicaid. Ultimately MVM looks for ways to promote improved health outcomes within the constraints of Medicaid budget limits and with this information, MVM makes recommendations for policy and program changes.

Query Facts

Iowa Medicaid claims data for calendar year 2012.