



# Medicaid Value Management (MVM)

*Realizing the fiscal value of quality care.*

January 2014

**CHIPRA Analysis Report:  
2013 Reporting Year**

2nd Qtr, SFY14

### Point of Interest:

- IME will report on 24 of the 26 measures in 2014.

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### CHIPRA Overview

On February 4, 2009, President Obama signed the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This legislation marked a new era in children’s coverage by providing states with significant new funding, new programmatic options, and a range of new incentives for covering children through Medicaid and the Children’s Health Insurance Program (CHIP).” (CMS, nd)

Medicaid and the Children’s Health Insurance Program (CHIP) are a major source of health coverage for low-income children ranging in age from infants to early adulthood. Together, these programs provide coverage for about 40 million children during the course of a year, providing access to a comprehensive set of benefits including preventive and primary care services and other medically necessary services. (DHS, 2011)

Health and Human Services (HHS) Secretary Kathleen Sebelius is required to report annually on the quality of the system of care for children in Medicaid/CHIP. As part of its mission to measure and improve the quality of care for children, CMS provided state health officials with an initial core set of children’s health care quality measures, twenty-four measures and technical specifications. These efforts align with

HHS National Quality Strategy’s three aims of better care, healthier people and communities and affordable care.

The Initial Core Set Measures are designed to provide information on the following broad areas:

- Prevention and Health Promotion
- Availability of medical care
- Management of Acute Conditions
- Family Experiences of Care

Implementation of this standardized set of measures is designed to help CMS and States create a national system for quality measurement and improvement. While reporting on the CHIPRA measures has begun, work continues on refining them. CMS has launched its CHIPRA Technical Assistance and Analytic Support Program. Through this program, Mathematica Policy Research, the National Committee for Quality Assurance (NCQA), the Center for Health Care Strategies (CHCS), and the National Initiative for Children’s Healthcare Quality (NICHQ) assist states in carrying out the measure specifications. A technical assistance mailbox was provided for this purpose and was used by IME to clarify specifications and reporting instructions.

Reporting of quality information through the CMS Abstraction & Reporting Tool (CART) began in 2005 when CHIP programs were encouraged to report annual data on four Healthcare Effectiveness Data and

Information Set (HEDIS®) measures. In Federal fiscal year 2010 (FFY 2010), 42 states began to voluntarily report some or all of the 24 quality measures in the initial core set for children to CARTS.

Each measure has a steward as listed in the table below. Data sources are administrative such as claims and registries. Many measures also have an option for reporting from hybrid specifications that include medical record review.

## Core Set Measures

Population/Community Health			
Measure Acronym	Title	Measure Steward	Description
HPV	Human Papilloma-virus (HPV) Vaccine for Female Adolescents	National Committee for Quality Assurance (NCQA)/Healthcare Effectiveness Data and Information Set (HEDIS) ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of female adolescents that turned 13 years old during the measurement year and had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender.
Clinical Care			
Measure Acronym	Title	Measure Steward	Description
CAP	Child and Adolescent Access to Primary Care Practitioners	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of children and adolescents ages 12 months to 19 years that had a visit with a PCP, including four separate percentages: Children ages 12 to 24 months and 25 months to 6 years that had a visit with a PCP during the measurement year Children ages 7 to 11 years and adolescents ages 12 to 19 years that had a visit with a PCP during the measurement year or the year prior to the measurement year.
CIS	Childhood Immunization Status	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday

Measure Acronym	Title	Measure Steward	Description
IMA	Immunization Status for Adolescents	CQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday
FPC	Frequency of Ongoing Prenatal Care	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: < 21 percent of expected visits 21 percent – 40 percent of expected visits 41 percent – 60 percent of expected visits 61 percent – 80 percent of expected visits ≥ 81 percent of expected visits
PPC	Timeliness of Prenatal Care	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment
LBW	Live Births Weighing Less Than 2,500 Grams	Centers for Disease Control and Prevention (CDC) ( <a href="http://www.cdc.gov/nchs">http://www.cdc.gov/nchs</a> )	Percentage of live births that weighed less than 2,500 grams in the state during the reporting period
CSEC	Cesarean Rate for Nulliparous Singleton Vertex	California Maternal Quality Care Collaborative ( <a href="http://www.cmqcc.org">http://www.cmqcc.org</a> )	Percentage of women that had a cesarean section among women with first live singleton births (also known as nulliparous term singleton vertex [NTSV] births) at 37 weeks of gestation or later
BHRA	Behavioral Health Risk Assessment (for Pregnant Women)	American Medical Association (AMA) – Physician Consortium for Performance Improvement (PCPI) ( <a href="http://www.amaassn.org/ama/pub/physician-resources/physicianconsortium-performanceimprovement.page">http://www.amaassn.org/ama/pub/physician-resources/physicianconsortium-performanceimprovement.page</a> )	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 that includes the following screenings at the first prenatal visit: depression, alcohol use, tobacco use, drug use, and intimate partner violence
DEV	Developmental Screening In the First Three Years of Life	Oregon Health and Science University ( <a href="http://www.oregonpip.org/focus/CHIPRA%20Core%20Measures.html">http://www.oregonpip.org/focus/CHIPRA%20Core%20Measures.html</a> )	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
PA1C	Annual Pediatric Hemoglobin A1C Testing	NCQA ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of children ages 5 to 17 with diabetes (type 1 and type 2) that had a Hemoglobin A1c (HbA1c) test during the measurement year

Measure Acronym	Title	Measure Steward	Description
W15	Well-Child Visits in the First 15 Months of Life	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of children that turned 15 months old during the measurement year and had zero, one, two, three, four, five, or six or more well-child visits with a PCP during their first 15 months of life
W34	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of children ages 3 to 6 that had one or more well-child visits with a PCP during the measurement year
AWC	Adolescent Well-Care Visit	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year
CHL	Chlamydia Screening in Women	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	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
PIDENT	Percentage Of Eligibles That Received Preventive Dental Services	CMS ( <a href="http://www.cms.gov/MedicaidEarlyPeriod-icScrn/03_StateAgencyResponsibilities.asp">http://www.cms.gov/MedicaidEarlyPeriod-icScrn/03_StateAgencyResponsibilities.asp</a> )	Percentage of individuals ages 1 to 20 that are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received preventive dental services
TDENT	Percentage Of Eligibles That Received Dental Treatment Services	CMS ( <a href="http://www.cms.gov/MedicaidEarlyPeriod-icScrn/03_StateAgencyResponsibilities.asp">http://www.cms.gov/MedicaidEarlyPeriod-icScrn/03_StateAgencyResponsibilities.asp</a> )	Percentage of individuals ages 1 to 20 that are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received dental treatment services
MMA	Medication Management for People with Asthma	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of children ages 5 to 20 that were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period Two rates are reported: Percentage of children that remained on an asthma controller medication for at least 50 percent of their treatment period Percentage of children that remained on an asthma controller medication for at least 75 percent of their treatment period. This measure is reported using the following age ranges: 5 to 11 years; 12 to 18 years; 19 to 20 years; and total

Care Coordination			
Measure Acronym	Title	Measure Steward	Description
FUH	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of discharges for children ages 6 to 20 that were hospitalized for treatment of selected mental health disorders and that had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge
ADD	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed, including two rates: one for the initiation phase and one for the continuation and maintenance phase
Safety			
Measure Acronym	Title	Measure Steward	Description
CLABSI	Pediatric Central Line-Associated Blood Stream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	Centers for Disease Control and Prevention ( <a href="http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf">www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf</a> )	Rate of central line-associated blood stream infections (CLABSI) in the pediatric and neonatal intensive care units during periods selected for surveillance
Efficiency and Cost Reduction			
Measure Acronym	Title	Measure Steward	Description
CWP	Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Percentage of children ages 2 to 18 that were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode
ASMER	Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits	Alabama Medicaid ( <a href="http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.7.0_Health_Information_Technology/4.7.1_Together_for_Quality/4.7.1.4_Asthma_Measures.aspx">http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.7.0_Health_Information_Technology/4.7.1_Together_for_Quality/4.7.1.4_Asthma_Measures.aspx</a> )	Percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room (ER) visits

AMB	Ambulatory Care – Emergency Department (ED) Visits	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> )	Rate of ED visits per 1,000 enrollee months among children up to age 19
<b>Person and Caregiver Centered Experience</b>			
Measure No.	Title	Measure Steward	Description
CPC	Consumer Assessment of Healthcare Providers and Systems® (CAHPS) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)	NCQA/HEDIS ( <a href="http://www.ncqa.org">http://www.ncqa.org</a> ) ( <a href="https://cahps.ahrq.gov/">https://cahps.ahrq.gov/</a> )	Survey on parents' experiences with their children's care

### IME Measure Collection Process

The following tasks were completed by the IME CHIPRA team to complete the measures and subsequent reporting:

- Submitted only one question to the technical assistance helpdesk, CMS [CHIPRAQualityTA@ees.hhs.gov](mailto:CHIPRAQualityTA@ees.hhs.gov).
- Received updates to previous year's Technical Specifications Manual in May 2013.
- Reviewed technical specifications for the three new measures and assigned a steward for data collection.
- Continued to use folder on IME Universal to hold specifications, reporting templates, data queries and results specific to each measure and tracking spreadsheet.
- Reviewed all measure specifications and changes. Determined that population size did not support reporting for measure CLABSI, pediatric central line associated blood stream infections.
- Determined 24 of the 26 measures would be reported in 2013. Assigned data query responsibility for each measure.
  - Two of the 24 measures to be reported for the 2013 reporting year will occur in March of 2014. The PDENT and TDENT measure results will be collected from the CMS 416 EPSDT report.
  - The BHRA measure will not be reported due to the technical specifications requiring data to be collected from electronic health records (EHR).
  - The CLABSI measure will not be reported due to the cases for Iowa Medicaid that met the technical specification requirement totaling less than 30.
- Entered measure results into the CARTS system.

### Barriers in Reporting Measures

In previous years it was noted that predominately barriers occurred due to specifications of the measures not being specific enough or not lining up perfectly with the claims system or with availa-

ble population data. This was not a significant barrier this reporting year due to the limited amount of changes made to the technical specifications compared to the 2012 reporting year.

In the 2012 reporting year, it was also noted that due to the large volume of data needed for the measures, the IME servers were often slow in response time which caused delays. To offset the strain on the servers in collecting data for CHIPRA measures, possible resolutions identified were to begin collecting data at least a month prior to the month due for reporting. The units within IME responsible for collecting the information proactively met and set a target date of December 1, 2013, for completion of the measures. This date allowed for 30 calendar days to address any errors with data or unexpected obstacles that surfaced.

Approximately half of the measures targeted for completion by December 1, 2013, were completed on or before that date. Two measures were previously identified to be submitted late, in March 2014, due to the information being collected from an annual EPSDT report. The CAHPS survey for 2012 was not available until after December 1, 2013, but was submitted timely to CMS via the CARTS tool.

### Iowa Medicaid CHIPRA Outcomes Reported for 2013 Using 2012 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.

Population/Community Health				
Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
HPV	Human Papilloma-virus (HPV) Vaccine for Female Adolescents	Program Integrity	New Measure for 2013 Reporting Year	<b>Numerator</b> = 320 <b>Denominator</b> = 4,748 <b>Rate</b> 6.74%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents	Program Integrity	<b>Age 3 - 11</b> <b>Numerator</b> = 45 <b>Denominator</b> = 39,719 <b>Rate</b> = 0.11%  <b>Age 12 - 17</b> <b>Numerator</b> = 19 <b>Denominator</b> = 17,660 <b>Rate</b> = 0.10%  <b>Combined</b> <b>Numerator</b> = 64 <b>Denominator</b> = 57,379 <b>Rate</b> = 0.11%	<b>Age 3 - 11</b> <b>Numerator</b> = 687 <b>Denominator</b> = 113,997 <b>Rate</b> = 0.60%  <b>Age 12 - 17</b> <b>Numerator</b> = 300 <b>Denominator</b> = 55,977 <b>Rate</b> = 0.54%  <b>Combined</b> <b>Numerator</b> = 987 <b>Denominator</b> = 169,974 <b>Rate</b> = 0.58%

Clinical Care				
Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
CAP	Child and Adolescent Access to Primary Care Practitioners	Program Integrity	<p><b>Denominator</b> Total number of eligible members = 183,607</p> <p><b>Eligible members (by age):</b>  <b>12-24 months</b> = 16,051  <b>Rate</b> = 94.82%  <b>25 months - 6 yrs</b> = 66,976  <b>Rate</b>: 85.16%  <b>7-11 yrs</b> = 46,124  <b>Rate</b>: 83.50%  <b>12-19 yrs</b> = 54,456  <b>Rate</b> = 82.94%</p> <p><b>Numerator</b> Eligible members (by age) with at least 1 PCP visit:  <b>12- 24 months</b> = 15,219  <b>25 months - 6 yrs</b> = 57,036  <b>7-11 yrs</b> = 38,515  <b>12-19 yrs</b> = 45,164</p>	<p><b>Denominator</b> Total number of eligible members = 190,415</p> <p><b>Eligible members (by age):</b>  <b>12 - 24 months</b> = 15,782  <b>Rate</b> = 96.0%  <b>25 months - 6 yrs</b> = 66,187  <b>Rate</b> = 87.2%  <b>7 - 11 yrs</b> = 48,881  <b>Rate</b> = 85.6%  <b>12 - 19 yrs</b> = 57,565  <b>Rate</b> = 85.3%</p> <p><b>Numerator</b> Eligible members (by age) with at least 1 PCP visit:  <b>12 - 24 months</b> = 15,154  <b>25 months - 6 yrs</b> = 59,466  <b>7 - 11 yrs</b> = 41,834  <b>12 - 19yrs</b> = 49,117</p>
CIS	Childhood Immunization Status	Program Integrity	<p><b>Denominator</b> = 13,387</p> <p><b>Numerators:</b>  <b>DTAP</b> = 5,368  <b>Rate</b> = 40.10%  <b>IPV</b> = 7,346  <b>Rate</b> = 54.87%  <b>MMR</b> = 8,594  <b>Rate</b> = 64.20%  <b>HiB</b> = 7,906  <b>Rate</b> = 59.06%  <b>HEPB</b> = 3,129  <b>Rate</b> = 23.37%  <b>VZV</b> = 8,393  <b>Rate</b> = 62.70%  <b>PCV</b> = 5,484  <b>Rate</b> = 40.97%  <b>HEPA</b> = 3,458  <b>Rate</b> = 25.83%  <b>RV</b> = 4,813  <b>Rate</b> = 35.95%  <b>FLU</b> = 3,642  <b>Rate</b> = 27.21%</p>	<p><b>Denominator</b> = 12,908</p> <p><b>Numerators:</b>  <b>DTAP</b> = 5,168  <b>Rate</b> = 40.04%  <b>IPV</b> = 6,983  <b>Rate</b> = 54.10%  <b>MMR</b> = 8,155  <b>Rate</b> = 63.18%  <b>HiB</b> = 7,291  <b>Rate</b> = 56.48%  <b>HEPB</b> = 3,552  <b>Rate</b> = 27.52%  <b>VZV</b> = 8,026  <b>Rate</b> = 62.18%  <b>PCV</b> = 5,273  <b>Rate</b> = 40.85%  <b>HEPA</b> = 7,540  <b>Rate</b> = 58.41%  <b>RV</b> = 4,805  <b>Rate</b> = 37.22%  <b>FLU</b> = 3,752  <b>Rate</b> = 29.07%</p>

Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
IMA	Immunization Status for Adolescents	Program Integrity	<b>Denominator</b> = 9,000 <b>Numerator 1</b> (Meningococcal) = 2,053 <b>Rate</b> = 22.81% <b>Numerator 2</b> (Tdap or TD) = 2,385 <b>Rate</b> = 26.50% <b>Numerator 3</b> (Combination 1 = 1,644 <b>Rate</b> = 18.27%	<b>Denominator</b> = 9,897 <b>Numerator 1</b> (Meningococcal) = 2464 <b>Rate</b> = 24.89% <b>Numerator 2</b> (Tdap or TD) = 2774 <b>Rate</b> = 28.02% <b>Numerator 3</b> (Combination 1) = 2012 <b>Rate</b> = 20.32
FPC	Frequency of Ongoing Prenatal Care	Member Services	<b>&lt;21 % of Expected Visits</b> <b>Numerator</b> = 438 <b>Denominator</b> = 12,401 <b>Rate</b> = 3.53% <b>21-40% of Expected Visits</b> <b>Numerator</b> = 2,399 <b>Denominator</b> , 12,401 <b>Rate</b> = 19.35% <b>41-60% of Expected Visits</b> <b>Numerator</b> = 2,727 <b>Denominator</b> = 12,401 <b>Rate</b> = 21.99% <b>61-80% of Expected Visits</b> <b>Numerator</b> = 1,880 <b>Denominator</b> = 12,401 <b>Rate</b> = 15.16% <b>≥ 81% of Expected Visits</b> <b>Numerator</b> = 3,558 <b>Denominator</b> = 12,401 <b>Rate</b> = 28.69	<b>&lt;21 % of Expected Visits</b> <b>Numerator</b> = 573 <b>Denominator</b> = 11,680 <b>Rate</b> = 4.91% <b>21-40% of Expected Visits</b> <b>Numerator</b> = 3211 <b>Denominator</b> = 11680 <b>Rate</b> = 27.49% <b>41-60% of Expected Visits</b> <b>Numerator</b> = 3089 <b>Denominator</b> = 11680 <b>Rate</b> = 26.45% <b>61-80% of Expected Visits</b> <b>Numerator</b> = 1683 <b>Denominator</b> = 11680 <b>Rate</b> = 14.41% <b>≥81% of Expected Visits</b> <b>Numerator</b> = 2458 <b>Denominator</b> = 11680 <b>Rate</b> = 21.04%
Clinical Care Clinical Care Clinical Care Clinical Care Clinical Care				
Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
PPC	Timeliness of Prenatal Care	Member Services	<b>Numerator</b> = 11,002 <b>Denominator</b> = 12,401 <b>Rate</b> = 88.72%	<b>Numerator</b> = 11,001 <b>Denominator</b> = 11,680 <b>Rate</b> = 94.19%
LBW	Live Births Weighing Less Than 2,500 Grams	IDPH	<b>Numerator</b> = 1,019 <b>Denominator</b> = 15,357 <b>Rate</b> = 6.6%	<b>Numerator</b> = 1,094 <b>Denominator</b> = 15,598 <b>Rate</b> = 7.0%
CSEC	Cesarean Rate for Nulliparous Singleton Vertex	IDPH	<b>Numerator</b> = 2,359 <b>Denominator</b> = 8,483 <b>Rate</b> = 27.8%	<b>Numerator</b> = 2510 <b>Denominator</b> = 8702 <b>Rate</b> = 28.8%
BHRA	Behavioral Health Risk Assessment (for Pregnant Women)		New Measure for 2013 Reporting Year	Not Reporting in 2013

Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
DEV	Developmental Screening In the First Three Years of Life	Program Integrity	Not reported due to need for hybrid method	<b>Ages 0-1</b> <b>Numerator 1</b> = 132 <b>Denominator 1</b> = 137 <b>Rate 1</b> = 96.4% <b>Ages 1-2</b> <b>Numerator 2</b> = 104 <b>Denominator 2</b> = 137 <b>Rate 2</b> = 75.9% <b>Ages 2-3</b> <b>Numerator 3</b> = 89 <b>Denominator 3</b> = 137 <b>Rate 3</b> = 65.7% <b>Combined</b> <b>Numerator 4</b> = 326 <b>Denominator 4</b> = 411 <b>Rate 4</b> = 79.3%
PA1C	Annual Pediatric Hemoglobin A1C Testing	Member Services	<b>Numerator</b> = 360 <b>Denominator</b> = 431 <b>Rate</b> = 83.53%	<b>Numerator</b> = 382 <b>Denominator</b> = 479 <b>Rate</b> = 79.75%
W15	Well-Child Visits in the First 15 Months of Life	Program Integrity	<b>Denominator</b> = 18,508 <b>Numerator 1 (0 visits)</b> = 1,122 / 6.1% <b>Numerator 2 (1 visit)</b> = 607 / 3.3% <b>Numerator 3 (2 visits)</b> = 846 / 4.6% <b>Numerator 4 (3 visits)</b> = 1,162 / 6.3% <b>Numerator 5 (4 visits)</b> = 1,645 / 8.9% <b>Numerator 6 (5 visits)</b> = 2,491 / 13.5% <b>Numerator 7 (≥ 6 visits)</b> = 10,635 / 57.5%	<b>Denominator</b> = 14,076 <b>Numerator 1 (0 visits)</b> = 614 / 4.4% <b>Numerator 2 (1 visit)</b> = 570 / 4.0% <b>Numerator 3 (2 visits)</b> = 713 / 5.1% <b>Numerator 4 (3 visits)</b> = 1,176 / 8.4% <b>Numerator 5 (4 visits)</b> = 2,190 / 15.6% <b>Numerator 6 (5 visits)</b> = 4,661 / 33.1% <b>Numerator 7 (≥ 6 visits)</b> = 4,152 / 29.5%
W34	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Program Integrity	<b>Numerator</b> = 31,166 <b>Denominator</b> = 54,396 <b>Rate</b> = 57.3%	<b>Numerator</b> = 35,129 <b>Denominator</b> = 55,890 <b>Rate</b> = 62.9%
AWC	Adolescent Well-Care Visit	Program Integrity	<b>Numerator</b> = 21,678 <b>Denominator</b> = 79,346 <b>Rate</b> = 27.3%	<b>Numerator</b> = 27,211 <b>Denominator</b> = 82,035 <b>Rate</b> = 33.2%
CHL	Chlamydia Screening in Women	Program Integrity	<b>Denominator</b> Total number of eligible members = 14,501 (continuous enrollment, sexually active, not excluded) <b>Numerator</b> Total number of screened members = 6,498 <b>Rate</b> = 44.8%	<b>Denominator</b> Total number of eligible members = 21,207 (continuous enrollment, sexually active, not excluded) <b>Numerator</b> Total number of screened members = 6,085 <b>Rate</b> = 28.7%

Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
PIDENT	Percentage Of Eligibles That Received Preventive Dental Services	CORE (416 Report)	Not reported due to instructions in 12/6/12 webinar.	To be reported from the EPSDT 416 Report in March 2014.
TDENT	Percentage Of Eligibles That Received Dental Treatment Services	CORE (416 Report)	Not reported due to instructions in 12/6/12 webinar.	To be reported from the EPSDT 416 Report in March 2014.
MMA	Medication Management for People with Asthma	Member Services	New Measure for 2013 Reporting Year	<p><b>Frequency of denominator age stratifications</b>  <b>5 - 11</b> = 6,063  <b>12 - 18</b> = 4,413  <b>19 - 20</b> = 578  <b>Total</b> = 11,054</p> <p><b>Percent on asthma controller medication at least 50 percent of treatment period</b></p> <p><b>Ages 5 - 11</b>  <b>Rate</b> = 37.64%  <b>Numerator</b> = 2,282  <b>Denominator</b> = 6,063</p> <p><b>Ages 12 - 18</b>  <b>Rate</b> = 29.07%  <b>Numerator</b> = 1,283  <b>Denominator</b> = 4,413</p> <p><b>Ages 19 - 20</b>  <b>Rate</b> = 23.53%  <b>Numerator</b> = 136  <b>Denominator</b> = 578</p> <p><b>Total</b>  <b>Rate</b> = 33.48%  <b>Numerator</b> = 3,701  <b>Denominator</b> = 11,054</p> <p><b>Percent on asthma controlled medication at least 75 percent of treatment period</b></p> <p><b>Ages 5 - 11</b>  <b>Rate</b> = 23.62%  <b>Numerator</b> = 1,432  <b>Denominator</b> = 6,063</p> <p><b>Ages 12-18</b>  <b>Rate</b> = 18.04%  <b>Numerator</b> = 796  <b>Denominator</b> = 4,413</p> <p><b>Ages 19 - 20</b>  <b>Rate</b> = 20.96%  <b>Numerator</b> = 2,317  <b>Denominator</b> = 11,054</p>

Care Coordination				
Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
FUH	Follow-Up After Hospitalization for Mental Illness	Magellan	<b>7-day Rate</b> = 69.3% <b>30-day Rate</b> = 79.2%	<b>7-day Rate</b> = 67.6% <b>30-day Rate</b> = 78.4%
ADD	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	Magellan and Medical Services	<b>Rate 1 - Initiation Phase</b> <b>Rate</b> = 45.31% <b>Numerator</b> = 4,011 <b>Denominator</b> = 8,852  <b>Rate 2 - Continuation &amp; Maintenance</b> <b>Rate</b> = 73.76% <b>Numerator</b> = 7,568 <b>Denominator</b> = 10,260	<b>Rate 1 - Initiation Phase</b> <b>Rate</b> = 51.78% <b>Numerator</b> = 2712 <b>Denominator</b> = 5237  <b>Rate 2 - Continuation &amp; Maintenance</b> <b>Rate</b> = 43.10% <b>Numerator</b> = 3816 <b>Denominator</b> = 8853
Safety				
Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
CLABSI	Pediatric Central Line-Associated Blood Stream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	Program Integrity	Not reported due to cases < 30 (4 cases).	Not reporting due to cases < 30 (5 cases).
Efficiency and Cost Reduction				
Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
CWP	Appropriate Testing for Children with Pharyngitis	Medical Services	<b>Numerator</b> = 1,123 <b>Denominator</b> = 5,003 <b>Rate</b> = 22.4%	<b>Numerator</b> = 7,996 <b>Denominator</b> = 16,302 <b>Rate</b> = 49.0%
ASMER	Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits	Medical Services	<b>Numerator</b> = 2410 <b>Denominator</b> = 48,189 <b>Rate</b> = 5%	<b>Numerator</b> = 2,912 <b>Denominator</b> = 20,638 <b>Rate</b> = 14.1%

Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
AMB	Ambulatory Care – Emergency Department (ED) Visits	Medical Services	<b>Age/ Member months</b> <1 yr = 76,952 1-9 yrs = 1,299,392 10-19 yrs = 1,188,736 Total = 2,565,080  <b>Age / ED visits /ED visits per 1000 Member months</b> <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	<b>Age/Member months</b> <1 = 235,543 1-9 = 1,670,129 10-19 = 1,312,094 Total = 3,217,766  <b>Age/ED Visits/ED visits per month per 1000 Member months</b> <1 = 24,585 visits; 104.4 1-9 = 85,669 visits; 51.3 10-19 = 56,881 visits; 43.4 Total = 167,135 visits; 51.9
<b>Person and Caregiver Centered Experience</b>				
Measure Acronym	Title	Measure Collection 2013	2012 Reporting Year Results	2013 Reporting Year Results
CPC	Consumer Assessment of Healthcare Providers and Systems® (CAHPS) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)	Public Policy Center	Not reported. Measure required the CAHPS Health Plan Survey 4.0H but for Iowa, the 2011 report 4.0 will be the only one available was only available.	Completed by the Public Policy Center at the University of Iowa.

## Performance Improvement Process

In the 2011 reporting, states were afforded the opportunity to elect to engage in a PIP or action plan with the goal of improving care as evidenced by improved measures. As part of the submission process, CMS inquired after each measure within the CARTS tool, “What quality improvement activities that involve the Medicaid and/or CHIP program and benefit Medicaid and/or CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?” In 2011, Iowa Medicaid identified several quality improvement plans when the data was reported via the CARTS tool.

The 2012 CARTS tool did not contain the fields this year to report the explanation of progress towards the goals. An IME Action Plan Group met on March 6, 2013, to review the 2012 CHIPRA results and determine an action plan for future reporting of the measures. The group consisted of representatives from *hawk-i*, Medical Services, Member Services, Policy, Program Integrity, and Provider Services. It was determined that IME would not map out an action plan on any of the measures at that time. Instead, IME would continue to gather the data for at least two more years to establish a baseline and trend of the measure outcomes. After two years additional years of collecting data, it is anticipated a group will be formed to analyze the information and develop action plans accordingly.

The 2013 CARTS tool also did not contain the fields to report the explanation of progress towards identified goals. The IME CHIPRA Action Plan Group met to discuss the 2013 reporting year results on January 8, 2014, to identify any performance improvement projects to implement in 2014 based on the results. The IME Action Plan Group decided to monitor several measures for improvement as a result of the initiatives implemented by the health homes. It was also decided that a future MVM study would be done regarding the ADD measure “Follow-up Care for Children Prescribed ADHD Medication” due to significant changes in the results for this measure from the previous year. This MVM study will include medical record review that will be conducted by the Medical Necessity team of Program Integrity.

## Summary of 2013 Reporting Year Results

- A total of 24 measures will be reported for the 2013 reporting year.
  - Two of the three new measures for the 2013 reporting year were completed. The results of these measures, Human Papillomavirus (HPV) and Medication Management for People with Asthma (MMA), will provide a baseline data to compare future years' reporting.
    - Improvement may be seen in future years regarding the MMA measure as a result of a quality improvement project for the adult quality measures.
  - Two measures will be collected by CMS in March from the CMS 416 report, also referred to as the EPSDT report. These two measures will be the Total Eligibles Who Receive Preventive Dental Services (PDENT) and the Total Eligibles Who Received Dental Treatment Services (TDENT).
- The Behavioral Health Risk Assessment for pregnant women (BHRA) was not collected or reported on for the 2013 reporting year. This measure, which was new for 2013, is designed to collect information from the electronic health record (EHR).
  - It is anticipated the Iowa Health Information Network (IHIN) may include sufficient information to allow for reporting in the 2014 reporting year.
- The results of the Central Line -Associated Blood Stream Infection (CLABSI) measure was not reported to CMS for the 2013 reporting year due to the number of cases being less than 30. The minimum for reporting as defined by the technical specifications for the CHIPRA measures.
  - A chart review of the five cases was completed by the Program Integrity, Medical Necessity team. The outcome of these chart reviews are included in a MVM study completed concurrent with this study.
- A significant change was noted in both components of the measure regarding "Follow-Up Care for Children Prescribed ADHD Medication" (ADD) from the previous reporting year. The cause for the change is unknown.
  - As a result Program Integrity will look at member specific claims data and medical records to determine if changes in prescribing patterns following AAP recommendations may have contributed to the difference in results from the previous reporting year.
- All other measures reported nominal fluctuations from the previous year.
- It is anticipated MVM will be able to begin trending results for specific measures as IME enters into the fourth year of CHIPRA reporting.
  - This may be hindered if significant changes are made to the technical specifications for these measures in future years.

## Recommendations

- **Assigned responsibility of data collected for measures previously reported** should continue to be collected by the unit responsible for data collection in the 2014 reporting year.
- **Assign responsibility of measure(s) not previously reported** by end of 4<sup>th</sup> Qtr, SFY14.
- **Program Integrity, Medical Necessity Team to complete record review for hybrid measures** in 1<sup>st</sup> Qtr SFY14.
- **Program Integrity, Medical Necessity to provide chart review for ADD measure** to inform future MVM regarding this quality measure.
- **Conduct a MVM study regarding the ADD measure** due to concerns regarding the change results from the previous year.
- **Continue to monitor future results** for trends.

## References

- Medicaid-CHIP Program Information. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIPRA.html>
- The Department of Health and Human Services Children's Health Insurance Program Reauthorization Act 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP.
- CMS, Initial Core Set of Children's Health Care Quality Measures: Technical Specifications and Resource Manual for Federal Fiscal Year 2013 Reporting, Updated May 2013. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf>

## Medicaid Value Management (MVM)

Iowa Medicaid Enterprise  
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Phone: 877-446-3787  
Fax: 515-725-1354

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



January 2014

Inpatient Quality Indicators

2nd Qtr, SFY14

### Points of interest:

- Iowa Medicaid performed better than the national comparison in 10 IQI measures.
- For the first time since 2007, Iowa Medicaid had zero occurrences of mortalities associated with gastrointestinal hemorrhage.

### Inside this report

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Iowa's Successful Initiatives	15
Recommendations	16

## 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.

These indicators were developed at Stanford University and the University of California through a contract with AHRQ. With 32 measures in all, the IQIs provide the opportunity to evaluate the quality of care during inpatient hospitalizations related to specific concerns.

This is the analysis of Iowa Medicaid claims data from state calendar year 2012.

The IQIs are a set of measures that provide an insight into hospital quality of care using hospital administrative data.

“These indicators reflect quality of care inside hospitals and include inpatient mortality for certain procedures and medical conditions; utilization of procedures for which there are questions of overuse, underuse, and misuse; and volume of procedures for which there is some evidence that a higher volume of procedures is associated with lower mor-

tality.

The IQIs can be used to help hospitals identify potential problem areas that might need further study; provide the opportunity to assess quality of care inside the hospital using administrative data found in the typical discharge record; include mortality indicators for conditions or procedures for which mortality can vary from hospital to hospital; include utilization indicators for procedures for which utilization varies across hospitals or geographic areas; and, include volume indicators for procedures for which outcomes may be related to the volume of those procedures performed.” (AHRQ, 2012)

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 SFY12 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 per-

cent confidence interval, it will be noted for the respective measure.

Iowa Medicaid reported zero occurrence for the following IQI measures:

- IQI #8 Esophageal Resection Mortality Rate
- IQI #9 Pancreatic Resection Mortality Rate
- IQI #18 Gastrointestinal Hemorrhage Mortality Rate
- IQI #19 Hip Fracture Mortality Rate
- IQI #24 Incidental Appendectomy in the Elderly Rate
- IQI #31 Carotic Endarterectomy Mortality Rate

Measures one through seven are volume measures and do not have a comparison rate available. 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.

Low volume size resulted in an elevated rate for Iowa Medicaid for two measures.

- IQI #11 Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate--two mortalities were reported out of ten procedures billed to Iowa Medicaid.
- IQI #14 Hip Replacement Mortality Rate--one mortality was reported out of 120 procedures billed to Iowa Medicaid.

## Inpatient Quality Indicators (IQIs)

Indicator	IME Volume
#1 Esophageal Resection Volume	3
#2 Pancreatic Resection Volume	5
#4 Abdominal Aortic Aneurysm Repair (AAA) Volume	10
#5 Coronary Artery Bypass Graft (CABG) Volume	96
#6 Percutaneous Transluminal Coronary Angioplasty (PTCA) Volume	294
#7 Carotid Endarterectomy (CEA) Volume	36

Indicator	Iowa Medicaid Numerator	Iowa Medicaid Denominator	Iowa Medicaid Rate per 100,000	Iowa Medicaid 95% CI Indicator	Observed (comparison) Rate per 100,000
#8 Esophageal Resection Mortality Rate	0	2	0.00	0 - 0	4,851.20
#9 Pancreatic Resection Mortality Rate	0	2	0.00	0 - 0	4,050.90
#11 Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate	2	10	20,000.00	0 - 44,792	3,945.70
#12 Coronary Artery Bypass Graft (CABG) Mortality Rate	2	89	2,247.00	0 - 5,326	2,049.20
#13 Craniotomy Mortality Rate	7	124	5,645.00	1,582 - 9,707	4,148.10
#14 Hip Replacement Mortality Rate	1	120	833.00	0 - 2,459	7,950.00
#15 Acute Myocardial Infarction (AMI) Mortality Rate	1	287	4,059.00	1,524 - 6,593	5,144.10
#16 Heart Failure Mortality Rate	8	372	2,150.00	676 - 3,624	2,243.60
#17 Acute Stroke Mortality Rate	17	172	9,883.00	5,423 - 14,343	7,710.90

Indicator		Iowa Medicaid Numerator	Iowa Medicaid Denominator	Iowa Medicaid Rate per 100,000	Iowa Medicaid 95% CI Indicator	Observed (comparison) Rate per 100,000
#18	Gastrointestinal Hemorrhage Mortality Rate	0	59	0.00	0 - 0	1,746.80
#19	Hip Fracture Mortality Rate	0	2	0.00	0 - 0	2,161.00
#20	Pneumonia Mortality Rate	10	534	1,872.00	722 - 3,022	2,722.70
#21	Cesarean Delivery Rate, Uncomplicated	3,631	13,249	27,405.00	26,646 - 28,165	29,502.00
#22	Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated	195	2,118	9,206.00	7,975 - 10,438	9,622.40
#23	Laparoscopic Cholecystectomy Rate	245	275	89,010.00	85,117 - 92,904	83,572.10
#24	Incidental Appendectomy in the Elderly Rate	0	10	0.00	0 - 0	1,024.30
#25	Bilateral Cardiac Catheterization Rate	2	456	438.00	0 - 1,045	1,400.00
#26	CABG Rate	94	1,494,658	6.29	5.02 - 7.56	146.85
#27	PTCA Rate	273	1,494,658	18.27	16.10 - 20.43	374.95
#28	Hysterectomy Rate	223	1,196,199	18.64	16.20 - 21.09	315.10
#29	Laminectomy Rate	421	2,350,647	17.91	16.20 - 19.62	282.60
#30	Percutaneous Coronary Intervention (PCI) Mortality Rate	1	253	1,423.00	0 - 2,986	1,213.80
#31	Carotid Endarterectomy Mortality Rate	0	36	0.00	0 - 0	360.70
#32	Acute Myocardial Infarction (AMI) Mortality Rate, Without Transfer Cases	1	169	591.00	0 - 1,748	5,488.00
#33	Primary Cesarean Delivery Rate, Uncomplicated	1708	11,131	15,344.00	14,674 - 16,014	17,704.00
#34	VBAC Rate, All	225	2,356	9,550.00	8,363 - 10,736	9,542.10

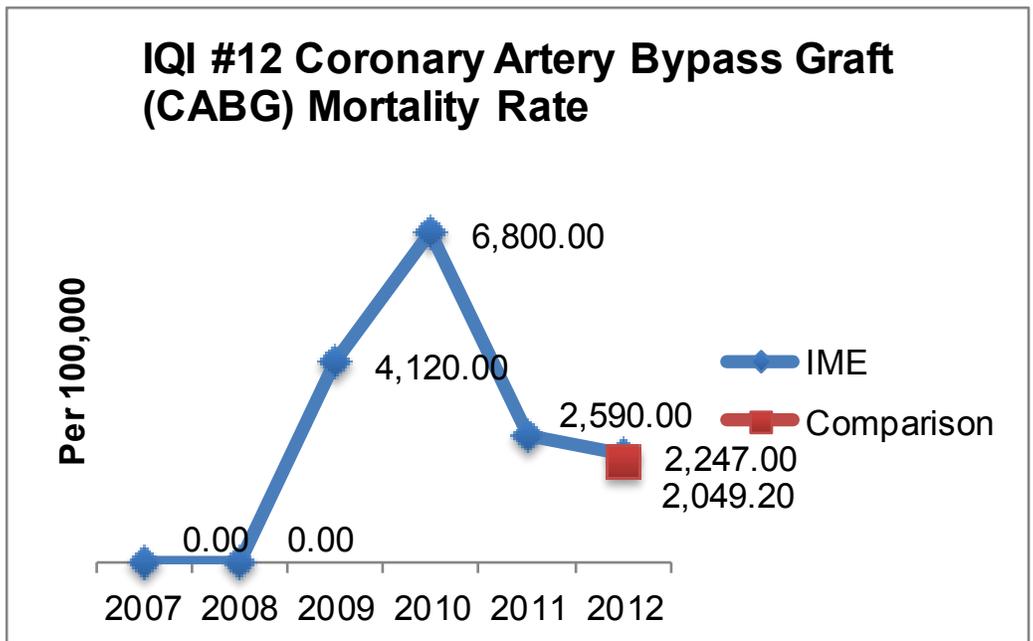
### IQI #12 Coronary Artery Bypass Graft (CABG) Mortality

This measure identifies in-hospital death discharges with coronary artery bypass graft (CABG) in persons aged 40 years and older. Obstetric discharges and transfers to another hospital were excluded. (AHRQ, 2012)

The results of CABG usually are excellent. The surgery improves or completely relieves angina symptoms in most patients. Although symptoms can recur, many people remain symptom-free for as long as 10 to 15 years. CABG also may lower your risk of having a heart attack and help you live longer.

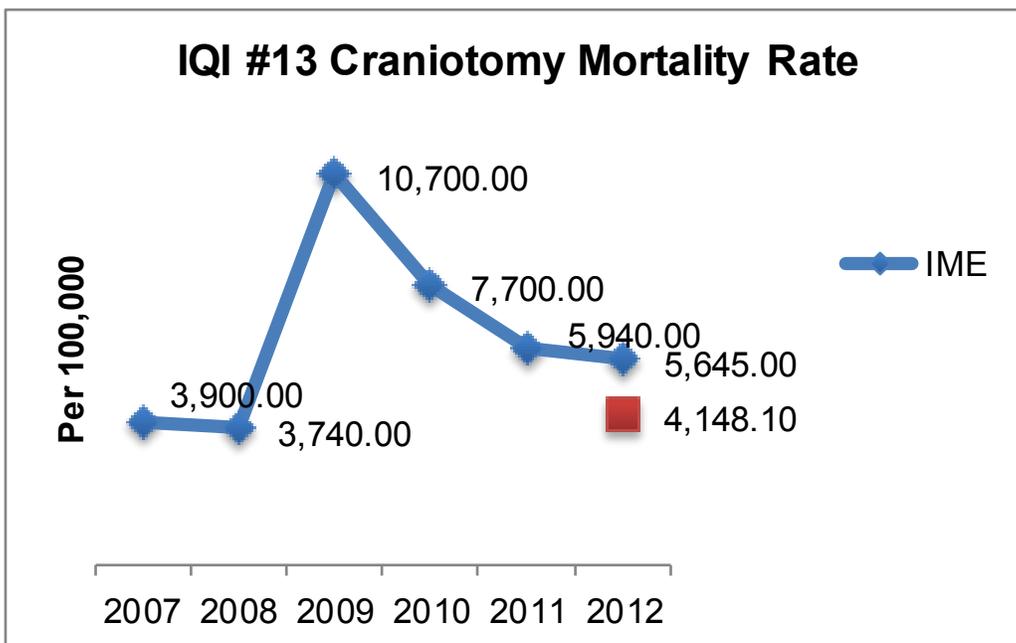
Ongoing studies are comparing the treatment results of angioplasty (PTCA) versus bypass (CABG surgery) in patients who are candidates for either procedure. Both procedures are very effective in reducing angina symptoms, preventing heart attacks, and reducing death. Many studies have either shown similar benefits or slight advantage to CABG (primarily in severe diabetics), although current studies are evaluating the two procedures utilizing the most current improved techniques (for example, newer "medicated" stents and the off-pump CABG); this data is still being collected. The best choice for an individual patient is best made by their cardiologist, surgeon, and primary doctor. (National Heart, Lung & Blood Institute of Health, 2013)

\* IME CI for this indicator is 0 - 5,326 per 100,000 population.

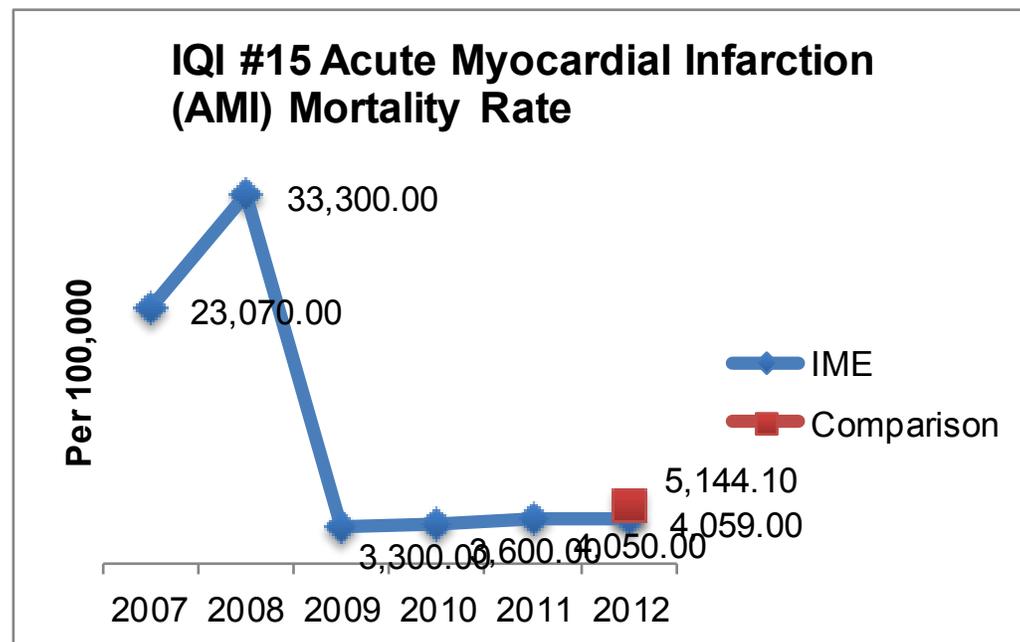


### IQI #13 Craniotomy Mortality Rate

This measure identifies in-hospital death discharges with craniotomy for persons aged 18 years and older. Patients with a principal diagnosis of head trauma, obstetric discharges and transfers to another hospital were excluded. (AHRQ, 2012)



\* IME CI for this indicator is 1,582 - 9,707 per 100,000 population.



### IQI #15 Acute Myocardial Infarction (AMI) Mortality Rate

This measure identifies in-hospital death discharges with acute myocardial infarction (AMI) as a principal diagnosis for persons aged 18 years and older. Obstetric discharges and transfers to another hospital were excluded. (AHRQ, 2012)

AMI remains a leading cause of morbidity and

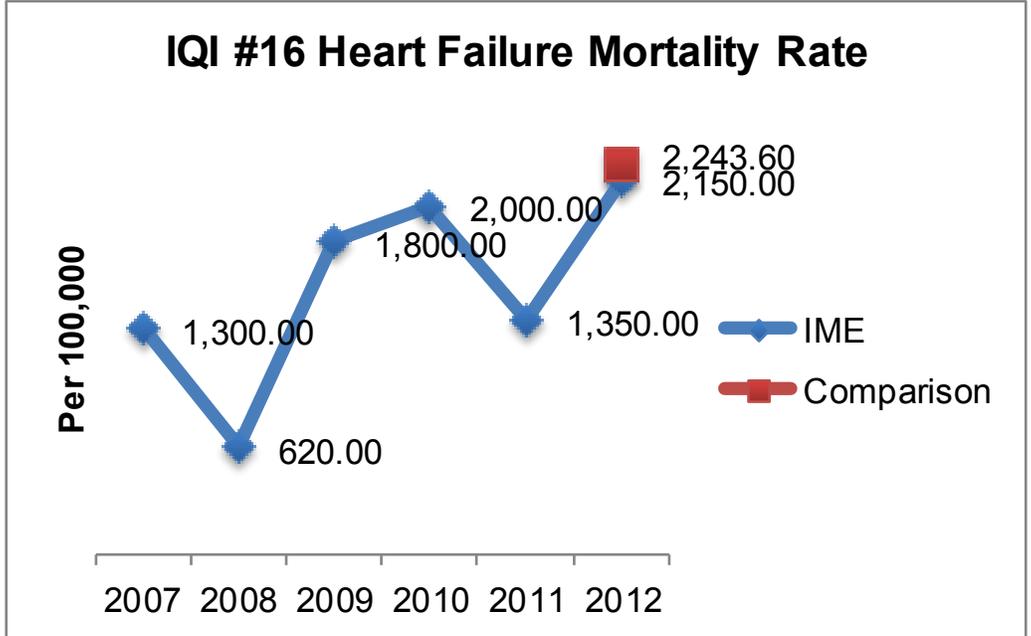
mortality worldwide. Patients with diabetes have a substantially greater risk of atherosclerotic vascular disease in the heart as well as in other vascular beds. Diabetes increases the risk of MI because it increases the rate of atherosclerotic progression and adversely affects the lipid profile. This accelerated form of atherosclerosis occurs regardless of whether a patient has insulin-dependent or non-insulin-dependent diabetes. (Cleveland Clinic, 2013)

\* IME CI for this indicator is 1,524 - 6,593 per 100,000 population.

**IQI #16 Heart Failure Mortality Rate**

This measure identifies in-hospital death discharges with a principal diagnosis of heart failure for persons aged 18 years and older. Obstetric discharges and transfers to another hospital were excluded. (AHRQ, 2012)

The best way to prevent heart failure is to control conditions that cause heart failure, such as coronary artery disease, high blood pressure, diabetes or obesity. (Mayo Clinic, 2013)



\* IME CI for this indicator is 676 - 3,624 per 100,000 population.

**IQI #17 Acute Stroke Mortality Rate**

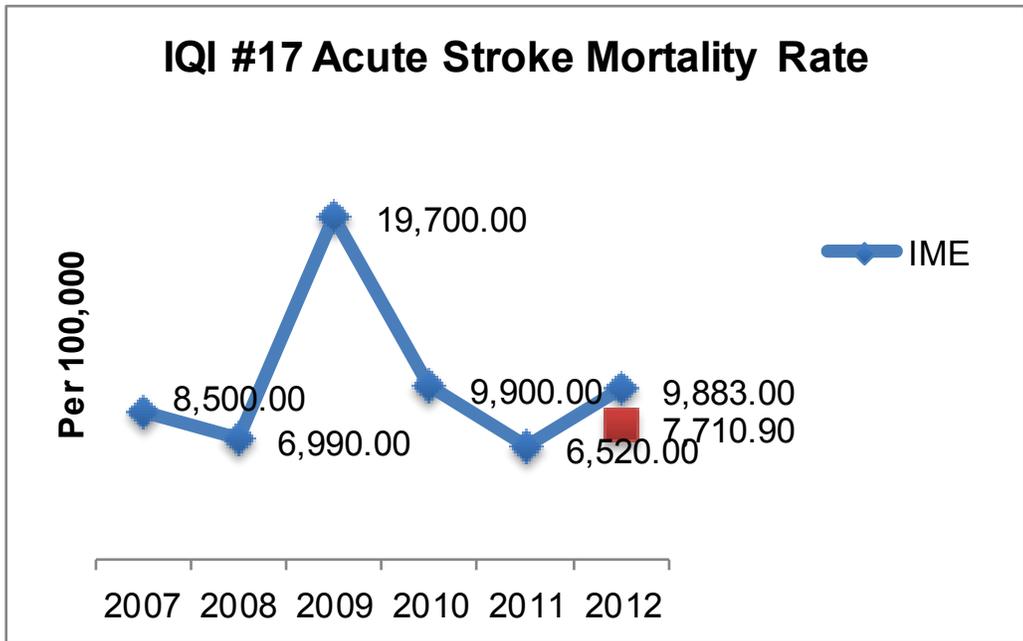
**IQI #17 Acute Stroke Mortality Rate**

This measure identifies in-hospital death discharges with a principal diagnosis of acute stroke for persons aged 18 years and older. Obstetric discharges and transfers to another hospital were excluded. (AHRQ, 2012)

Stroke is most commonly caused by uncontrolled hypertension. Hypertension is a chronic condition

of elevated blood pressure that seldom requires hospitalization; however left untreated or uncontrolled may lead to serious complications such as stroke or death.

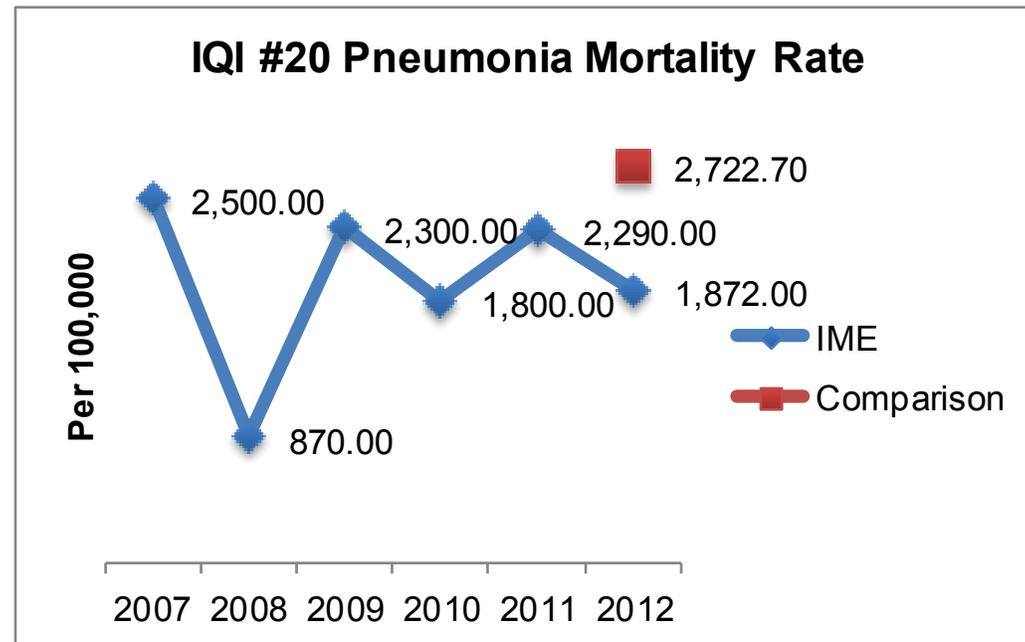
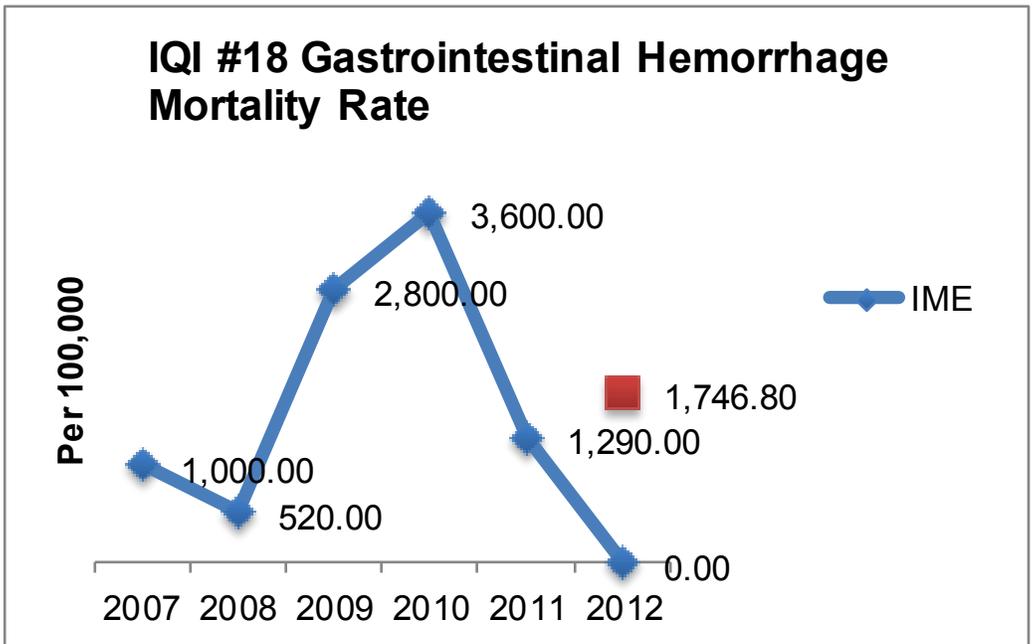
\* IME CI for this indicator is 5,423 - 14,343 per 100,000 population.



**IQI #18 Gastrointestinal Hemorrhage Mortality Rate**

This measure identifies in-hospital death discharges with gastrointestinal hemorrhage as a principal diagnosis for persons aged 18 years and older. Obstetric discharges and transfers to another hospital were excluded. (AHRQ, 2012)

IME did not have any mortalities associated with gastrointestinal hemorrhage in 2012.



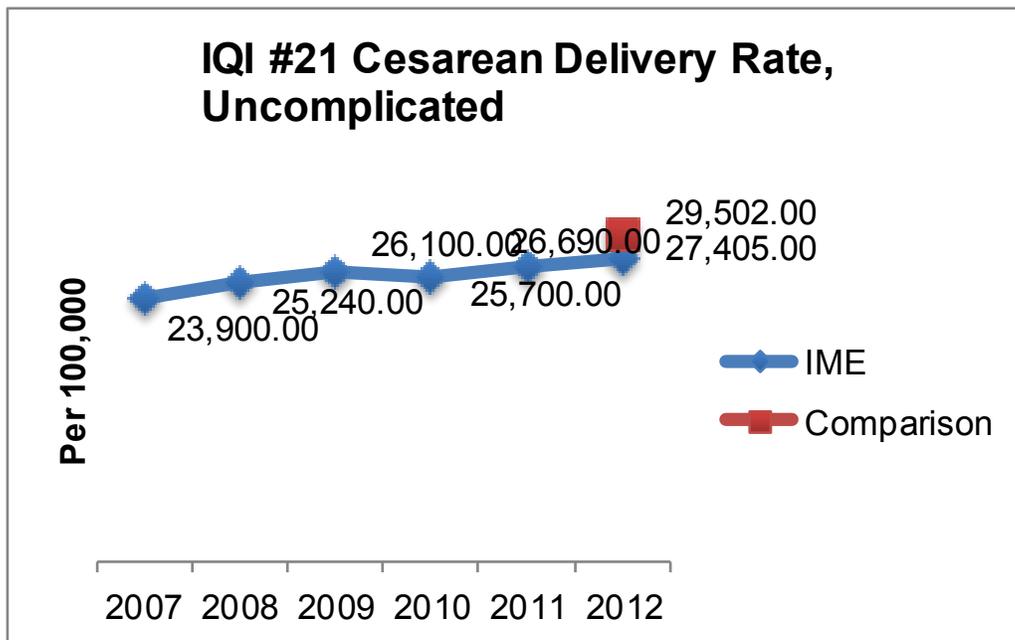
**IQI # 20 Pneumonia Mortality Rate**

This measure identifies in-hospital death discharges with a principal diagnosis of pneumonia for persons aged 18 years and older. Obstetric discharges and transfers to another hospital were excluded. (AHRQ, 2012)

\* IME CI for this indicator is 722 - 3,022 per 100,000 population.

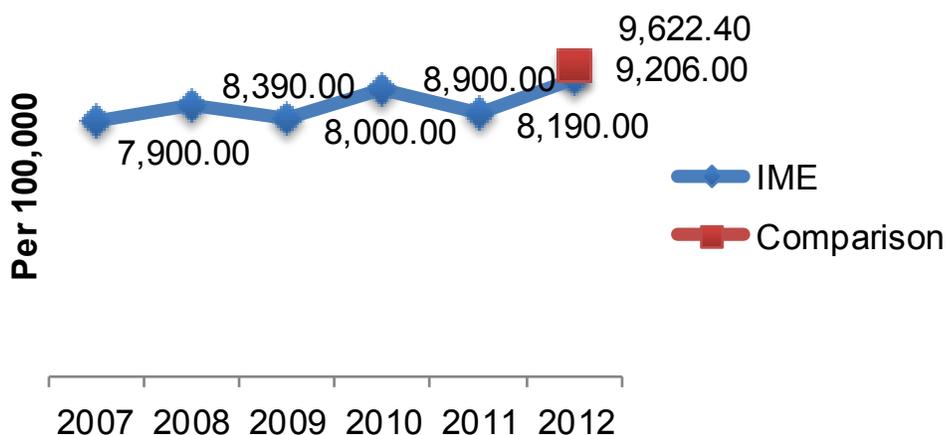
### IQI #21 Cesarean Delivery Rate, Uncomplicated

This measure identifies cesarean deliveries without a hysterectomy procedure. Deliveries with complications such as abnormal presentation, preterm delivery, fetal death, multiple gestation diagnoses, or a breech presentation were excluded. (AHRQ, 2012)



\* IME CI for this indicator is 26,646 - 28,165 per 100,000 population.

### IQI #22 Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated



### IQI #22 Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated

This measure identifies vaginal births by persons who have had previous cesarean deliveries. Deliveries with complications such as abnormal presentation, preterm delivery, fetal death, multiple gestation diagnoses, or a breech presentation were excluded. (AHRQ, 2012)

\* IME CI for this indicator is 7,975 - 10,438 per 100,000 population.

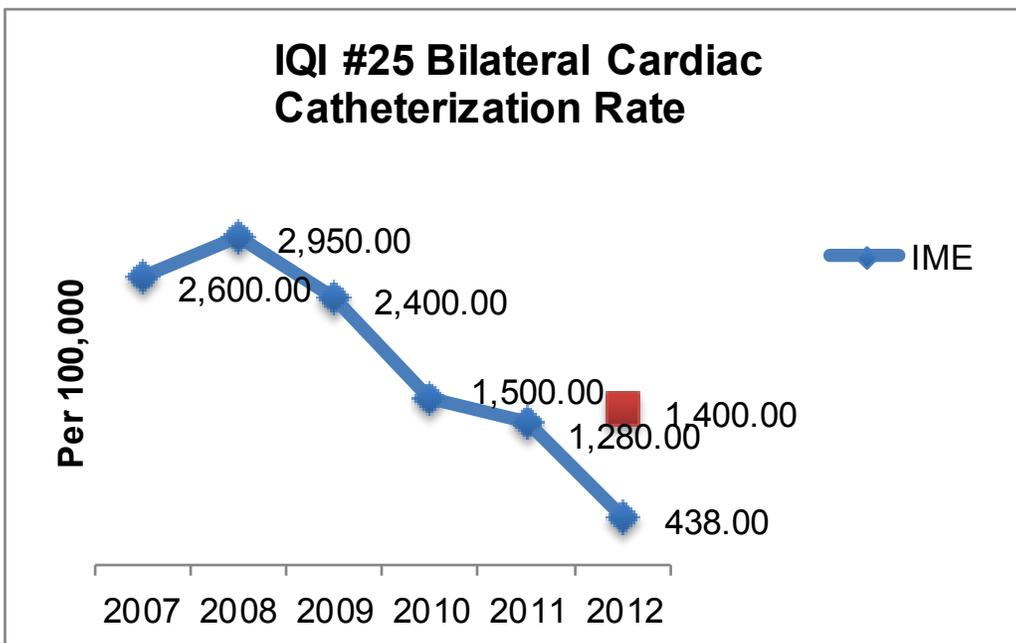
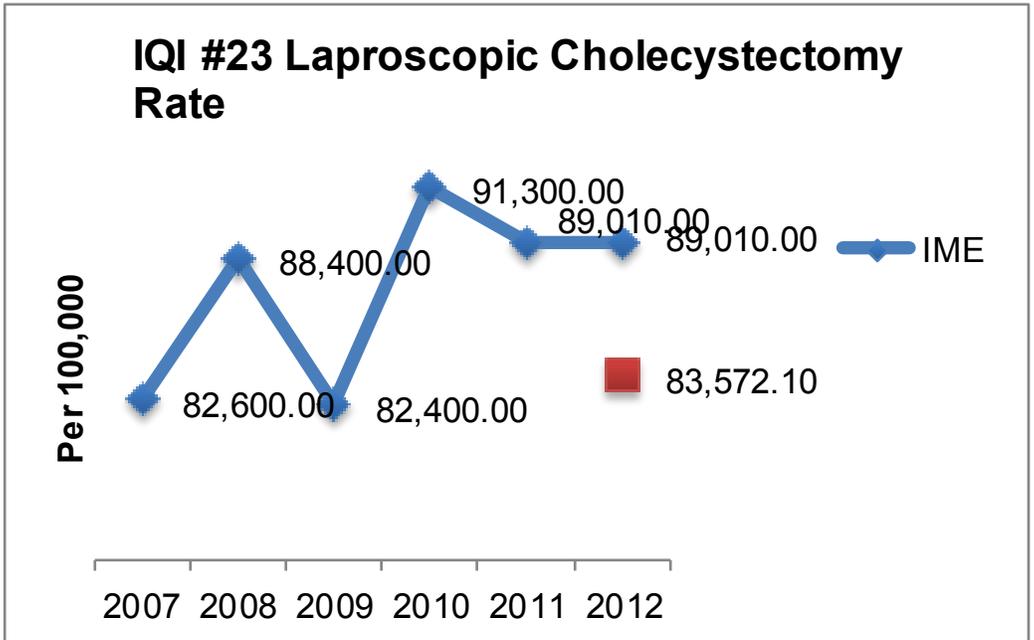
### IQI #23 Laparoscopic Cholecystectomy Rate

This measure identifies discharges for laparoscopic cholecystectomy for persons aged 18 years or older with a diagnosis of cholecystitis and/or cholelithiasis. Obstetric discharges were excluded. (AHRQ, 2012)

Cholecystitis is inflammation of the gallbladder. 95 percent of cholecystitis cases are caused by

gallstones which are formed by cholesterol and bilirubin in bile, often referred to as “biliary sludge.” This bile is necessary to aid in the digestion of fats. When stones are present the ability of the body to digest fats is impeded by the blockage of the necessary ducts, which results in pain and discomfort. A cholecystectomy is the surgical removal of the gallbladder. (Medical News Today, 2009)

\* IME CI for this indicator is 85,117 - 92,904 per 100,000 population.



### IQI #25 Bilateral Cardiac Catheterization Rate

This measure identifies hospital discharges for bilateral cardiac catheterization for persons aged 18 years and older with a diagnosis of coronary artery disease. Valid indications for right side catheterization, such as acute rheumatic pericarditis, mitral or aortic stenosis, myocarditis, etc., and obstetric discharges were excluded. (AHRQ, 2012)

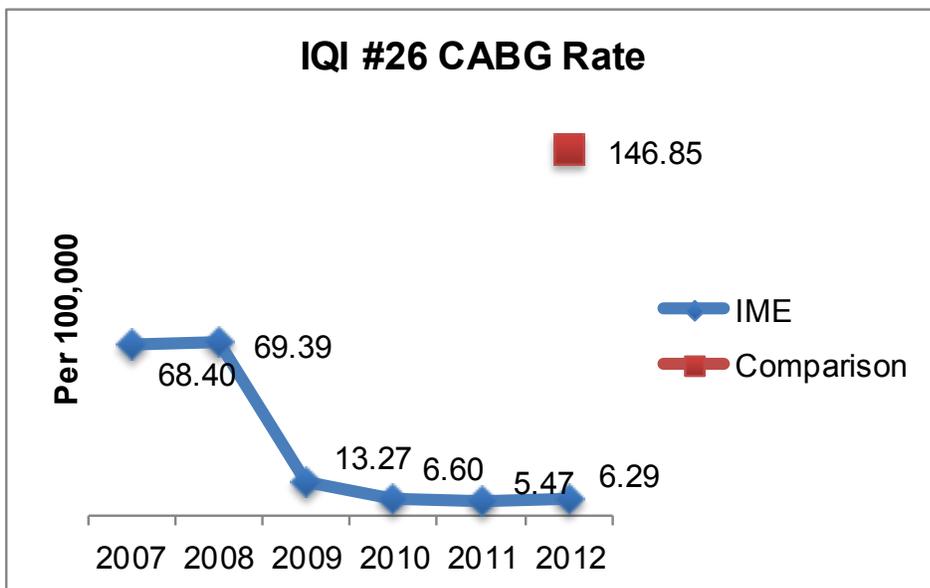
Cardiac catheterizations are usually only done on the left side of the heart. Cardiac catheterizations on the right-side of the heart provide little additional benefit to the patient unless other conditions are present to necessitate a right-sided catheterization, such as hypertension, right-sided valve abnormalities and congenital heart disease. (Northwestern Memorial Hospital, 2013). In this measure, a rate lower than the comparison may be indicative of more appropriate care being provided.

\* IME CI for this indicator is 0 - 1,045 per 100,000 population.

### IQI #26 Coronary Artery Bypass Graft (CABG) Rate

This measure identifies hospital discharges for coronary artery bypass graft for persons aged 40 years and older. (AHRQ, 2012)

A lower rate in this measure may indicate more appropriate selection of patients to benefit from this procedure.

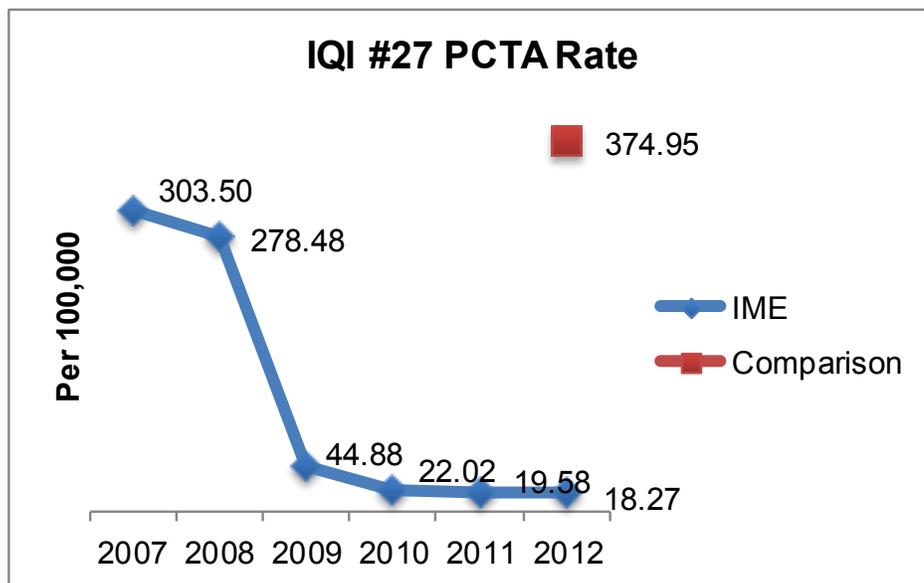


\* IME CI for this indicator is 5.02 - 7.56 per 100,000 population.

### IQI #27 Percutaneous Coronary Intervention (PCI) Rate

This measure identifies hospital discharges for percutaneous coronary intervention for persons aged 40 years and older. (AHRQ, 2012)

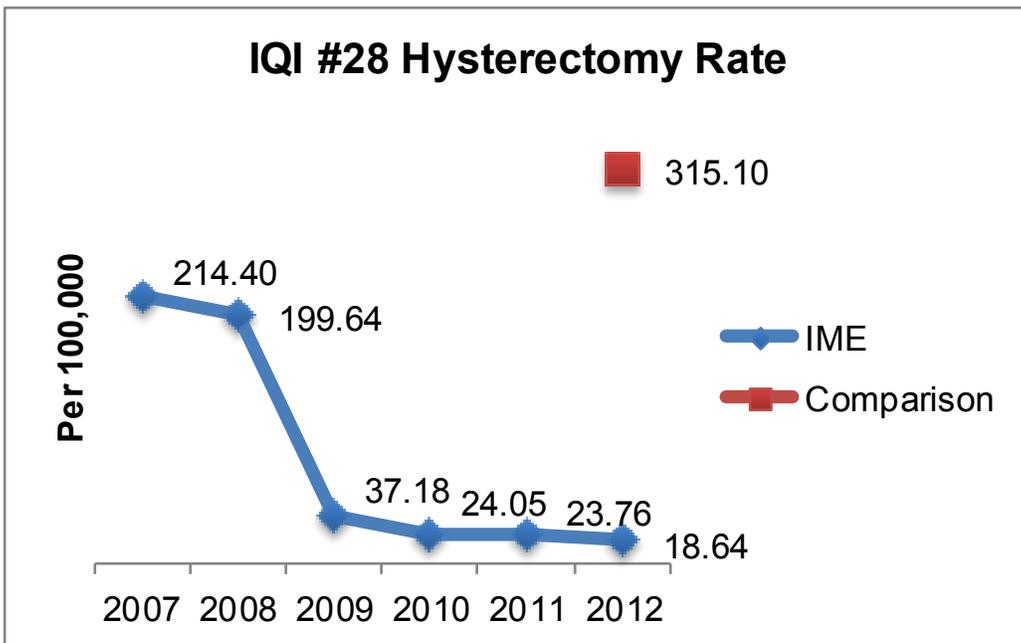
A lower rate in this measure may indicate more appropriate selection of patients to benefit from this procedure.



\* IME CI for this indicator is 16.10 - 20.43 per 100,000 population.

### IQI #28 Hysterectomy Rate

This measure identifies hysterectomy hospital discharges procedures for females aged 18 years and older. Genital cancer discharges, pelvic or lower-abdominal trauma discharges and obstetric discharges were excluded. (AHRQ, 2012)



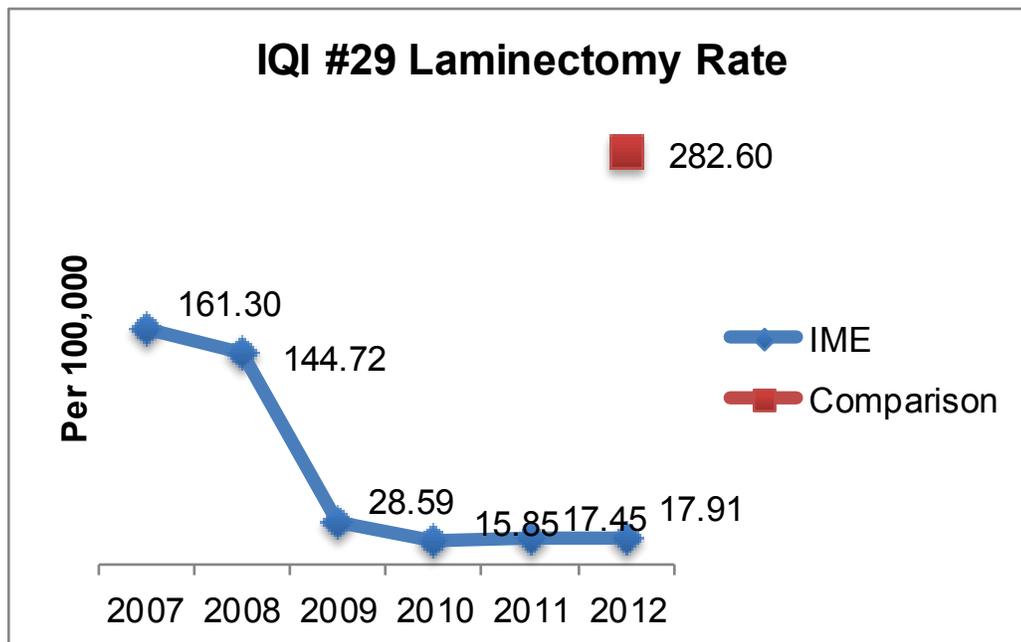
\* IME CI for this indicator is 16.20 - 19.62 per 100,000 population.

### IQI #29 Laminectomy Rate

### IQI #29 Laminectomy or Spinal Fusion Rate

This measure identifies laminectomies or spinal fusion discharges for persons aged 18 years and older. Obstetric discharges were excluded. (AHRQ, 2012)

Surgical treatment of back pain is not a first line treatment. A lower rate would represent greater success in treating pain with more conservative treatments.

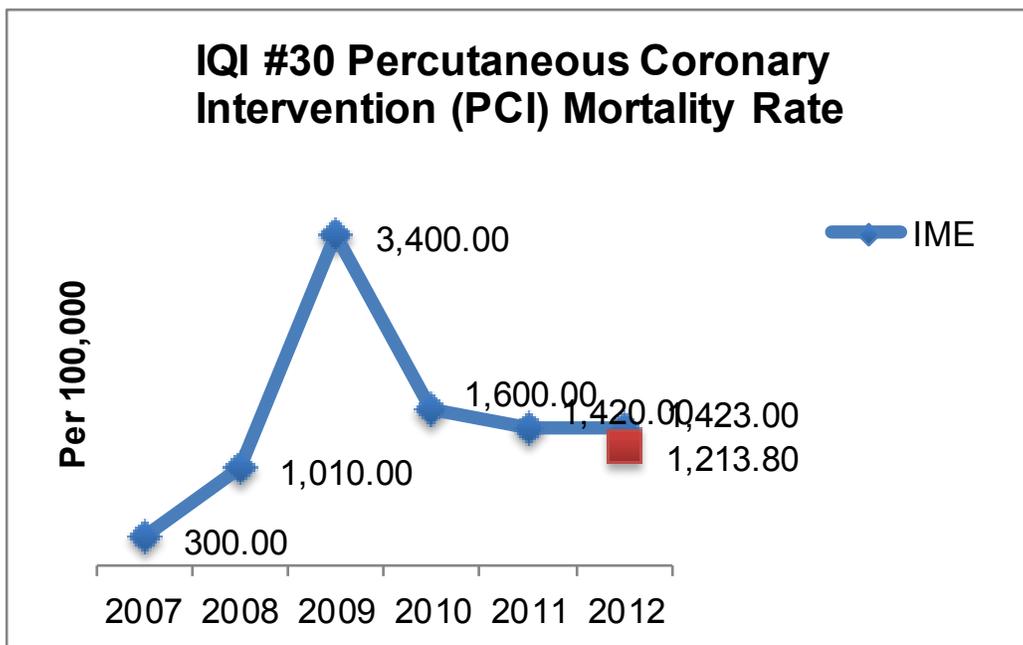


The rate would also be affected by rates of disease prevalence. Many cases of lower back pain are preventable by encouraging healthy lifestyles and weight and promoting proper lifting technique at all times.

\* IME CI for this indicator is 16.20 - 19.62 per 100,000 population.

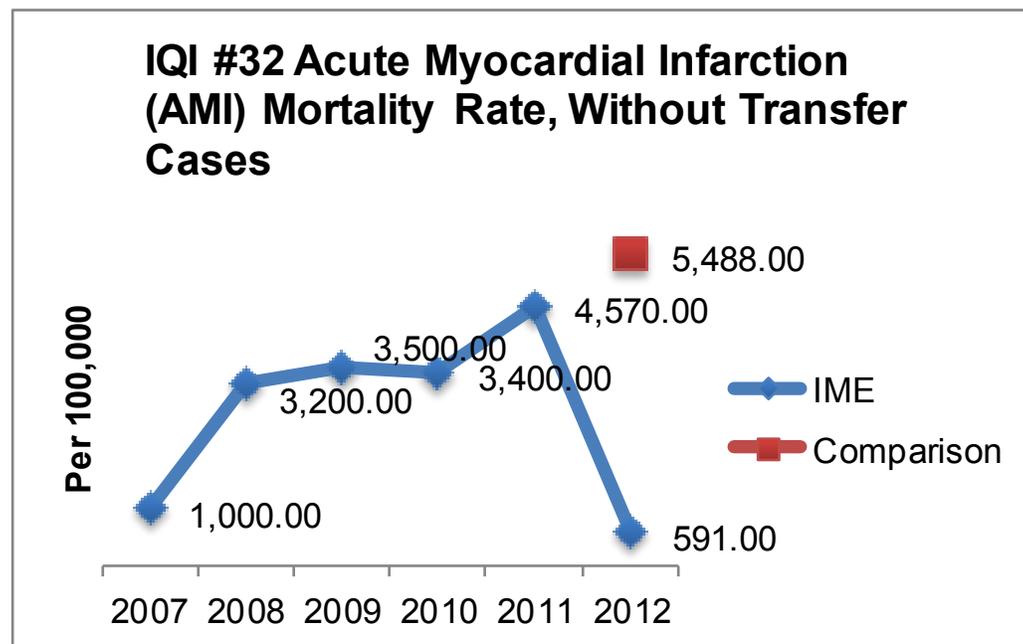
### IQI #30 Percutaneous Coronary Intervention (PCI) Mortality Rate

This measure identifies in-hospital death discharges for persons aged 49 years and older. Obstetric discharges and transfers to another hospital were excluded. (AHRQ, 2012)



\* IME CI for this indicator is 0 - 2,986 per 100,000 population.

### IQI #32 Acute Myocardial Infarction (AMI) Mortality Rate, Without Transfer Cases



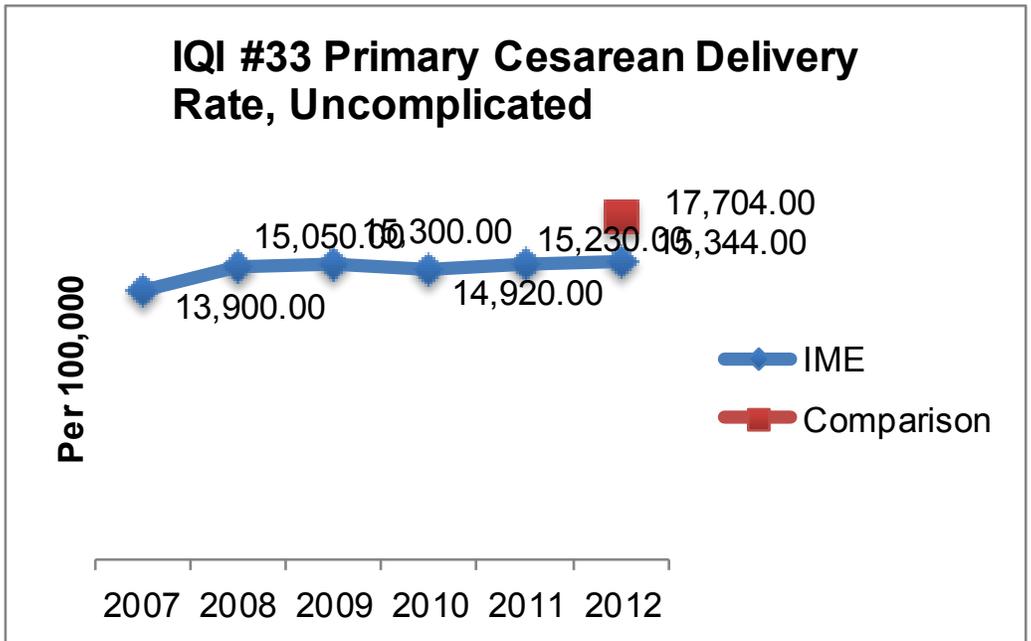
### IQI #32 Acute Myocardial Infarction (AMI) Mortality Rate, Without Transfer Cases

This measure identifies in-hospital death discharges with a principal diagnosis of acute myocardial infarction for persons aged 18 years and older. Obstetric discharges, transfers to another hospital and transfers from another acute care hospital were excluded. (AHRQ, 2012)

\* IME CI for this indicator is 0 - 1,748 per 100,000 population.

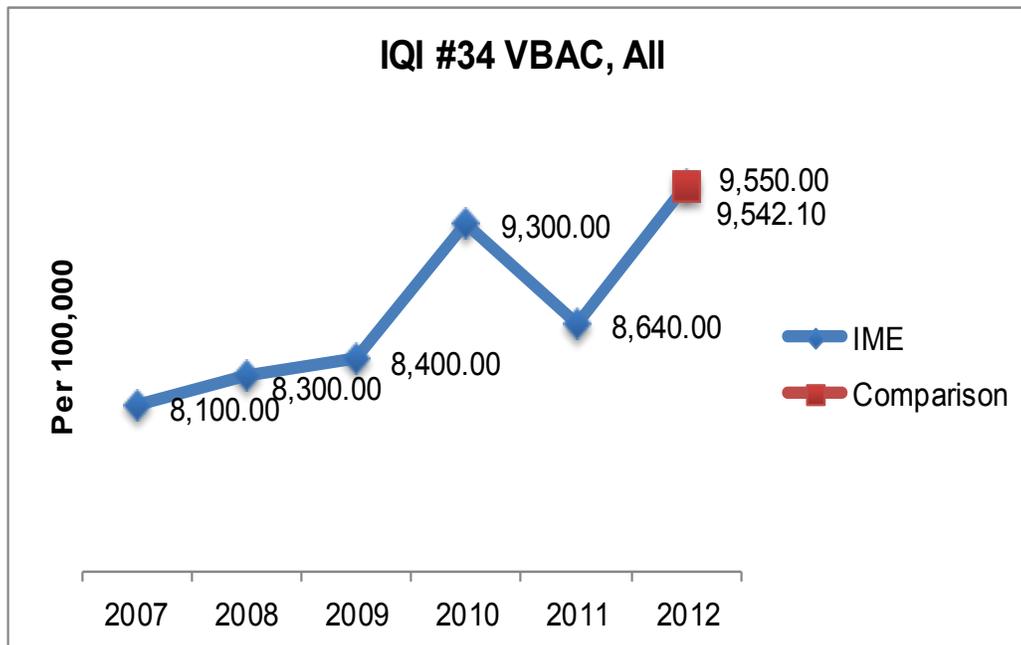
**IQI #33 Primary Cesarean Delivery Rate, Uncomplicated**

This measure identifies first-time cesarean deliveries without a hysterectomy procedure. Deliveries with complications such as abnormal presentation, preterm delivery, fetal death, multiple gestation diagnoses, or a breech presentation were excluded. (AHRQ, 2012)



\* IME CI for this indicator is 14,674 - 16,014 per 100,000 population.

**IQI #34 VBAC, All**



**IQI #34 Vaginal Birth After Cesarean (VBAC) Rate, All**

This measure identifies vaginal birth deliveries by persons who have had previous cesarean deliveries. (AHRQ, 2012)

The American College of Obstetrics and Gynecologists (ACOG) and the Royal College of Obstetricians and Gynecologists (RCOG) agree that “most women with a history of

one or two uncomplicated low transverse cesarean sections, in an otherwise uncomplicated pregnancy at term with no contraindications to vaginal birth, are candidates and should be counseled about VBAC.” (AHRQ, 2011) There is further agreement that women at high risk for complications are not generally candidates for VBAC.

\* IME CI for this indicator is 8,363 - 10,736 per 100,000 population.

## Summary

In summary, Iowa Medicaid performed better than the national benchmark in the following IQIs:

- IQI #14 Hip Replacement Mortality Rate
- IQI #21 Cesarean Delivery Rate, Uncomplicated
- IQI #23 Laproscopic Cholecystectomy Rate
- IQI #25 Bilateral Cardiac Catheterization Rate
- IQI #26 CABG Rate
- IQI #27 PTCA Rate
- IQI #28 Hysterectomy Rate
- IQI #29 Laminectomy Rate
- IQI #32 Acute Myocardial Infarction (AMI) Mortality Rate, Without Transfer Cases
- IQI #33 Primary Cesarean Section Delivery Rate, Uncomplicated

Iowa Medicaid did not perform worse than the national comparison in any IQIs.

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

- IQI #11 Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate
- IQI #12 Coronary Artery Bypass Graft (CABG) Mortality Rate
- IQI #13 Craniotomy Mortality Rate
- IQI #15 Acute Myocardial Infarction (AMI) Mortality Rate
- IQI #16 Heart Failure Mortality Rate
- IQI #17 Acute Stroke Mortality Rate
- IQI #20 Pneumonia Mortality Rate
- IQI #22 Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated
- IQI #30 Percutaneous Coronary Intervention (PCI) Mortality Rate
- IQI #34 VBAC Rate, All

It should be noted for IQI measure #22, a lower score indicates fewer VBAC procedures being done which may contradict ACOG recommendations and thus a lower score for this measure does not necessarily correlate with a positive result.

Iowa Medicaid reported zero occurrence for the following IQI measures:

- IQI #8 Esophageal Resection Mortality Rate
- IQI #9 Pancreatic Resection Mortality Rate
- IQI #18 Gastrointestinal Hemorrhage Mortality Rate
- IQI #19 Hip Fracture Mortality Rate
- IQI #24 Incidental Appendectomy in the Elderly Rate
- IQI #31 Carotid Endarterectomy Mortality Rate

## Iowa Medicaid's Successful Initiatives

The Maternal Health Taskforce was implemented in 2009 to address growing concerns in maternal and newborn care. Increases in premature deliveries, cesarean section deliveries and low birth-weight infants are of concern to state, national and world health organizations.

The Maternal Health Taskforce is facilitated by Iowa Medicaid's Medical Director with representation by community stakeholders such as state Medicaid policy staff, University of Iowa perinatal centers, March of Dimes, Iowa Department of Public Health, to name a few in addition to the individual programs within Iowa Medicaid including Medical and Member Services as well as the state's Title V agencies.

This taskforce has worked to join efforts in community outreach and education and bringing together the resources available to each participant to the larger group. These joint efforts have

paid off and Iowa Medicaid began seeing the trends move in a positive direction. Some of the targeted initiatives of this task force have been:

- Education and outreach regarding availability of smoking cessation programs.
- Participation in the hospital engagement network to support the state's initiative to reduce preterm births and late-term elective cesarean sections or inductions before 39 weeks gestation.
- Participation in the Medicaid Medical Directors Learning Network (MMDLN) Perinatal Project.

The Maternal Health Taskforce discontinued routine meetings during 2010 and was reconvened in 2011 when a need was identified to continue the joint efforts.

Since the first quarter of state fiscal year 2012, the Maternal Health Taskforce has met quarterly to discuss concerns and opportunities to support optimal health outcomes for this population served by Iowa Medicaid.

## Recommendations

- Complete in-depth analysis of specific areas of concerns regarding measures that have a negative trend.
  - IQI #16 Heart Failure Mortality Rate
  - IQI #30 Percutaneous Coronary Intervention (PCI) Mortality Rate
- Continue participation in the maternal health taskforce.
- Continue to participate in the Medicaid Medical Directors Network (MMDN) and the projects that are applicable to the Iowa Medicaid population.

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## Medicaid Value Management (MVM)

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### About MVM

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## Query Facts



# Medicaid Value Management (MVM)

*Realizing the fiscal value of quality care.*

January 2014

## Central Line-associated Blood Stream Infections (CLABSI)

2nd Qtr, SFY14

### Point of Interest:

- For the 2013 reporting year, only five members met the technical specifications for the Central Line-associated Blood Stream Infection (CLABSI).

### In this report:

Medical Record Review	3
Summary	4
Recommendations	4

### CHIPRA Overview

On February 4, 2009, President Obama signed the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This legislation marked a new era in children’s coverage by providing states with significant new funding, new programmatic options, and a range of new incentives for covering children through Medicaid and the Children’s Health Insurance Program (CHIP). (Medicaid.gov 2011)

Medicaid and the CHIP program are a major source of health coverage for low-income children ranging in age from infants to early adulthood. Together, these programs provide coverage for about 40 million children during the course of a year, providing access to a comprehensive set of benefits including preventive and primary care services and other medically necessary services. Health and Human Services (HHS) Secretary Sebelius is required to report annually on the quality of the system of care for children in Medicaid/CHIP. As part of its mission to measure and improve the quality of care for children, CMS provided state health officials with an initial core set of children’s health care quality measures, twenty-four measures and technical specifications. These efforts align with HHS National Quality Strategy’s three aims of better care, healthier people and communities and af-

fordable care.

In 2011, Iowa Medicaid Enterprise began voluntarily reporting the CHIPRA quality measures. At that time, two on 19 of the 24 CHIPRA measures. Two of the measures were not reported on because of the need for a desk review of the medical records; these measures, are referred to as “hybrid” measures.

This MVM report is the outcome of the chart review of the records selected for CHIPRA Measure CLABSI: Pediatric Central-Line Associated Infections.



### CHIPRA Measure 19 Technical Specifications

**Description:** “The rate of central line-associated blood stream infections (CLABSI) identified during periods for surveillance as a function of the number of central line catheter days selected for surveillance in pediatric and neonatal intensive care units. The central line associated blood-stream infection is an infection in a patient that had a central line inserted within the 48 hour period before the onset of the infection.

The CLABSI measure targets members who were patients in ICUs and NICUs.

### Definitions:

**Intensive Care Unit** — A nursing care area in which at least 80 percent of the patients require intensive observation, diagnosis, and therapeutic procedures.

**Central line**—An intravascular catheter that terminates at or close to the heart in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring.

**Infusion**—The introduction of a solution through a blood vessel via a catheter lumen. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis.

**Umbilical catheter**—A central vascular device inserted through the umbilical artery or vein in a neonate.

**Temporary central line**—A non-tunneled catheter.

**Permanent central line**—Includes tunneled catheters, including certain dialysis catheters and implanted catheters (including ports).

### Exclusions:

Hospitals with fewer than 50 central line days per year.

### Anchor Date:

Cases in which the infections are during the timeframe of selected surveillance.

For the purpose of this review, cases were selected with an infection occurring during calendar year 2012.

### Numerator:

Total number of observed healthcare associated CLABSI among patients in ICUs and NICUs.

CLABSI Criteria: Laboratory-confirmed bloodstream infection (LCBI)

Must meet one of the following criteria:

**Criterion 1:** Patient has a recognized pathogen cultured from one or more blood cultures and organism cultured from blood is not related to an infection at another site.

**Criterion 2:** patient has at least one of the following signs or symptoms:

- fever (> 38 degrees Celsius),
- chills, or
- hypotension and signs and symptoms, and
- positive laboratory results are not related to an infection at another site and common skin contaminant is cultured from two or more blood cultures drawn on separate occasions.

**Criterion 3:** Patient less than 1 year of age has at least one of the following signs or symptoms:

- fever (> 38 degrees Celsius core),
- hypothermia (<36 degrees Celsius core),
- apnea, or

- bradycardia and signs and symptoms, and
- positive laboratory results are not related to an infection at another site and common skin contaminant is cultured from two or more blood cultures drawn on separate occasions.

### Denominator:

Total number of expected CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population. Central line device-day denominator data that are collected differ according to the location of the patients being monitored.

1. Number of appropriate device days for locations under CLABSI surveillance during the time period.
2. CLABSI rate per 1000 device days for the same location types from the identified population.
3. Definition of device days: Device days are used for denominators. Device day denominator data that are collected differ according to the location of the patients being monitored.
  - a. For ICUs, the number of patients with one or more central lines of any type is collected daily at the same time each day during the month.
  - b. In NICUs, because of differing infection risks, the number of patients with central lines and those with umbilical catheter and a central line, count the day only as an umbilical catheter day. For the NICU infants, patients are

further stratified by birth weight in five categories since risk of blood stream infections (BSI) also varies by birth weight.

### Medical Record Review

Five children were identified through claims data as having a diagnosis of a central line-associated blood stream infection (CLABSI) and met all other technical specification requirements which occurred during the calendar year of 2012—the timeframe of surveillance; in a Pediatric Intensive Care Unit (PICU) or a Neonatal Intensive Care Unit (NICU) which also had 50 central line days for the period of surveillance.

The Program Integrity Medical Necessity (PIMN) team requested records on all five members for review and found no quality of care concerns with regard to the care inpatient hospital care provided.

The results of the record review are as follows:

1. An eight month-old with Down Syndrome and a history of repaired complete atrioventricular canal defect. Documentation indicated the member had positive blood cultures for *Staphylococcus epidermidis* on two consecutive dates. The records indicate this member had concurrent diagnoses of influenza and a central line-associated blood stream infection.

Five children were identified through claims data as having diagnosis of CLABSI and met all other technical specification requirements.

2. A four month-old male with short-gut syndrome admitted for an acute inpatient hospitalization with a fever. The medical record also indicated this child had a reported rash around the central line insertion site for a few weeks prior to admission. Blood cultures completed were positive for *Staphylococcus aureus*. The medical record support this member had a central line infection at the time of admission.
3. A 10 month-old with diagnosis of Acute myelogenous leukemia (AML). Admitted for an acute inpatient hospitalization with a fever. Blood cultures collected from the central line catheter were positive for enterococcus species. The medical record supported this member had a central line infection at the time of admission.
4. A three month-old with diagnosis of Chronic Kidney Disease (CKD) admitted for an acute inpatient hospitalization with fever. Initial blood cultures were positive for *Alcaligenes faecalis* and *Klebsiella oxytoca*. Subsequent blood cultures were positive for *Stenotrophomonas maltophilia*. The medical record supported this member had a central line infection at the time of admission.
5. A three-month old with a diagnosis hepatoblastoma admitted for an acute inpatient hospitalization for inpatient chemotherapy. He was also neutropenic. Blood cultures were taken each time he had a fever; two months into his hospitalization a blood culture tested positive for *Serratia marcescens* bacteremia. Although the member had one positive blood culture additional cultures drawn from the central line later the same day and three days later were negative. This is not consistent with the diagnosis of a central line-associated blood stream infection. The documentation submitted for this member indi-

cates he did not have a central line-associated blood stream infection.

## Conclusion

In conclusion, based on claims data and record review Iowa Medicaid pediatric members do not appear to experience excessive central line-associated blood stream infections. Four members reviewed which had a hospitalization with a central line-associated blood stream infection, it appears either the infection preempted the hospitalization. One member was noted to have had a positive culture, however the review of the medical record did not support a diagnosis of a central line-associated blood stream infection.

The results of this study are similar to a study conducted the previous reporting year for this CHIPRA measure.

Additional claims analysis for the five members reviewed for this report showed none of the five members were receiving home health services prior to their acute inpatient admission.

## Recommendations

- Continue to monitor CLABSI as part of the CHIPRA reporting measures.
- If sample size is less than 30 cases, discontinue future medical record review of cases for this measure.
  - Per the CHIPRA technical specifications manual and CARTS template which indicates states may elect not to report on measures with a sample size less than 30 which meet the technical specifications; or
- If sample size is greater than 30 cases, Program Integrity will conduct chart review of all

cases up to a maximum of 411.

- Per response to previous CHIPRA technical assistance questions, CMS has determined 411 to be the desired volume for a representative sample of the population.

## References

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### Query Facts

Iowa Medicaid claims data and record review for inpatient hospital stays.



January 2014

## Home and Vehicle Modifications: Recommendations and More

2nd Qtr, SFY14

### Point of interest:

- Changes are recommended to promote increased transparency for the Home and Vehicle Modification program.

### Inside this report:

Top 10 Recommendations	2
Recommended Provider Manual Updates	9
Additional Resource Research	12
Other Stakeholder Recommendations	14

### Follow-up to previous HVM MVM report

The purpose of this home and vehicle modifications (HVM) follow-up report is to further analyze recommendations made with the previous HVM MVM as directed by the Long-Term Care Bureau Chief and Program Managers.

Within the context of this MVM report, the top 10 recommendations from the previous report will be identified with detailed explanation to support the recommendations chosen.

Follow-up on additional resources available, such as Easter Seals of Iowa and the Iowa Department of the Blind will also be addressed within this report.

the administration of policy with regard to HVMs. Additional recommendations were identified that may be more appropriately included in a provider manual update as well as any recommendations that may be difficult to implement. Complimentary recommendations were combined into single recommendations.

The results of this collaborative effort are the top 10 recommendations that will be discussed on the next several pages.

The changes recommended will promote increased transparency for the program and provide choices for the member that are more defined and less confusing.

### Process for selecting top 10

To select the top 10 recommendations that would likely effectuate consistent application of the HVM benefit and ensure member needs are met, the MVM program collaborated with Medical Services' Exception to Policy (ETP) and Waiver Prior Authorization (WPA) programs.

The representatives for each program met to discuss which recommendations would best support



## Top 10 Recommendations

1. **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. **Replace language with “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.”**

This recommendation was chosen to support the Department’s ability to prior authorize HVMs based on the member’s specific medical need.

### Potential Impacts

- **Member** -- It is anticipated this change would result in minimal impacts to the member. The exception would be for the few members who wish to access the HVM policy for safety or welfare reasons that are not medically related, but rather psycho-social in nature.
- **Provider** -- There is not anticipated impact to the providers with this change in language.
- **Fiscal** -- This change in language will further clarify the intended application of the HVM policy. As a result, the Department may realize cost avoidance for modification requests that are not medically necessary due to clarification of this rule.
- **Administrative** -- It is anticipated this rule change will result in decreased administrative burden by reducing unnecessary modification requests and associated appeals.

2. **Change current IAC by adding language specifying 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.**

- a. **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.

This recommendation is a combination of two previous recommendations and was selected to further support a definition of what should be considered home or vehicle owner responsibility. This language is also consistent with other state Medicaid programs.

### Potential Impacts

- **Member** -- There is no anticipated impact to the member with this change.
- **Provider** -- There is no anticipated impact to the provider with this change. This change will provide clarity in rule to differentiate between covered modifications for home and/or vehicle.
- **Fiscal** -- This change in language will further clarify the intended application of the HVM policy. As a result, the Department may realize cost avoidance for modification requests that are not medically necessary of clarification of this rule.
- **Administrative** -- It is anticipated this rule change will result in decreased administrative burden by reducing unnecessary modification requests and associated appeals.

### 3. Add language within the IAC which requires a physician order (MD, DO, PA, ARNP) for all HVMs.

This recommendation was chosen to 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 order for HVM services. State specific information is available in the Compendium of Home Modification and Assistive Technology Policy and Practice.

Additional information regarding states' Medicaid coverage for HVMs can be found in the **Compendium of Home Modification and Assistive Technology Policy and Practice Across the States**

**Volume I:** [Final Report](#)

**Volume II:** [State Profiles \(Alabama through Missouri\)](#)

**Volume III:** [State Profiles \(Montana through Wyoming\)](#)

#### Potential Impacts

- **Member** -- There is the potential for delay in services pending receipt of physician order for the modification requested. However, it is believed the delay will be minimal and the benefit of coordinated care will better support the member's health and safety.
- **Provider** -- The physician will be more involved in the member's care.
- **Fiscal** -- Additional physician visits may be requested prior to a physician agreeing to order the necessary modifications. This would primarily be for the members whose physician was not aware the member had additional needs. It is anticipated the physician will order the modifications in conjunction with feedback from a physical and/or occupational therapy evaluation.

Additionally, unnecessary modifications may be avoided with a collaborative effort to look at the members overall health and safety needs and abilities prior to conducting a costly modification to the home and/or vehicle.

This requirement will enhance the overall quality of the member's care.

- **Administrative** -- Additional time may be spent on the requests obtaining the required physician orders. This may include additional administrative time spent on behalf of the ordering physician.
- ### 4. 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 recommendation was selected to align with other benefit coverage for Iowa Medicaid, such as durable medical equipment (DME). This is also consistent with coverage language provided by Indiana Medicaid.

#### Potential Impacts

- **Member** -- There is minimal impact for the member anticipated from this rule change due to current processes denying duplicate modifications in most instances. The member's medical need will still be met through coverage of the initial modification. Disallowing duplicate items will reduce coverage for items requested primarily for convenience.
- **Provider** -- There is no anticipated impact to the provider from this rule change.
- **Fiscal** -- The fiscal impact from this rule change would be cost avoidance from denial of duplicate modifications.

- **Administrative** -- Defining in rule the exclusion of duplicative items from coverage will improve support for the Department's decision in appeals.

##### 5. **Explore use of an environmental consultation by an occupational therapist prior to submission of a request for a HVM.**

This recommendation was selected to work with recommendation number three above requiring a physician order for HVMs. 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 will assist the physician in coordination of all aspects of the member's medical and assistive needs.

The occupational therapy evaluation would be a covered benefit under the state plan. Current fee schedule reimbursement for this service are \$56.76 (CPT 97003) for the evaluation and \$26.68 (CPT 97004) should a reevaluation be needed.

The requirement of an occupational evaluation for HVMs is also consistent with Oregon Medicaid.

##### **Potential Impacts**

- **Member** -- There is the potential for delay in services pending receipt of an occupational therapist report for the modification requested. However, it is believed the delay will be minimal and the benefit of coordinated care will better support the member's health and safety. The member will ultimately receive modifications that are based on a professional evaluation which will adequately meet their needs.
- **Provider** -- There is no anticipated impact on the provider from this rule change. The bid

should be conducted following the occupational therapy evaluation.

- **Fiscal** -- The cost of an occupational therapy evaluation would be incurred by the State Plan benefit.

Additional physician visits may be requested prior to a physician agreeing to order the therapy evaluation. This would primarily be for the members whose physician was not aware the member had additional needs.

Additionally, unnecessary modifications may be avoided with a collaborative effort to look at the members overall health and safety needs and abilities prior to conducting a costly modification to the home and/or vehicle. This would result in potential cost avoidance for the Department.

Conversely, the professional evaluation may lead to identifying further modification needs which would increase the cost to the Department but would further support the member's safety and independence within their home which further supports the BIPP initiative.

- **Administrative** -- Additional time may be spent scheduling the evaluation and obtaining the outcome report for submission with the HVM request.
- ##### 6. **Define home (environmental) modifications within the IAC independent from vehicle modifications; and**
- a. **Define coverage of home (environmental) modification specifically addressing new construction versus modification of an existing dwelling.** The table starting on page nine provides recommendations for specific home modifications for both new construction and existing dwelling.

- b. **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)
- c. **Define vehicle modifications within IAC separate from home (environmental) modifications.**

This recommendation is a combination of three previous recommendations. Overall, it is believed that due to the distinct differences in coverage needs for home and vehicle modifications a separate code for each is warranted to allow for specificity of the benefit. Specifying coverage for home and vehicle separately would support program integrity oversight through transparency in the program coupled with changes implemented with the atypical code conversion in July 2013, allowing for distinct coding of claims for home modification versus vehicle modification.

This is also consistent with multiple state Medicaid programs. 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.

### Potential Impacts

- **Member** -- This would impact members who are in the process of building a new home at the time of the modification request. Currently, modifications may be requested for new construction to offset the cost of making the dwelling under construction accessible to the member with assistive needs. This rule

change would specify limitations to the coverage for such modifications under the HVM benefit.

Additionally, this rule change would provide clarity for modifications intended to be covered for home and/or vehicle that is further supported by the recent coding changes to allow providers to bill separately for these modifications.

- **Provider** -- The impact for providers would be related to the restructuring of the benefit around newly constructed dwellings. The limitations may have a fiscal impact on some waiver providers.
  - **Fiscal** -- The fiscal impact to the Department for this rule change would be largely due to the restructuring of the benefit with regard to newly constructed dwellings. Limiting or eliminating coverage in some areas may result in cost avoidance for the Medicaid program. This cost avoidance would be for modifications of items that would be required for any new construction but determined that an accessible or safety version is needed to meet the member’s need.
  - **Administrative** -- Defining in rule the specific modifications intended for coverage for the home versus vehicle will improve support for the Department’s decision in appeals.
7. **Add language to code specifying “Home adaptation expenses should be based on contractor grade materials in all instances.”**

This recommendation was selected to further support in the appeals process the application of an existing rule relating to least costly service to meet the member’s medical or remedial need. This will provide support in appeals when the material(s) approved are adequate

to meet the member's needs and are less costly than what was requested. Language has been established by New York Medicaid.

The following have been identified by the ETP and WPA teams in Medical Services as potential impacts of this recommendation:

- **Member** -- The member's medical need will still be met through coverage of the initial modification. Disallowing materials other than contractor grade materials will reduce coverage for items requested primarily for convenience or for aesthetic purposes.
  - **Provider** -- The impact to the provider will be in the reimbursement only for constructor grade materials that adequately meet the members needs rather more costly materials (e.g., granite countertops) that do not serve a medical purpose.
  - **Fiscal** -- The Department will likely realize cost avoidance by limiting the reimbursement for materials used to contractor grade only.
  - **Administrative** -- Defining in rule the specification that only contractor grade materials will be covered will further support for the Department's decision in appeals relating to the least costly item that adequately meets the member's needs.
8. **Add language to IAC limiting coverage for the same home (environmental) modifications to only two different residences in a five (5) year timeframe** for the same member with the following **exclusions: fire, natural disaster, court or other legal actions.**
- a. **Add language to IAC limiting coverage for the same 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.**

This recommendation was modified from the previous recommendation to allow coverage for home (environmental) modifications to only two different residences in a five year timeframe. This modification in the recommendation was made to align with a second recommendation regarding frequency of vehicle modifications. The two recommendations specify a five year timeframe which would be supported by the ability of review staff to access historical claims data in MMIS which is only readily available for five years.

### Potential Impacts

- **Member** -- For members who relocate more than twice in a five-year period or replace/change vehicles more than once in a five-year period, this rule will impact the funding available through the waiver.

If a member's assistive needs change, a new modification may be requested based on these changes. These modification requests may still be covered based on the changes in the member's condition.

- **Provider** -- The impact on the providers is anticipated to be minimal.
- **Fiscal** -- The Department will likely see some cost avoidance from completing multiple modifications, similar in scope, for the same member within a short time frame.
- **Administrative** -- Defining in rule the limitations for frequency of completing the same modification multiple times will further support for the Department's decision in ap-

peals. This may result in increased exception to policy requests for members who relocate more than twice in a five-year period or replace/change vehicles more than once in a five-year period.

#### 9. **Remove language within the IAC allowing for HVM coverage for bath chairs and transfer benches.**

This recommendation was selected to support 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. Requiring coverage for such items through state plan versus waiver will stretch the waiver dollar further to provide other home and/or community based services that are needed.

#### Potential Impacts

- **Member** -- This may result in faster service for members to consistently access the items through the State Plan benefit.

This will also allow the waiver dollars previously spent on this equipment to be reallocated to other services required to meet the member's medical or remedial needs.

- **Provider** -- Providers who are enrolled only as waiver providers (provider type 99) will be required to enroll as a DME provider (provider type 12) if they wish to continue to provide and bill these items to Medicaid members.
- **Fiscal** -- The Department may realize some cost avoidance based on the consistency reimbursement across DME providers for these items.
- **Administrative** -- The change in rule effective September 1, 2013, expanded coverage of

these items to all members via the State Plan benefit. By removing these items from coverage in the waiver program, the waiver dollars are able to be better allocated to other services that meet the member's needs. In addition, this supports the preamble of chapter 83 which specifies services covered under waiver are not otherwise available to the member.

This will further support the Department's decision in waiver related appeals when the member is directed to access the State Plan for these items.

This will remove conflicting statements within the Iowa code.

#### 10. **Add language to the IAC specifying that for home modifications in excess of \$5,000, the Department will protect its interest through liens or other legally available means.**

This recommendation was chosen because it 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. This is also consistent with Oregon's Medicaid program.

#### Potential Impacts

- **Member** -- For members who have modifications completed that may not intend to remain in the current residence indefinitely, this may impact their decision to have a modification completed that is funded through the waiver.
- **Provider** -- This rule may impact providers who routinely complete high cost modifications if members opt to not have the entire modification complete. However, it is also believed that allowing coverage for only

contractor grade materials (recommendation number 7) may reduce the overall cost of some modifications and reduce the impact of this rule on providers and members.

- **Fiscal** -- The Department would recover monies for properties which were modified and sold prior to becoming part of the estate and made available through the estate recovery program.
- **Administrative** -- There may be a significant amount of administrative resources spent to ensure the member is aware of this rule prior to agreeing to the modification as well as submitting any legal documentation on behalf of the Department to facilitate the follow through of this rule.

### Additional Recommendation

**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.

Implementation of such a program for Iowa Medicaid may be difficult due to the logistics of identifying the Department representative(s) responsible for signing and the completed document and facilitating mediation of any differences between consumer and provider.



## Recommended Provider Manual Updates

The following are previous recommendations that if added to a provider manual may further support existing policy or changes in policy that have been identified in the top 10 section of this report.

1. As payer of last resort, **when appropriate other resources** such as the VA benefit for veterans or the Iowa Program for Assistive Technology (IPAT) **should be consulted prior to submitting a request to Iowa Medicaid.**
2. **Add language 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.
3. To further support the recommendation **“Define coverage of home (environmental) modification specifically addressing new construction versus modification of an existing dwelling.”** The table below and on the next page may be beneficial to include in a provider manual updates as it 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	<b>Existing Dwelling and New Construction:</b> 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	<b>New Construction:</b> 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	<b>New Construction:</b> Bathing facilities would be installed in a new construction; appropriate shower should be installed at the time of construction.
Bathroom Modification; Shower; Walk-In (when less costly alternatives are contraindicated; e.g., tub-cut)	Yes	No	<b>New Construction:</b> 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; Sink; Lowering Existing Sink	Yes	No	<b>New Construction:</b> A sink would be installed in a new construction, and therefore height can be adjusted at the time of installation; consider requiring a wall mounted sink.
Bathroom Modification; Sink; Pedestal	Yes	No	<b>New Construction:</b> 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	<b>New Construction:</b> 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	<b>Existing Dwelling:</b> Allow only if it is associated with a ramp (footings and landings) or required for a bathroom modification. <b>New Construction:</b> Allow only if it is associated with a ramp (footings and landings) or exterior lift.
Concrete; Exterior hard surface pathways	Yes with limitations	No	<b>Existing Dwelling:</b> 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. <b>New Construction:</b> 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	<b>Existing Dwelling and New Construction:</b> Allow only when attached to a ramp; reimbursement for deck or landing with a turn radius of 60 inches. <b>New Construction:</b> See recommendations for ramp coverage.
Door Widening; Bathroom (when swing clear hinges are contraindicated)	Yes	No	<b>New Construction:</b> Doors and doorways would be installed in a new construction; appropriate entry width should be considered in the new construction design.
Door Widening; Garage	Yes with limitations	No	<b>Existing Dwelling:</b> Recommendation to allow door widening only for access to attached garage and home. <b>New Construction:</b> 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; House Entry (when swing clear hinges are contraindicated)	Yes	No	<b>New Construction:</b> 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 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.
Flooring; low pile carpeting or slip resistant flooring	Yes with limitations	No	<b>Existing Dwelling:</b> 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). <b>New Construction:</b> 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	<b>New Construction:</b> 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	<b>New Construction:</b> 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	<b>New Construction:</b> Entry to the home would be required for a new construction; appropriate entry needs should be considered in the new construction design.
Ramp; Treated Wood	Yes	No	<b>New Construction:</b> 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	
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	<b>Existing and New Construction:</b> Recommend reimbursement only for specialized lock components not provided with standard windows <u>and</u> only when a documented history of elopement is present.

### Additional Resource Research

#### Easter Seals of Iowa

On December 17, 2013, representatives from the Program Integrity MVM program and Medical Services' Exception to Policy and Waiver Prior Authorization programs toured Easter Seals of Iowa and had the opportunity to see the loan closet noted in the previous MVM report. The purpose of this tour was to get an understanding of the types of equipment that may be available to members to rent for a nominal one-time cost if other funding is not available.

Observations of the tour were as follows:

The Easter Seals of Iowa works with the Iowa Program for Assistive Technology (IPAT) to provide Iowans in need with assistive technology to promote safety and independence. The IPAT program, carried out by Easter Seals of Iowa consist of three components.

1. Recycling of Durable Medical Equipment (DME). This allows medical equipment that is donated to be distributed to others in the community with a need for a nominal fee. All equipment that is donated is reviewed and

assessed for safety prior to being recycled for redistribution.

2. The lending library allows Iowans to trial some equipment for up to 30 days in their home environment to determine if it will meet their needs. The members are provided with resource information of where they can purchase the items trialed via the lending library.
3. The demonstration center allows consumers to view some of the assistive devices to see what may be available to meet their needs.

Below are some photographs of the demonstration center at Easter Seals of Iowa in Des Moines.



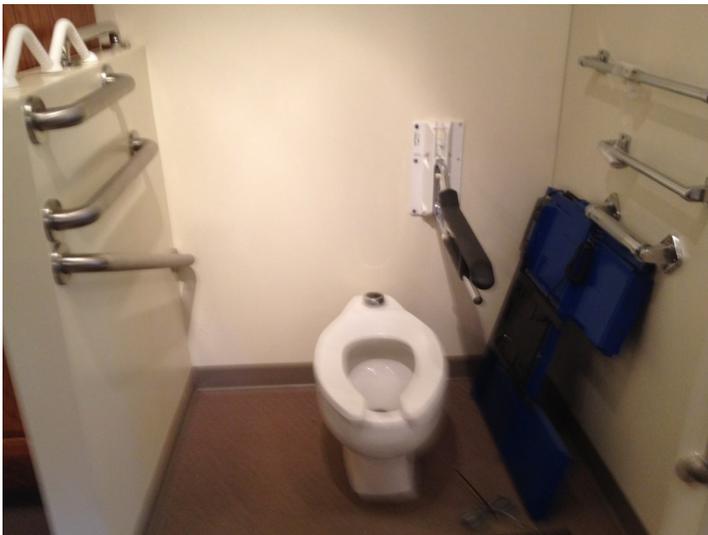
Cabinets with shelving on hinges provide ease of access to promote independence within the kitchen.



Accessible controls on the stove to support greater independence with meal prep. Installation of the mirror behind the stove allows the consumer to visualize what is being prepared on the stovetop.



The safety bath provides an opportunity for consumers to see a variety of options. A U-handle grab bar attached to the tub provides assistance when entering and exiting the tub. This grab bar can be repositioned to meet the members needs or removed if needed. For consumers who require a lift for assistance in and out of the tub, the demonstration center has an aqua-lift for display. This lift connects to the faucet in the tub and is powered by the water pressure in the home.



This area of the demonstration center highlights a variety of grab bars to assist the consumer. Including one designed to pivot up and out of the wall to facilitate transfers.



The last picture on the previous page is of a safety shower, also referred to as a walk-in shower, on display at the demonstration center. To facilitate access to the shower when the bathroom floor is not flush with the shower, the demonstration center has used threshold ramps. Use of threshold ramps would be less costly than replacing flooring to be level with the shower and may also be cleared out of the way when they are not needed.

A virtual tour of the lending library and demonstration center at Easter Seals of Iowa, titled "Film Clip of Easter Seals Center," can be viewed at <http://www.ivrs.iowa.gov/Assistive/IntranetATFiles/AssistiveTechnology/NewATPage.html>

### Iowa Department of the Blind

Discussion with the previous MVM study regarding other resources available suggested the Iowa Department for the Blind may be a viable resource for some adaptive equipment.

A follow-up call with a representative by the Iowa Department for the Blind was conducted by the waiver prior authorization program. The representative from the Iowa Department for the Blind stated they do offer various types of talking devices to assist the person with their disability and getting through day-to-day life. However, they do not have a "giveaway" program or a "loan closet" type program. They are affiliated with a store where a person can purchase the devices and if the person does not have the funds to purchase the needed item(s) a repayment loan plan may be an option to allow the member to purchase the item with an affordable monthly payment, until the cost of the item is paid in-full.

Although the Iowa Department of the Blind does have grants available, the representative stated grants were not available for these types of needs.

### Additional Assistive Technology Resources

Assistive technology may also be available through diagnosis specific organizations such as the Muscular Dystrophy Association (MDA).

### Other Stakeholder Recommendations

A document submitted January 2, 2014, by Iowa COMPASS provided suggestions to the Olmstead Task Force on ways to improve access to Assistive Technology (AT) through Iowa Medicaid. The following recommendations were noted in this document with regard to HVMS.

1. "Repairs for home and vehicle modifications should be covered. Currently, HVM repairs are prohibited. As this is not cost effective, IME routinely grants exceptions to policy for modification repair requests. These requests are costly for IME and a time-consuming barrier for Iowans with disabilities.
2. Do not require competitive bids for HVM under \$500: The requirement for three bids for home and vehicle modifications can be a barrier.
3. Increase or remove the lifetime maximum for HVM under the Elderly and Intellectual Disability waivers. The current lifetime maximum is a barrier when the available dollars do not provide the needed modifications. The \$1,000 limit on the Elderly waiver is particularly low and in most cases, would not be enough to build a simple home ramp.
4. Change the HVM list to a non-exclusive one. The Iowa Administrative Code currently includes a limited definition of these modifications: *Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly ad-*

*dress the member's medical or remedial need. 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.*

5. Review the list of approved HVM Exceptions to Policy requests for patterns that indicate regular approval so that these items can be added to the HVM list.” (Iowa COMPASS, 2013)

The first recommendation of the Iowa Compass is similar to one of the original recommendations made with the previous HVM MVM.

The second recommendation of the Iowa Compass to remove the competitive bid requirement for HVMs under \$500 would reduce administrative burden on the providers, case managers as well as IME staff when processing these HVMs. The MVM team in conjunction with the ETP and WPA teams in Medical Services also support this recommendation.

The third recommendation of the Iowa COMPASS is one that would require more discussion at a policy level.

The fourth recommendation addresses changing the list in code to be non-exclusive. The MVM team in conjunction with the ETP and WPA teams in Medical Services agrees that having a list of modifications for which the Department intends to be covered under the waiver benefit is essential to the successful administration of the program. However, this may be an area where the Department could collaborate with outside stakeholders, such as IPAT and the Olmstead Taskforce to determine if there are other items that need to be included in the list and are fiscally reasonable for the state to do so.

The fifth recommendation is to review approved ETPs for patterns. The majority of HVMs requested through ETP are for items that are on

the list of covered modifications. The overwhelming majority of the ETP requests as they relate to HVM is for funding in excess of a monthly, annual or lifetime cap for services. The outcome of such an analysis may further direct discussion of Iowa Compass' fourth recommendation.

## Appendix

1. HVM MVM Recommendation Summary
2. All Inclusive List of Recommendations From the Previous HVM MVM Report
3. Easter Seals Outcome Data 2012-2013
4. Iowa Compass, Overview of Recommendations for Olmstead (January 2, 2014)

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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.

**HVM Recommendations MVM:  
Appendix**

1. HVM MVM Recommendation Summary
2. All Inclusive List of Recommendations From the Previous HVM MVM Report
3. Easter Seals Outcome Data 2012-2013
4. Iowa Compass, Overview of Recommendations for Olmstead (January 2, 2014)

## HVM MVM Recommendation Summary

Recommendation	Rationale	Impacts				
		Member	Provider	Fiscal	Administrative	
1	Replace language in code to state “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 change in language would further support the Department’s ability to prior authorize HVMs based on the member’s specific medical need.	It is anticipated this change would result in minimal impacts to the member. The exception would be for the few members who wish to access the HVM policy for safety or welfare reasons that are not medically related, but rather psycho-social in nature.	There is not anticipated impact to the providers with this change in language.	This change in language will further clarify the intended application of the HVM policy. As a result, the Department may realize cost avoidance for modification requests that are not medically necessary due to clarification of this rule.	It is anticipated this rule change will result in decreased administrative burden by reducing unnecessary modification requests and associated appeals.
2	Change current IAC by adding language specifying exclusions as modifications which are of general utility. Define General utility as a service that is generally available to the public and/or standard responsibilities of any home or vehicle owner	This change in rule language would further support a definition of what should be considered home or vehicle owner responsibility.	There is no anticipated impact to the member with this change.	There is no anticipated impact to the provider with this change. This change will provide clarity in rule to differentiate between covered modifications for home and/or vehicle.	This change in language will further clarify the intended application of the HVM policy. As a result, the Department may realize cost avoidance for modification requests that are not medically necessary of clarification of this rule.	It is anticipated this rule change will result in decreased administrative burden by reducing unnecessary modification requests and associated appeals.
3	Add language to IAC requiring a physician order (MD, DO, PA, ARNP) for all HVMs	This change will further support care coordination by ensuring the primary care provider is aware of any adaptive needs for the member.  This requirement will enhance the overall quality of the member’s care.	There is the potential for delay in services pending receipt of physician order for the modification requested. However, it is believed the delay will be minimal and the benefit of coordinated care will better support the member’s health and safety.	The physician will be more involved in the member’s care.	Additional physician visits may be requested prior to a physician agreeing to order the necessary modifications.  Additionally, unnecessary modifications may be avoided with a collaborative effort to look at the members overall health and safety needs and abilities prior to conducting a costly modification to the home and/or vehicle.	Additional time may be spent on the requests obtaining the required physician orders.

**HVM MVM Recommendation Summary**

Recommendation	Rationale	Impacts			
		Member	Provider	Fiscal	Administrative
4	Add language to IAC excluding duplicate HVMS	<p>There is minimal impact for the member anticipated from this rule change due to current processes denying duplicate modifications in most instances.</p> <p>The member's medical need will still be met through coverage of the initial modification.</p>	There is no anticipated impact to the provider from this rule change.	<p>The fiscal impact from this rule change would be cost avoidance from denial of duplicate modifications.</p> <p>The rule change would further support the Department in administrative appeal hearings for the denied service.</p>	Defining in rule the exclusion of duplicative items from coverage will improve support for the Department's decision in appeals.
5	Utilize environmental consultation by an occupational therapist prior to requesting a HVM.	<p>There is the potential for delay in services pending receipt of an occupational therapist report for the modification requested.</p> <p>However, it is believed the delay will be minimal and the benefit of coordinated care.</p> <p>The member will ultimately receive modifications that are based on a professional evaluation which will adequately meet their needs.</p>	There is no anticipated impact on the provider from this rule change. The bid should be conducted following the occupational therapy evaluation.	<p>The cost of an occupational therapy evaluation would be incurred by the State Plan benefit.</p> <p>Additional physician visits may be requested prior to a physician agreeing to order the therapy evaluation.</p> <p>Unnecessary modifications may be avoided with a collaborative effort to look at the members overall health and safety needs and abilities prior to conducting a costly modification to the home and/or vehicle. This would result in potential cost avoidance for the Department.</p> <p>Conversely, the professional evaluation may lead to identifying further modification needs which would increase the cost to the Department but would further support the member's safety and independence within their home which further supports the BIPP initiative.</p>	Additional time may be spent scheduling the evaluation and obtaining the outcome report for submission with the HVM request.

**HVM MVM Recommendation Summary**

Recommendation	Rationale	Impacts			
		Member	Provider	Fiscal	Administrative
<p>6</p> <p>Define coverage for home and vehicle modifications separately within the IAC.</p> <p>Define coverage benefits and limitations for existing dwelling versus new construction.</p> <p>Define “exterior hard surface pathways”</p>	<p>Due to the distinct differences in coverage needs for home and vehicle modifications a separate code for each is warranted to allow for specificity of the benefit. Specifying coverage for home and vehicle separately would support program integrity oversight through transparency in the program coupled with changes implemented with the atypical code conversion in July 2013, allowing for distinct coding of claims for home modification versus vehicle modification.</p>	<p>This would impact members who are in the process of building a new home at the time of the modification request. Currently, modifications may be requested for new construction to offset the cost of making the dwelling under construction accessible to the member with assistive needs. This rule change would specify limitations to the coverage for such modifications under the HVM benefit.</p>	<p>The impact for providers would be related to the restructuring of the benefit around newly constructed dwellings. The limitations may have a fiscal impact on some waiver providers.</p>	<p>The fiscal impact to the Department for this rule change would be largely due to the restructuring of the benefit with regard to newly constructed dwellings.</p> <p>Limiting or eliminating coverage in some areas may result in cost avoidance for the Medicaid program. This cost avoidance would be for modifications of items that would be required for any new construction but determined that an accessible or safety version is needed to meet the member’s need.</p>	<p>Defining in rule the specific modifications intended for coverage for the home versus vehicle will improve support for the Department’s decision in appeals.</p>
<p>7</p> <p>Add language to IAC specifying “Home adaptation expenses should be based on contractor grade materials in all instances.”</p>	<p>This will provide support in appeals when the material(s) approved are adequate to meet the member’s needs and are less costly than what was requested. Language has been established by New York Medicaid.</p>	<p>The member’s medical need will still be met through coverage of the initial modification. Disallowing materials other than contractor grade materials will reduce coverage for items requested primarily for convenience or for aesthetic purposes.</p>	<p>The impact to the provider will be in the reimbursement only for contractor grade materials that adequately meet the member’s needs rather more costly materials (e.g., granite countertops) that do not serve a medical purpose.</p>	<p>The Department will likely realize cost avoidance by limiting the reimbursement for materials used to construction grade only.</p>	<p>Defining in rule the specification that only construction grade materials will be covered will further support for the Department’s decision in appeals relating to the least costly item that adequately meets the member’s needs.</p>

## HVM MVM Recommendation Summary

Recommendation	Rationale	Impacts			
		Member	Provider	Fiscal	Administrative
<p>8 Add language to IAC limiting coverage for the same home modifications to only two different residences in a five (5) year timeframe.</p> <p>Add language limiting coverage for the same vehicle modifications to only one (1) in a five year timeframe.</p>	<p>Exclusions to this rule have been identified as theft, fire, accident, natural disaster, court or other legal actions.</p> <p>This change will further reduce coverage of duplicate modifications within a shortened time frame.</p>	<p>For members who relocate more than twice in a five-year period or replace change vehicles more than once in a five-year period, this rule will impact the funding available through the waiver.</p> <p>If a member's assistive needs change, a new modification may be requested based on these changes. These modification requests may still be covered based on the changes in the member's condition.</p>	<p>The impact on the providers is anticipated to be minimal.</p>	<p>The Department will likely see some cost avoidance from completing multiple modifications, similar in scope, for the same member within a short time frame.</p>	<p>Defining in rule the limitations for frequency of completing the same modification multiple times will further support for the Department's decision in appeals. This may result in increased exception to policy requests for members who relocate more than twice in a five-year period or replace change vehicles more than once in a five-year period.</p>
<p>9 Remove language from IAC allowing HVM coverage for bath chairs and transfer benches.</p>	<p>This change will support 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.</p> <p>Requiring coverage for such items through state plan versus waiver will stretch the waiver dollar further to provide other home and/or community based services that are needed.</p>	<p>This may result in faster service for members to consistently access the items through the State Plan benefit.</p> <p>This will also allow the waiver dollars previously spent on this equipment to be reallocated to other services required to meet the member's medical or remedial needs.</p>	<p>Providers who are enrolled only as waiver providers (provider type 99) will be required to enroll as a DME provider (provider type 12) if they wish to continue to provide and bill these items to Medicaid members.</p>	<p>The Department may realize some cost avoidance based on the consistency reimbursement across DME providers for these items.</p> <p>By removing these items from coverage in the waiver program, the waiver dollars are able to be better allocated to other services that meet the member's needs. In addition, this supports the preamble of chapter 83 which specifies services covered under waiver are not otherwise available to the member.</p>	<p>This will further support the Department's decision in waiver related appeals when the member is directed to access the State Plan for these items.</p> <p>This will remove conflicting statements within the Iowa code.</p>

## HVM MVM Recommendation Summary

Recommendation	Rationale	Impacts				
		Member	Provider	Fiscal	Administrative	
10	<p>Add language to IAC specifying for home modifications in excess of \$5,000, the Department will protect it's interest through liens or other legally available means.</p>	<p>This change 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.</p>	<p>For members who have modifications completed that may not intend to remain in the current residence indefinitely, this may impact their decision to have a modification completed that is funded through the waiver.</p>	<p>This rule may impact providers who routinely complete high cost modifications if members opt to not have the entire modification complete.</p> <p>However, it is also believed that by allowing coverage for only contractor grade materials (recommendation number 7) may reduce the overall cost of some modifications and reduce the impact of this rule on providers and members.</p>	<p>The Department would recover monies for properties which were modified and sold prior to becoming part of the estate and made available through the estate recovery program.</p>	<p>There may be a significant amount of administrative resources spent to ensure the member is aware of this rule prior to agreeing to the modification as well as submitting any legal documentation on behalf of the Department to facilitate the follow through of this rule.</p>

## All Inclusive List of Recommendations From the Previous HVM MVM Report

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 cited 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 order 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 beginning 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	<b>Existing Dwelling and New Construction:</b> 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	<b>New Construction:</b> 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	<b>New Construction:</b> Bathing facilities would be installed in a new construction; appropriate shower should be installed at the time of construction.
Bathroom Modification; Shower; Walk-In (when less costly alternatives are contraindicated; e.g., tub-cut)	Yes	No	<b>New Construction:</b> 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	<b>New Construction:</b> 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	<b>New Construction:</b> 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	<b>New Construction:</b> 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	<b>Existing Dwelling:</b> Allow only if it is associated with a ramp (footings and landings) or required for a bathroom modification.  <b>New Construction:</b> Allow only if it is associated with a ramp (footings and landings) or exterior lift.

Medically Necessary Home Modification	Recommended Coverage		Comments
	Existing Dwelling	New Construction	
Concrete; Exterior hard surface pathways	Yes with limitations	No	<p><b>Existing Dwelling:</b> 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.</p> <p><b>New Construction:</b> Entry to the home would be required for new construction; appropriate entry, including needed walkways, should be considered in the new construction design.</p>
Deck/Landing	Yes with limitations	Yes with limitations	<p><b>Existing Dwelling and New Construction:</b> Allow only when attached to a ramp; reimbursement for deck or landing with a turn radius of 60 inches.</p> <p><b>New Construction:</b> See recommendations for ramp coverage.</p>
Door Widening; Bathroom (when swing clear hinges are contraindicated)	Yes	No	<p><b>New Construction:</b> Doors and doorways would be installed in a new construction; appropriate entry width should be considered in the new construction design.</p>
Door Widening; Garage	Yes with limitations	No	<p><b>Existing Dwelling:</b> Recommendation to allow door widening only for access to attached garage and home.</p> <p><b>New Construction:</b> Doors and doorways would be installed in a new construction; appropriate entry width should be considered in the new construction design.</p>
Door Widening; House Entry (when swing clear hinges are contraindicated)	Yes	No	<p><b>New Construction:</b> Doors and doorways would be installed in a new construction; appropriate entry width should be considered in the new construction design.</p>
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	<p>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.</p>
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 with limitations	Yes with limitations	<p>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.</p>

Medically Necessary Home Modification	Recommended Coverage		Comments
	Existing Dwelling	New Construction	
Flooring; low pile carpeting or slip resistant flooring	Yes with limitations	No	<p><b>Existing Dwelling:</b> 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).</p> <p><b>New Construction:</b> Flooring would be required for new construction therefore appropriate flooring should be considered in the new construction design.</p>
Ramp; Aluminum (when treated wood is contraindicated)	Yes	No	<p><b>New Construction:</b> Entry to the home would be required for a new construction; appropriate entry needs should be considered in the new construction design.</p>
Ramp; Portable (when stationary ramp is contraindicated)	Yes	No	<p><b>New Construction:</b> Entry to the home would be required for a new construction; appropriate entry needs should be considered in the new construction design.</p>
Ramp; Portable (when stationary ramp is contraindicated)	Yes	No	<p><b>New Construction:</b> Entry to the home would be required for a new construction; appropriate entry needs should be considered in the new construction design.</p>
Ramp; Treated Wood	Yes	No	<p><b>New Construction:</b> Entry to the home would be required for a new construction; appropriate entry needs should be considered in the new construction design.</p>
Stair Glide	Yes with limitations	Yes with limitations	<p>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.</p>
Window and/or Door Locks	Yes with limitations	Yes with limitations	<p><b>Existing and New Construction:</b> Recommend reimbursement only for specialized lock components not provided with standard windows <u>and</u> only when a documented history of elopement is present.</p>

12. **enrolling as a Iowa 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 un-

- less 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 its 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) modifications.** 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 pre-**

**viously 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 popu-**

**lation 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



## Easter Seals Iowa Assistive Technology Center

Donated durable medical equipment is refurbished and provided to individuals in need, at a low cost. Equipment is available by application and requires a prescription from a medical professional prior to obtaining.

**Through the recycling of durable medical equipment, over \$300,000 was saved through this reutilization program in Iowa.**

### Demonstration Center

The demonstration center showcases different types of assistive technologies including grab bars, modified cupboards, lowered countertops, roll in shower, and lifts. This program offers consumers an opportunity to try out equipment before it is purchased or brought into the home.

**295 demonstrations were presented to nearly 500 participants across the state. 80% of these participants found the device would meet their needs. 20% found that the device would either not meet their needs or had not made a decision.**

### Lending Library

Equipment and resources are available for families, individuals, counselors and schools. Up to five pieces of equipment can be checked out for 30 days to decide on the success before purchase.

**157 devices were loaned across Iowa to assist people in making a decision on which device best meets the needs in their environment. 93% of participants decided that the device would meet their needs. 6% of participants decided that the device would not meet their needs. 92% of participants were satisfied or highly satisfied with the services they received.**

2012-2013 Outcome Data

The Assistive Technology Center (AT Center) houses three Easter Seals Iowa programs: **Equipment Loan, the Demonstration Center, and the Lending Library.** All of these are statewide programs serving all 99 counties in Iowa.

Easter Seals Iowa's mission is to provide exceptional services to ensure that all people with disabilities or special needs and their families have equal opportunities to live, learn, work, and play in their communities.

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# Iowa Medicaid, Medicaid waivers and Assistive Technology: An overview and recommendations for improved access

## The Iowa Medicaid State Plan and Assistive Technology

### Overview

The Iowa Medicaid State Plan provides assistive technology through its coverage of durable medical equipment (DME), prosthetics and orthotics.

DME is defined as equipment that:

- ◆ Can withstand repeated use,
- ◆ Is appropriate for use in the home.
- ◆ Is primarily and customarily used to serve a medical purpose, and
- ◆ Is generally not useful to a person in the absence of an illness or injury.

[[http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual\\_Documents/Provman/medequip.pdf](http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/medequip.pdf) - pg. 12]

Additionally, “Durable medical equipment, supplies, and prosthetic devices must be required by the member because of the member’s medical condition. The item shall be necessary and reasonable, as determined by Iowa Medical Enterprise (IME) medical staff. An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body member.”

[[http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual\\_Documents/Provman/medequip.pdf](http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/medequip.pdf) - pg. 6]

The Iowa Administrative Code correctly identifies that the list of equipment covered is not an exhaustive one. In practice, however, both DME vendors and IME reviewers utilize the list of covered equipment as definitive. Currently, Iowans who require medically necessary DME that is not on the list can submit an Exception To Policy request for coverage. The barrier that this causes is that under current Iowa law, such a request does not have appeal rights.

### Recommendation

1. The Iowa Medicaid Enterprise needs to build a process for requests for DME that are not currently on the list. Guidance should be provided to vendors that advises them that the list of DME in the rule is not exhaustive and the procedures that the vendor should undertake for unlisted items. Moreover, in the event that an item is denied, IME should state whether or not the item is considered to be DME. This process must be one that maintains appeals rights for Iowa Medicaid members.
2. Review the list of approved Exceptions to Policy requests for patterns that indicate regular approval so that these items can be added to the representative DME list. [Note: In 2013, the Medicaid agency promulgated regulations providing coverage for 2 additional types of DME that had previously only been granted through Exceptions to Policy. For the first time, the Agency cited the administrative costs of

individualizing decisions for these types of equipment as a factor in adding them to the State Plan.]

## Dual Eligible Iowans and Assistive Technology

### **Overview**

Iowa Medicaid members who also have Medicare are described as “dually eligible.” Medicare Part B pays for DME. For dual eligible Iowans, Medicare is the first, or primary, payer and Iowa Medicaid is the secondary payer. The coverage criteria for DME is often the same under both Medicare Part B and Iowa Medicaid. However, multiple barriers can occur when the coverage is different. The lack of a prior approval process from Medicare (in most cases) is one such barrier. With no prior approval process, the vendor puts itself at risk that no payment will be made. Moreover, there is no way to generate an appealable Explanation of Benefits (EOB) in the Medicare system with the actual provision of service. Other barriers are the differences in coverage criteria between the two programs for certain types of equipment and the difference in fee schedules for certain types of DME between Iowa Medicaid and Medicare. These barriers often mean that DME vendors throughout Iowa continue to be reluctant to provide medically necessary, covered assistive technology to dual eligible Iowans.

### **Recommendations**

Iowa Medicaid should change and improve their internal approval processes regarding dual eligible claims:

1. That policy is clarified to provide that there is no requirement of an EOB in those instances where there is no reasonable expectation of coverage through Medicare; and
2. that a Prior Authorization request be considered without an EOB when a vendor has reasonable concerns about non-coverage under Medicare.

## Medicaid Home and Community Based Services (HCBS) Waivers and Assistive Technology

### **Overview**

Iowa has seven HCBS waivers. Six of these provide some type and amount of assistive technology coverage in addition to the DME coverage provided by the Iowa Medicaid State Plan. There is no additional assistive technology provided under the HIV/AIDS waiver.

### **Environmental Modifications, Adaptive Devices**

This category of assistive technology is provided under the Children’s Mental Health waiver. These are:

“...Items installed or used within the child’s home that address specific documented mental health, health or safety concerns. This service shall be provided under the recommendation and direction of the mental health professionals that are included on

the child's interdisciplinary team. Items may include, but are not limited to, smoke alarms, window/door alarms, pager supports, motion sensors and fencing."

This category of assistive technology is unique to this waiver.

### **Specialized Medical Equipment**

This category of assistive technology is provided under two waivers:

1. Brain Injury waiver
2. Physical Disability waiver

These items are:

"... medically necessary equipment as determined by a medical professional ... It is designed for the personal use by the member and provides for the safety and health of the individual. ... This includes, but is not limited to the following: Electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and non-covered environmental control units."

### **Home and Vehicle Modifications**

This category of assistive technology is provided under five waivers:

1. Health & Disability waiver (maximum of \$6,000/year)
2. Elderly waiver (lifetime maximum of \$1,000)
3. Intellectual Disability waiver (lifetime maximum of \$5,000)
4. Brain Injury waiver (maximum of \$6,000/year)
5. Physical Disability waiver (maximum of \$6,000/year)

IME provides a list of 23 covered Home and Vehicle Modifications. Unlike the description for the A.T. provided as both **Environmental Modifications**, **Adaptive Devices** and **Specialized Medical Equipment**, the **Home and Vehicle Modifications** list specifically states it is exclusive.

### **Recommendations**

1. Repairs for home and vehicle modifications should be covered. Currently, HVM repairs are prohibited. As this is not cost effective, IME routinely grants exceptions to policy for modification repair requests. These requests are costly for IME and a time-consuming barrier for lowans with disabilities.
2. Do not require competitive bids for HVM under \$500: The requirement for three bids for home and vehicle modifications can be a barrier.
3. Increase or remove the lifetime maximum for HVM under the Elderly and Intellectual Disability waivers. The current lifetime maximum is a barrier when the available dollars do not provide the needed modifications. The \$1,000 limit on the Elderly waiver is particularly low and in most cases, would not be enough to build a simple home ramp.
4. Change the HVM list to a non-exclusive one. The Iowa Administrative Code currently includes a limited definition of these modifications: *Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. 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.*

5. Review the list of approved HVM Exceptions to Policy requests for patterns that indicate regular approval so that these items can be added to the HVM list.



February 2014

## Respiratory Syncytial Virus (RSV)-related Hospitalizations

2nd Qtr, SFY14

Points of Interest, SFY13:

- 760 unique members with RSV-related acute inpatient hospitalizations.
- 806 RSV-related acute inpatient hospitalizations.
- 517 unique members received palivizumab (Synagis®)
- 23 members with a RSV-related acute inpatient hospitalization also received palivizumab (Synagis®)

### In this report

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### What is Respiratory Syncytial Virus (RSV)?

Respiratory Syncytial Virus (RSV) is the most common cause of bronchiolitis and pneumonia in children younger than age one in the United States.

A 1997 study published in the Journal of Pediatrics showed that two-thirds of infants are infected with RSV during the first year of life and almost 100 percent by age two. (Russell, et al, 1997) Similarities were previously noted in a 1979 New England Journal of Medicine article which reported that the attack rate of approaches 100 percent in certain settings such as day-care centers. (Henderson, et al., 1979)

Because of lung development in premature infants, young children with known chronic lung disease(s) (CLD) or the potential complications of congenital heart disease(s) (CHD) with an associated respiratory infection, prophylactic treatment is recommended for these high-risk groups. (American Lung Association, n.d.)

The only currently-available prophylactic treatment for RSV is palivizumab (Synagis®)

A 1998 article published in the Journal of Pediatrics noted “Palivizumab prophylaxis resulted in a 55% reduction in hospitalization as a result of RSV...Children with prematurity but without BPD [bronchopulmonary dysplasia] had a 78% reduction in RSV hospitalization; children with BPD had a 39% reduction.” (Impact-RSV Study, 1998)

### What is palivizumab (Synagis®)?

Palivizumab (Synagis®) is a synthetic monoclonal antibody given to high-risk infants and children under the age of two. Synagis® was FDA approved in June, 1998 for the prevention of serious lower respiratory tract disease (LRTI) in pediatric patients. Synagis® has been shown to reduce hospitalization caused by respiratory syncytial virus (RSV) but has not been proven to prevent mortality or improve any other outcome measures. Safety and efficacy has been established in infants with a history of premature birth born at or before 35 weeks gestation, infants and young children with a diagnosis of bronchopulmonary dysplasia (BPD) or a hemodynamically significant CHD.

Dosing is recommended monthly during the RSV season.

### How does palivizumab (Synagis®) work?

In short, palivizumab (Synagis®) fuses with the viral molecules in RSV and inhibits the ability to replicate at the molecular level. The inhibition of RSV to replicate results in a reduction in the colonization capabilities of the virus in the lungs. This process ultimately decreases the severity of complications or the presenting symptoms of illness. (MedImmune, 2011)

### Premature Lung Development

The picture below demonstrates the development of the alveoli (air sacs) within the lungs of an infant and the typical maturation and development. Prior to 36 weeks gestation, most infants' lungs are not fully developed with a capacity to move air as freely as their term cohorts.

Young children with other chronic conditions such as a CLD or CHD may also have impaired lung function. For this reason, when viruses such as RSV or infections such as bronchiolitis, bronchitis or pneumonia are present, the premature infant or young child has a reduced capability to remove secretions which may cause severe respiratory problems. Use of palivizumab (Synagis®) reduces the severity of RSV in these populations and thus reduces the risk of severe complications if RSV is contacted.

**PREMATURE BIRTH INTERRUPTS LUNG DEVELOPMENT**

The diagram illustrates the progression of lung development. It is divided into three main stages: FETAL DEVELOPMENT, PREMATURE\*, and TERM\*. FETAL DEVELOPMENT includes 8 weeks GA and 16 weeks GA. PREMATURE\* includes 24 to 35 weeks GA. TERM\* includes 36 weeks to 3 years. The images show the increasing complexity and density of the lung's branching structure over time.

- Although alveoli are present in some infants as early as 32 weeks GA, they are not uniformly present until 36 weeks GA<sup>1</sup>

\*Pictures are artistic renditions of lung development and are designed to emphasize terminal acinus development and not the entire conducting airway system. Adapted from Moore 2003.<sup>2</sup>

<sup>1</sup> Langston C, et al. Am Rev Respir Dis. 1984;129:607-613.  
<sup>2</sup> Moore KL, Persaud TVN. In: *The developing human: clinically oriented embryology*. 7th ed. Philadelphia, PA: Saunders. 2003:241-253.

(MedImmune, n.d)

## The purpose of this MVM study.

The decision to authorize coverage of palivizumab (Synagis®) for initial administration in mid to late November led to inquiries regarding the number of hospitalizations which may have been prevented had this prophylactic treatment been provided in late October or early November. As a result of these inquiries, IME changed the start date for the 2013-2014 RSV season to allow authorization of palivizumab (Synagis®) starting November 1, 2013.

The next several pages of this report outlines the data queried for state fiscal years (SFY) 2009 through 2013, and the results of the queries. For the purpose of this study, claims were queried for members aged zero through two years. Due to palivizumab (Synagis®) not being indicated in members over the age of two, members over age two at the start of the SFY were excluded.

**NOTE:** Most infants hospitalized for RSV would not have been eligible for palivizumab (Synagis®). Some infants could be identified as not eligible for administration based on their age and date of birth (DOB). However, information obtained from claims data for inpatient RSV-related hospitalizations does not reflect all the necessary components to determine member eligibility for palivizumab (Synagis®), such as gestational age, environmental risk factors, etc. to be able to identify the true number of members hospitalized with RSV that may have been eligible to receive palivizumab (Synagis®).

- In SFY12, 40 members with an inpatient hospitalization for RSV would not have been eligible for palivizumab (Synagis®) based on their DOB.
- In SFY13, 90 members with an inpatient hospitalization for RSV would not have been eligible for palivizumab (Synagis®) based on their DOB.

## Palivizumab (Synagis®) Administration Start Dates

The process for determining the start date for authorization for palivizumab (Synagis®) is outlined in informational letter 1228, dated March 21, 2013.

“...**Start Date:** The start date will begin two weeks prior to the expected season start date for the state of Iowa....The expected season start date shall be derived from the median start date of the past five seasons using Iowa virological data. As defined by the United States National Respiratory and Enteric Virus Surveillance System (NREVSS), the RSV season starts when the first of two consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is  $\geq 10$  percent. The start date will be adjusted to an earlier date by Medicaid if indicated by the virological data. Medicaid will use virology data provided by the Iowa Department of Public Health (IDPH) to prospectively estimate the start of the RSV season and follow the virology data to the end of the season. The IDPH makes the data provided available to the public on the Department of Public Health’s website at: <http://www.idph.state.ia.us/Cade/Influenza.aspx>.”

The table at the top of the next page identifies key dates for the current and previous RSV seasons.

RSV Season	IA RSV Onset Date (CDC data)	Calculated Start Date*	Start Date IA Medicaid Administration (compared to season start)
2007-2008	12/22/2007		10/15/2007 (2 mo. early)
2008-2009	12/27/2008		10/30/2008 (2 mo. early)
2009-2010	11/14/2009		11/16/2009 (at start)
2010-2011	1/8/2011		11/16/2010 (~2 mo. early)
2011-2012	1/14/2012	12/18/2011	11/28/2011 (~2 mo. early)
2012-2013	11/17/2012	12/23/2012	11/26/2012 (1 week after start)
2013-2014	12/14/2013	12/16/2013	11/25/2013 -- original planned start date (2 weeks after planned start) **

\* Based on the median five year RSV season start from CDC data.

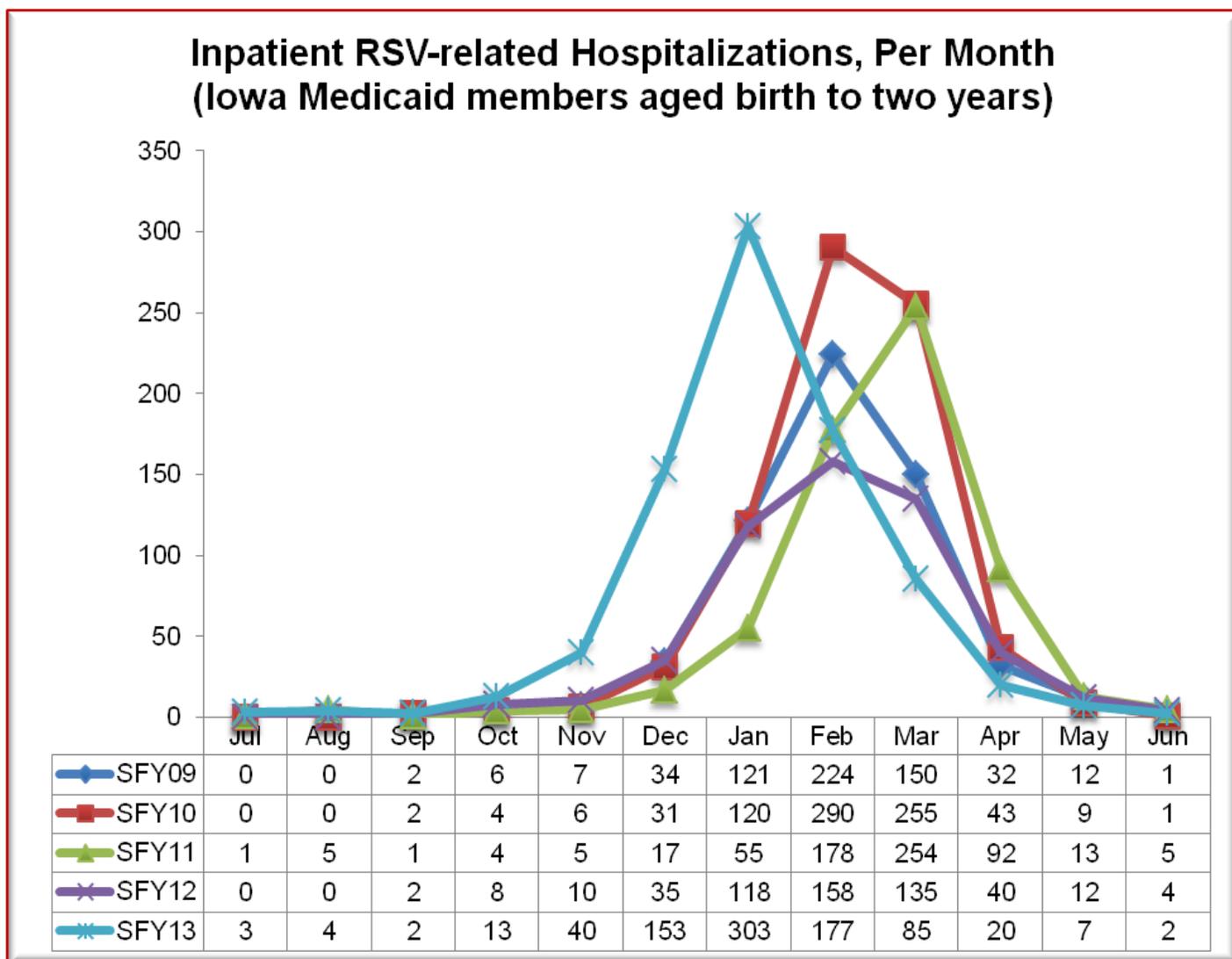
\*\* The administration start date for the 2013-2014 season was changed from November 25, 2013, to November 1, 2013.

### Inpatient Hospitalizations

Inpatient final paid claims were queried that contained the following diagnosis codes (any field on the claim):

- 466.11 Acute Bronchiolitis Due to RSV
- 480.1 Pneumonia Due to RSV
- 79.6 Respiratory Syncytial Virus (RSV)
- V04.82 Respiratory Syncytial Virus (RSV)

The graph below tracks Iowa Medicaid inpatient RSV-related hospitalizations, by month, for SFYs 09 through 13 for members aged zero to two years.



For SFY13, Iowa Medicaid had an acute inpatient admission rate of **2.2 percent** for children under the age of two for RSV-related diagnoses.

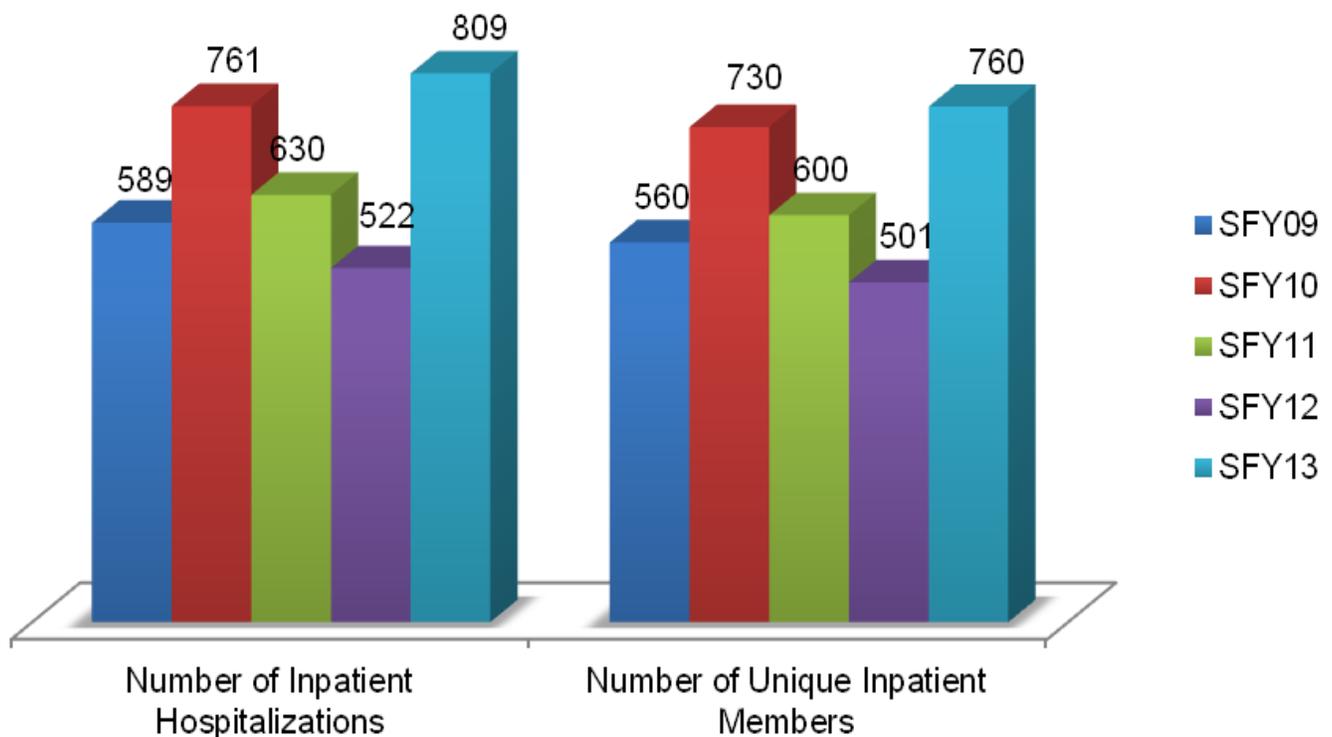
The inpatient hospitalizations queried for RSV followed a progression corresponding with the typical RSV season—November through March. In SFY12, the inpatient trend started to increase later in the year and declined later as well. In SFY13 there was an increase in hospitalizations earlier in the year, but the decline was earlier than in SFY12.

In SFY12, no inpatient hospitalizations submitted to IME for reimbursement were coded with RSV-related diagnoses for the months of July and August; SFY13 reported seven hospitalizations for July and August. RSV typically does not circulate in Iowa at all during the summer months. It is a statistical rule that when prevalence is very low, the likelihood of a test being falsely positive is high. Thus, a diagnosis of RSV illness at this time, even with a positive test, is unlikely and the diagnoses may be in error.

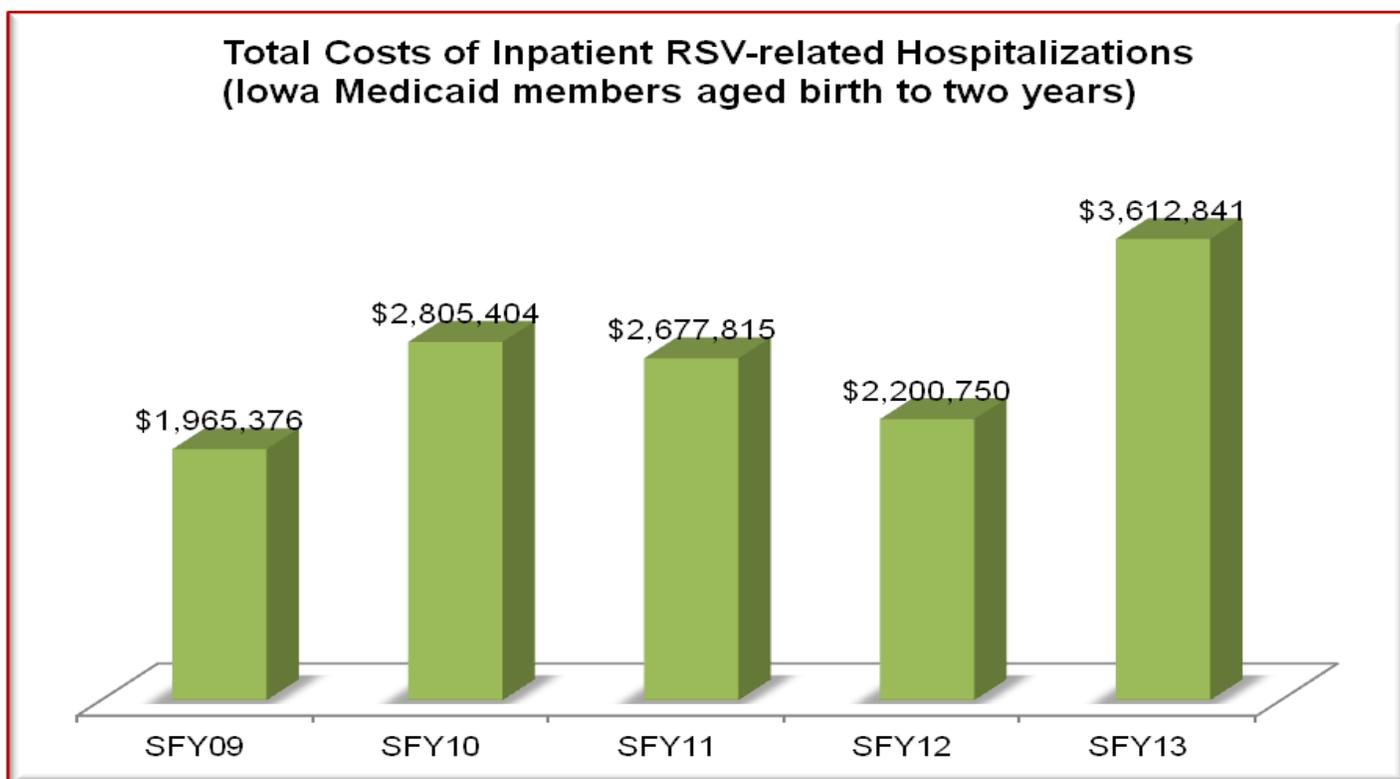
The graph below reflects the total number of inpatient RSV-related hospitalizations for each SFY and the unique members that comprised the hospitalizations. Some members were reported to have multiple RSV-related hospitalizations.

Claims data queried only identified the members hospitalized who were within an age range that may have benefited from prophylactic treatment for RSV.

### Inpatient RSV-related Hospitalizations (Iowa Medicaid members aged birth to two years)



The graph below reflects the total reimbursed cost by IME for RSV-related inpatient hospitalizations.



An increase in reimbursed cost of \$1,412,091 was noted from SFY12 to SFY13 for inpatient hospitalizations.

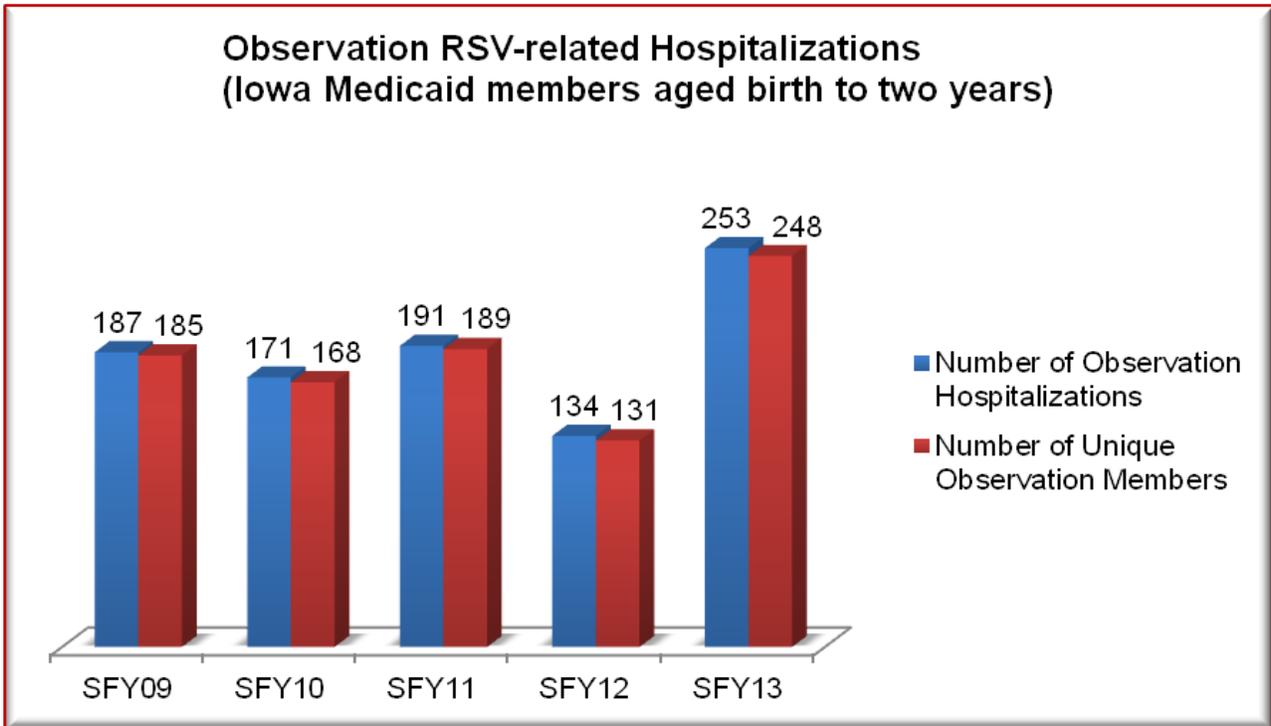
### Observation Hospitalizations

In addition to the diagnoses codes identified for inpatient hospitalizations, RSV-related observation stays were queried based on the following procedure codes:

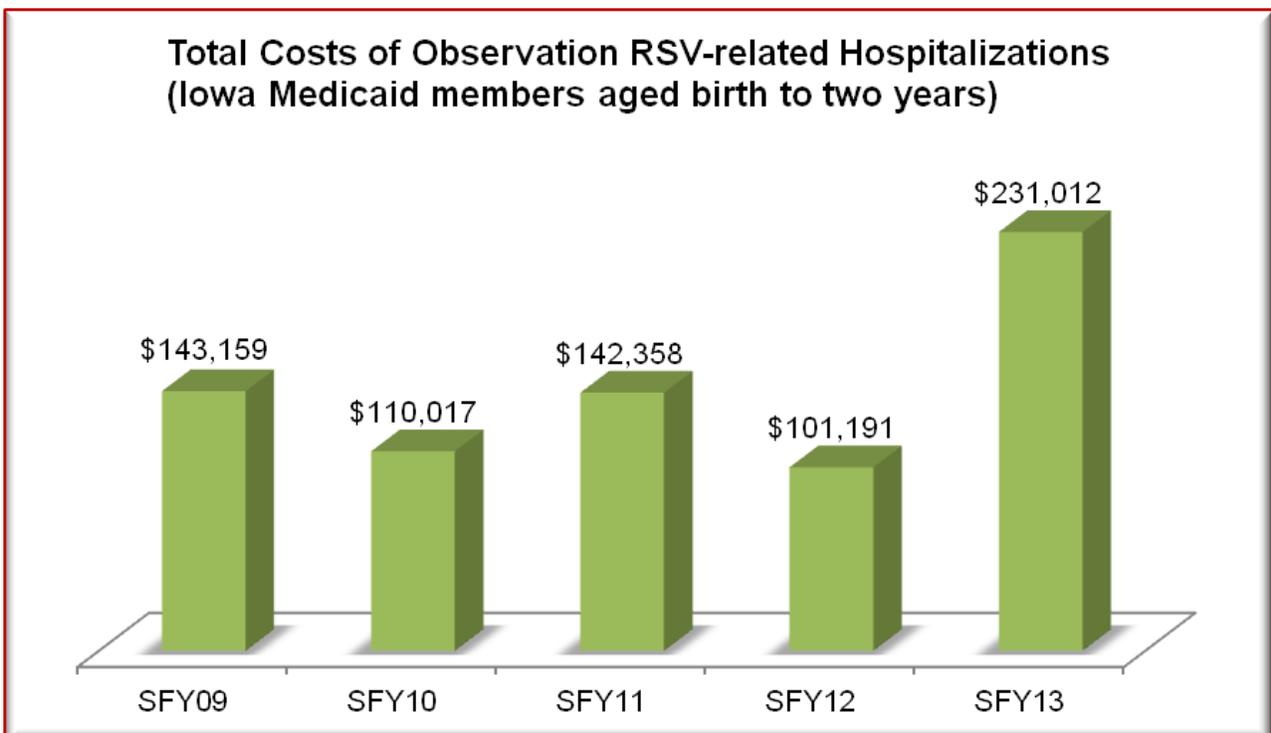
- 99217 Observation Care Discharge Day Management
- 99218 Initial Observation Care, Per Day...
- 99219 Initial Observation Care, Per Day...
- 99220 Initial Observation Care, Per Day
- G0378 Hospital Observation Service, Per Hour
- G0379 Direct Admission of Patient for Hospital Observation...

The graph on the top of page seven reflects the number of RSV-related observation hospitalizations for SFYs 09 through 13 as well as the number of unique members who comprised these observation stays. Each year has had at least one member with multiple RSV-related observation hospitalizations.

In each year studied some members were identified as having both acute inpatient and observation hospitalizations for RSV-related diagnoses.



The graph below reflects the total reimbursed cost by IME for RSV-related observation hospitalizations.



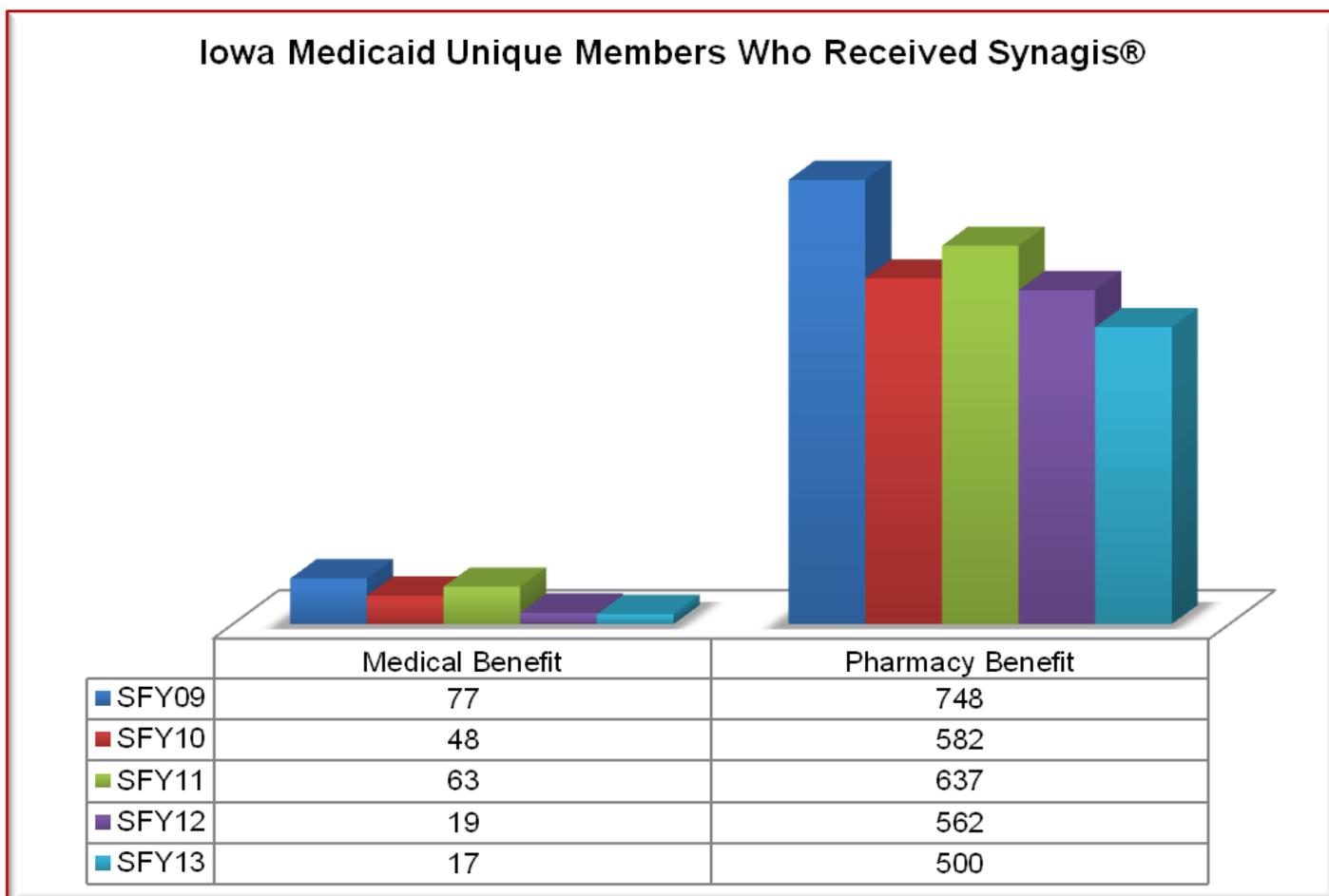
### Palivizumab (Synagis®) Utilization

Final paid claims for procedure code 90378 (Respiratory Immune Globulin, I.M. 50mg)—physician office reimbursement for the administration of palivizumab Synagis®.

Final paid claims for the following pharmacy NDCs—pharmacy reimbursement for administration of palivizumab Synagis® in a place of service other than a physician’s office:

- 60574411101
- 60574411201
- 60574411301
- 60574411401

The graph below reflects the number of unique members who received palivizumab (Synagis®) through either the medical or pharmacy benefit in SFYs 09 through 13.

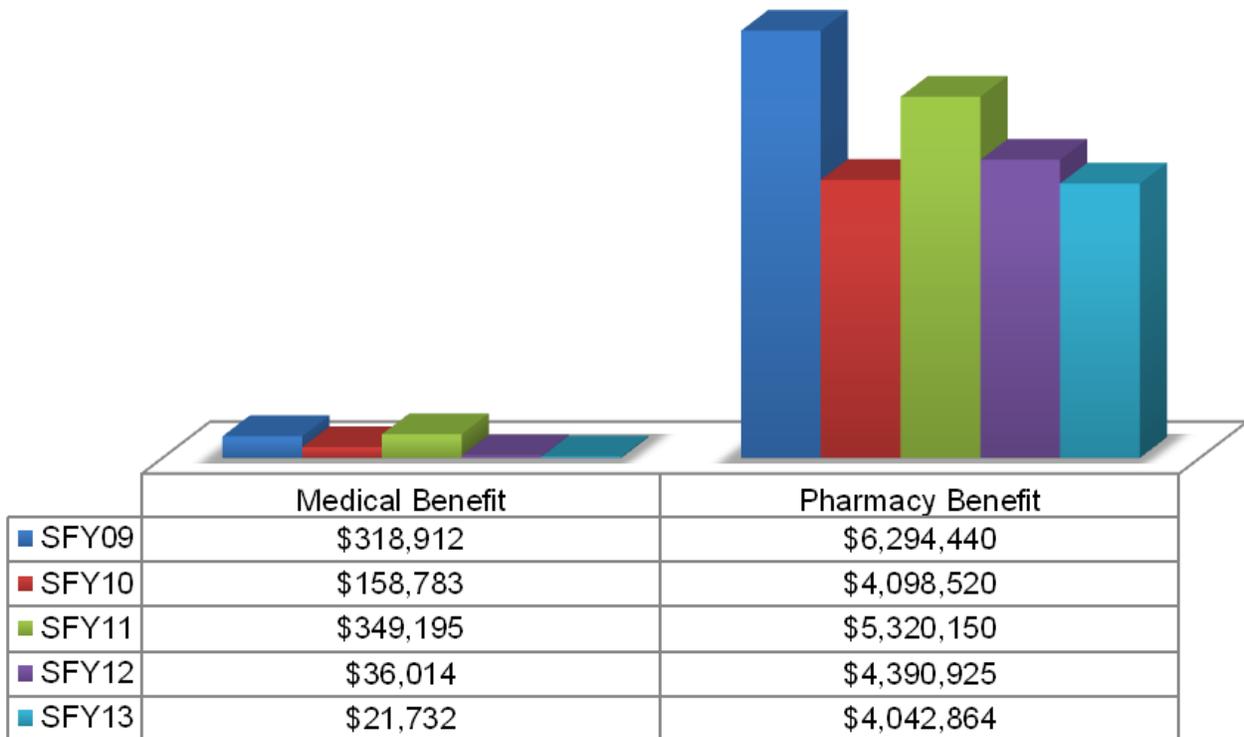


In SFY12, nine members accessed both the medical and pharmacy benefits to receive palivizumab (Synagis®); six members accessed both benefits in SFY13. There was no overlap in dates of service for members who accessed both the medical and pharmacy benefit.

The graph below reflects the total Iowa Medicaid reimbursed amount for palivizumab (Synagis®) through either the medical or pharmacy benefit in SFYs 09 through 13.

**NOTE:** The total cost reflected below is for palivizumab (Synagis®) only; associated costs for physician or home health administration are not reflected below.

**Iowa Medicaid Reimbursed Amounts for Synagis®**  
 (\*pharmacy benefit reimbursement reflected prior to rebate)



Additional doses of palivizumab (Synagis®) may have been provided during infant hospitalization in the neonatal intensive care unit (NICU) that are not reflected in the costs identified above or the unique member count identified on the previous page.

The table on the next page identifies the members who were noted to have both received palivizumab (Synagis®) and had an inpatient hospitalization for a RSV-related diagnosis during the SFYs 12 and 13.

**NOTE:** All members with a reported RSV-related inpatient hospitalization who also received palivizumab (Synagis®) during the same SFY received the prophylactic treatment through the pharmacy benefit.

SFY12				SFY13			
Synagis® (pharmacy) and an inpatient hospitalization	Hospitalization Date	Hospitalized before, during or after IME RSV/Synagis® season?	Was Synagis® administered before hospitalization (within 30 days)?	Synagis® (pharmacy) and an inpatient hospitalization	Hospitalization Date	Hospitalized before, during or after IME RSV/Synagis® season?	Was Synagis® administered before hospitalization (within 30 days)?
1 (SFY12)	12/9/2011	During	Yes (2 doses)	1 (SFY13)	1/21/2013	During	Yes (2 doses)
2 (SFY12)	3/17/2012	During	Yes (3 doses)	2 (SFY13)	10/23/2012	Before	No
3 (SFY12)	3/13/2012	During	Yes (4 doses)	3 (SFY13)	12/26/2012	During	Yes (2 doses)
4 (SFY12)	9/12/2011	Before	No	4 (SFY13)	2/11/2013	During	Yes (3 doses)
5 (SFY12)	12/14/2011	During	Yes (1 dose)	5 (SFY13)	7/16/2012	Before	No
6 (SFY12)	3/2/2012	During	Yes (4 doses)	6 (SFY13)	12/26/2012	During	No
7 (SFY12)	3/2/2012	During	Yes (4 doses)	7 (SFY13)	1/25/2013	During	Yes (1 dose)
8 (SFY12)	10/14/2011	Before	No	8 (SFY13)	11/23/2012	Before	No
9 (SFY12)	1/6/2012	During	Yes (2 doses)	9 (SFY13)	12/31/2012	During	Yes (2 doses)
10 (SFY12)	4/11/2012	After	**	10 (SFY13)	3/4/2013	During	Yes (4 doses)
11 (SFY12)	3/29/2012	During	**	11 (SFY13)	2/21/2013	During	Yes (2 doses)**
12 (SFY12)	2/23/2012	During	**	12 (SFY13)	1/8/2013	During	Yes (2 doses)
13 (SFY12)	3/26/2012	During	**	13 (SFY13)	1/10/2013	During	Yes (2 doses)
14 (SFY12)	2/15/2012	During	**	14 (SFY13)	1/28/2013	During	No
15 (SFY12)	12/31/2011	During	No	15 (SFY13)	11/17/2012	Before	No
16 (SFY12)	3/10/2012	During	Yes (2 doses)	16 (SFY13)	10/29/2012	Before	No**
17 (SFY12)	3/7/2012	During	Yes (1 dose)	17 (SFY13)	12/24/2012	During	Yes (1 dose)
18 (SFY12)	3/12/2012	During	No	18 (SFY13)	12/13/2012	During	No
19 (SFY12)	4/2/2012	After	Yes (2 doses)***	19 (SFY13)	12/21/2012	During	Yes (1 dose)
20 (SFY12)	3/28/2012	After*	Yes (2 doses)***	20 (SFY13)	11/18/2012	Before	No**
*After RSV/Synagis® season based on discharge date.							
** Did not receive complete (5 doses) for RSV/Synagis® season by March 31.							
*** Received one dose after RSV/Synagis® season							

*In SFY12*, 20 members who received palivizumab (Synagis®) also had an inpatient RSV-related hospitalization. Of the 20 members, one experienced a hospitalization before the IME RSV/palivizumab (Synagis®) season started for the SFY; three were hospitalized after March 31, 2012.

All members who were hospitalized during the SFY12 IME RSV/palivizumab (Synagis®) season received palivizumab (Synagis®) following the hospitalization. Although five members did not receive five doses due to not starting palivizumab (Synagis®) until after the hospitalization for the RSV-related diagnosis.

*In SFY13*, 23 members who received palivizumab (Synagis®) also had an inpatient RSV-related hospitalization. Of the 23 members, six were hospitalized before the IME RSV/palivizumab (Synagis®) season started for the SFY; none were hospitalized after March 31.

Unique to SFY13, compared to SFY12, was the number of members who were hospitalized for an RSV-related diagnosis with subsequent claims data did not show follow-up palivizumab (Synagis®) administration for the remainder of the season. Four members did not complete the RSV/palivizumab (Synagis®) season following the hospitalization. A change in coverage from SFY12 to SFY13 may have resulted in some members being eligible for fewer than five doses of palivizumab (Synagis®).

### **Denied palivizumab (Synagis®) prior authorizations**

Prior authorization data was queried to identify if any members who experienced an inpatient RSV-related hospitalization were denied prior approval for palivizumab (Synagis®) during the same SFY as the hospitalization.

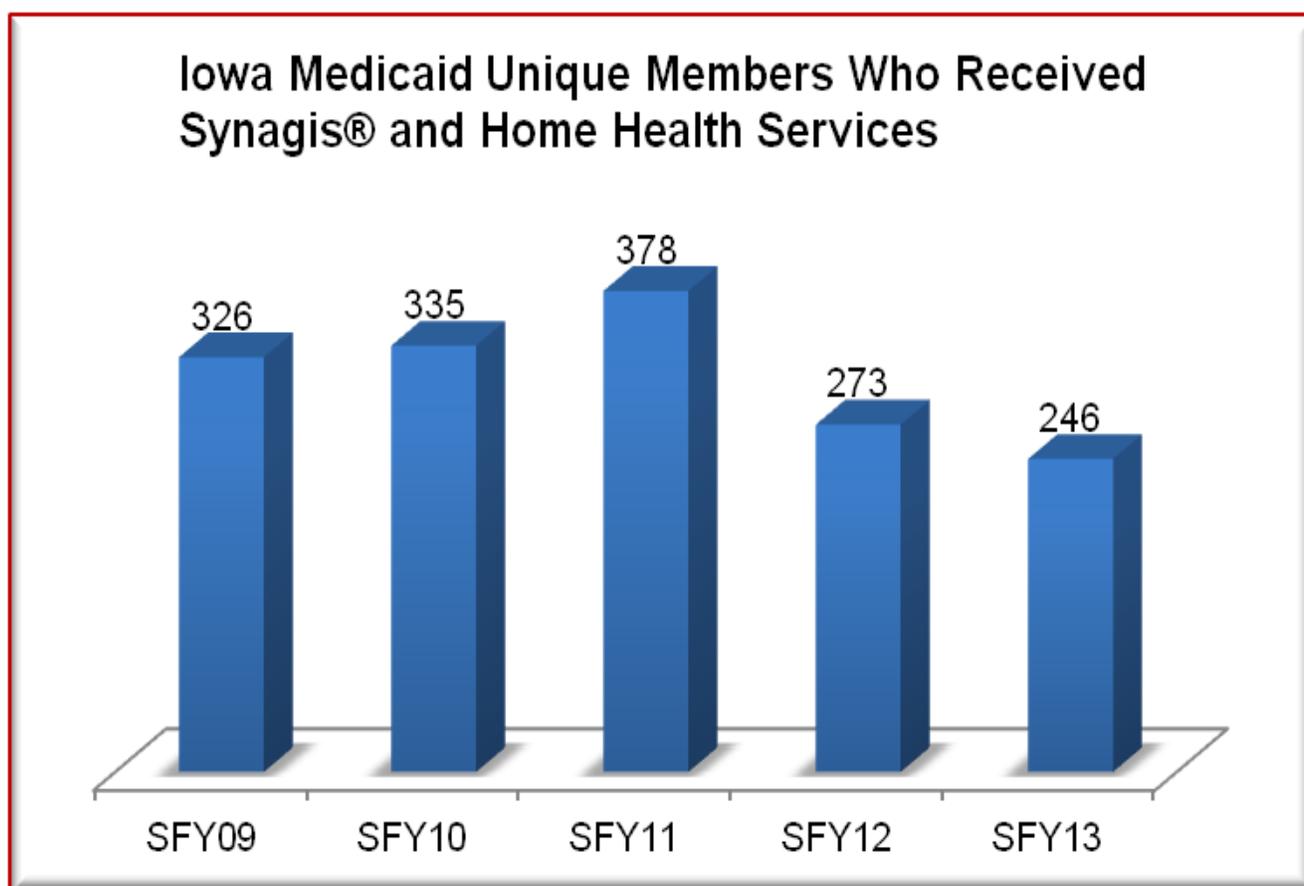
- There were not any members identified as having an inpatient RSV-related hospitalization in SFY12 or 13 that were previously denied prior authorization under the medical benefit.
- In SFY12, only three members identified as having a RSV-related hospitalization had a denied palivizumab (Synagis®) pharmacy prior authorization. These three members did not meet the gestational or chronological age criterion for the year requested.
- In SFY13, only eight members identified as having a RSV-related hospitalization had a denied palivizumab (Synagis®) pharmacy prior authorization. These eight members did not meet the gestational or chronological age criterion for the year requested.

Due to the low volume of denied prior authorization requests for members who had an acute inpatient admission for a RSV-related diagnosis, observation hospitalizations were not compared with denied prior authorization requests for this study.

## Home Health Utilization

The graph below identifies the number of unique members identified as receiving palivizumab (Synagis®) who were also receiving home health services during the corresponding SFY.

To identify the members who received palivizumab (Synagis®) and were also receiving home health services, a query of final paid claims for either procedure code S9123 or REV Code 551—Final paid claim for home health, skilled nursing or registered nurse (RN), services only. The query resulted in approximately half of the members for each SFY who accessed the pharmacy benefit for palivizumab (Synagis®) also had a home health claim. The members accessing palivizumab (Synagis®) via the pharmacy benefit are expected to have associated home health costs.



Home health visits for the sole purpose of administering palivizumab (Synagis®) may have been included in administrative costs for home health agencies to be cost settled with the year-end cost report. This may account for some of the low volume of home health visits billed in connection with a member receiving palivizumab (Synagis®).

Another factor likely contributing to the low volume of home health aid visits being billed may be a some physicians opting to have palivizumab (Synagis®) delivered to their office directly from the

pharmacy; the pharmacy would subsequently submit a claim to Iowa Medicaid for the drug.

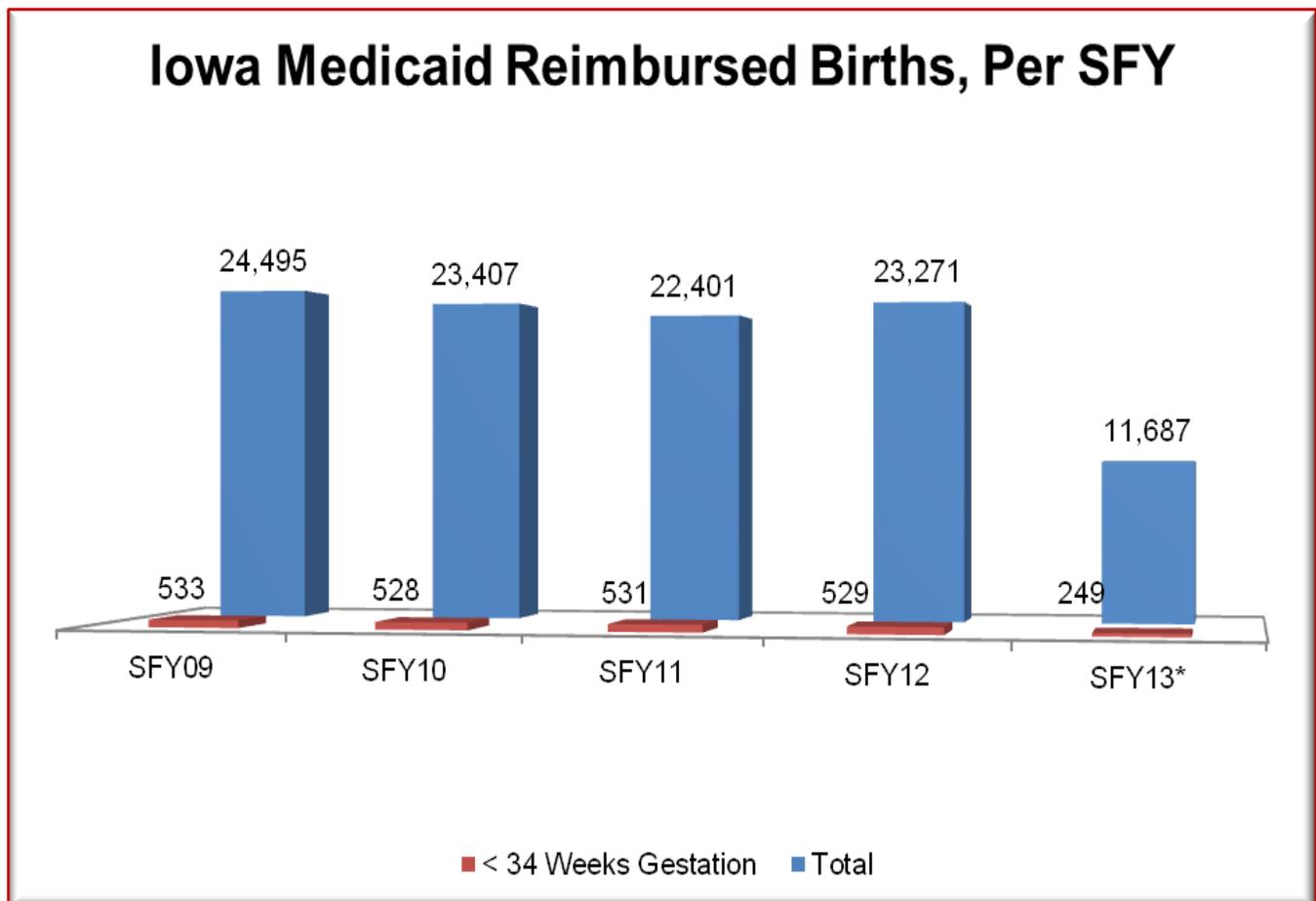
**Note:** Pharmacies and physicians are discouraged from having the member obtain the drug from the pharmacy and transporting it to the physician office for administration.

### Iowa Medicaid Preterm Births--Before 34 Weeks Gestation

Knowing that preterm infants are at greater risk of complications from RSV it was important to view the data available for infants born on or before 34 weeks gestation. This is also one of the criterion used for prior authorization of palivizumab (Synagis®).

The graph below identifies Medicaid births for SFYs 09 through 12 and the first six months of SFY13. The blue bar represents the total number Medicaid reimbursed births. The red bar represents Medicaid reimbursed births which occurred at or before 34 weeks gestation. Consistently, Iowa Medicaid has had 3.2 to 3.6 percent of births occur at or before 34 weeks gestation.

This information was provided to IME by the Iowa Department of Public Health, Bureau of Health Statistics for the purpose of this MVM study.



\* SFY13 information only available through December 31, 2012. (IDPH, 2013)

## Summary

The decision to authorize coverage of palivizumab (Synagis®) for initial administration in mid to late November led to inquiries regarding the number of hospitalizations which may have been prevented had this prophylactic treatment been provided in late October or early November. As a result of these inquiries, IME changed the start date for the 2013-2014 RSV season to allow authorization of palivizumab (Synagis®) starting November 1, 2013.

Through collaboration between the Program Integrity, Medical Services and the Pharmacy Units of Iowa Medicaid Enterprise claims, and prior authorization data was queried and studied to identify the children who had a RSV-related hospitalization as well as the children who received the palivizumab (Synagis®) injections.

The next several pages of this report outlines the data queried for state fiscal years (SFY) 2009 through 2013, and the results of the queries. For the purpose of this study, claims were queried for members aged zero through two years. Palivizumab (Synagis®) is not indicated over the age of two, so members over age two at the start of the SFY were excluded.

**NOTE:** Most infants hospitalized for RSV would not have been eligible for palivizumab (Synagis®). Some infants could be identified as not eligible for administration based on their age and date of birth. However, information obtained from claims data for inpatient RSV-related hospitalizations does not reflect all the necessary components to determine member eligibility for palivizumab (Synagis®), such as gestational age, environmental risk factors, etc. to be able to identify the true number of members hospitalized with RSV that may have been eligible to receive palivizumab (Synagis®).

The process for determining the start date for authorization for palivizumab (Synagis®) is outlined in informational letter 1228, dated March 21, 2013.

“...**Start Date:** The start date will begin two weeks prior to the expected season start date for the state of Iowa....The expected season start date shall be derived from the median start date of the past five seasons using Iowa virological data. As defined by the United States National Respiratory and Enteric Virus Surveillance System (NREVSS), the RSV season starts when the first of two consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is  $\geq 10$  percent. The start date will be adjusted to an earlier date by Medicaid if indicated by the virological data. Medicaid will use virology data provided by the Iowa Department of Public Health (IDPH) to prospectively estimate the start of the RSV season and follow the virology data to the end of the season. The IDPH makes the data provided available to the public on the Department of Public Health’s website at: <http://www.idph.state.ia.us/Cade/Influenza.aspx>.”

The table on the next page identifies key dates for the current and previous RSV seasons.

RSV Season	IA RSV Onset Date (CDC data)	Calculated Start Date*	Start Date IA Medicaid Administration (compared to season start)
2007-2008	12/22/2007		10/15/2007 (2 mo. early)
2008-2009	12/27/2008		10/30/2008 (2 mo. early)
2009-2010	11/14/2009		11/16/2009 (at start)
2010-2011	1/8/2011		11/16/2010 (~2 mo. early)
2011-2012	1/14/2012	12/18/2011	11/28/2011 (~2 mo. early)
2012-2013	11/17/2012	12/23/2012	11/26/2012 (1 week after start)
2013-2014	12/14/2013	12/16/2013	11/25/2013 -- original planned start date (2 weeks after planned start) **

\* Based on the median five year RSV season start from CDC data.

\*\* The administration start date for the 2013-2014 season was changed from November 25, 2013, to November 1, 2013.

## Collection Method

Claims data queried only identified the members hospitalized who were within an age range that may have benefited from prophylactic treatment for RSV.

**NOTE:** Information obtained from claims data for inpatient RSV-related hospitalizations does not reflect all the necessary components to determine member eligibility for palivizumab (Synagis®), such as gestational age, environmental risk factors, etc.. It should also be noted that some members with inpatient hospitalizations during SFYs 09 through 13 for RSV may not have been eligible for palivizumab (Synagis®) due to age based on date of birth (DOB).

## Acute Inpatient Hospitalizations

Inpatient final paid claims were queried that contained the following diagnosis codes (any field on the claim):

- 466.11 Acute Bronchiolitis Due to RSV
- 480.1 Pneumonia Due to RSV
- 79.6 Respiratory Syncytial Virus (RSV)
- V04.82 Respiratory Syncytial Virus (RSV)

### Observation Hospitalizations

In addition to the diagnoses codes identified for inpatient hospitalizations, RSV-related observation stays were queried based on the following procedure codes:

- 99217 Observation Care Discharge Day Management
- 99218 Initial Observation Care, Per Day...
- 99219 Initial Observation Care, Per Day...
- 99220 Initial Observation Care, Per Day
- G0378 Hospital Observation Service, Per Hour
- G0379 Direct Admission of Patient for Hospital Observation...

### Palivizumab (Synagis®) Utilization

Final paid claims for procedure code 90378 (Respiratory Immune Globulin, I.M. 50mg)—physician office reimbursement for the administration of Synagis®.

Final paid claims for the following pharmacy NDCs—pharmacy reimbursement for administration of Synagis® in a place of service other than a physician's office:

- 60574411101
- 60574411201
- 60574411301
- 60574411401

Prior authorization data was queried to identify if any members who experienced an inpatient RSV-related hospitalization was denied prior approval for palivizumab (Synagis®) during the same SFY as the hospitalization.

### Home Health Utilization

To identify the members who received palivizumab (Synagis®) and were also receiving home health services, a query of final paid claims for either procedure code S9123 or REV Code 551—Final paid claim for home health, skilled nursing or registered nurse (RN), services only.

## Outcomes

### Inpatient Hospitalizations

The inpatient hospitalizations queried for RSV followed a progression corresponding with the typical RSV season—November through March. In SFY12, the inpatient trend started to increase later in the year and declined later as well. In SFY13 also there was an increase in hospitalizations earlier in the year, but the decline was earlier than in SFY12.

An increase in acute inpatient RSV-related hospitalizations along with the associated costs was noted from SFY12 to 13. However, the volume in acute inpatient RSV-related hospitalizations has fluctuated over the past five SFYs.

### Observation Hospitalizations

An increase in observation admissions for RSV-related diagnoses along with costs was also noted from SFY12 to 13. However, similar to the acute inpatient admissions, the observation hospitalizations have also fluctuated over the past five SFYs.

### Palivizumab (Synagis®) Utilization

Both medical and pharmacy prior authorizations approvals for palivizumab (Synagis®) decreased from SFY12 to 13; correspondingly the reimbursement cost to Medicaid also decreased during this time frame.

All members with a reported RSV-related acute inpatient hospitalization who also received palivizumab (Synagis®) during the same SFY (SFYs 12 and 13) received the prophylactic treatment through the pharmacy benefit.

- *In SFY12*, 20 members who received palivizumab (Synagis®) also had an inpatient RSV-related hospitalization. Of the 20 members, one experienced a hospitalization before the IME RSV/palivizumab (Synagis®) season started for the SFY; three were hospitalized after March 31, 2012.
- All members who were hospitalized during the SFY12 IME RSV/palivizumab (Synagis®) season received palivizumab (Synagis®) following the hospitalization. Although five members did not receive five doses due to not starting palivizumab (Synagis®) until after the hospitalization for the RSV-related diagnosis.
- *In SFY13*, 23 members who received palivizumab (Synagis®) also had an inpatient RSV-related hospitalization. Of the 23 members, two were hospitalized before the IME RSV/palivizumab (Synagis®) season started for the SFY; none were hospitalized after March 31.
- Four members did not complete the RSV/palivizumab (Synagis®) season in SFY13 following the hospitalization. A change in coverage from SFY12 to SFY13 may have resulted in some members being eligible for fewer than five doses of palivizumab (Synagis®).

Prior authorization data was queried to identify if any members who experienced an inpatient RSV-

related hospitalization was denied prior approval for palivizumab (Synagis®) during the same SFY as the hospitalization.

- No members who with an inpatient RSV-related acute inpatient hospitalization were denied prior authorization under the medical benefit for SFYs12 or 13.
- In SFY12, three members who had an inpatient RSV-related acute inpatient hospitalization were denied authorization under the pharmacy benefit. All three members were denied due to not meeting the gestational or chronological age criterion.
- In SFY13, eight members who had an inpatient RSV-related acute inpatient hospitalization were denied authorization under the pharmacy benefit. All eight members were denied due to not meeting the gestational or chronological age criterion.

### Home Health Utilization

The total home health costs associated with administration of palivizumab (Synagis®) were not obtainable through claims data alone. Claims data was queried to identify the members who received palivizumab (Synagis®) and also receiving home health services. A query of final paid claims for either procedure code S9123 or REV Code 551—Final paid claim for home health, skilled nursing or registered nurse (RN), services only. The query resulted in approximately half of the members for each SFY who accessed the pharmacy benefit for palivizumab (Synagis®) also had a home health claim. The members accessing palivizumab (Synagis®) via the pharmacy benefit are expected to have associated home health costs.

### Conclusion

- For SFY13, Iowa Medicaid had an acute inpatient admission rate of **2.2 percent** for children under the age of two for RSV-related diagnoses. This was the highest admission rate for any of the five years studied.
  - SFY12, acute inpatient RSV-related admission rate was 1.4 percent.
  - SFY11, acute inpatient RSV-related admission rate was 1.6 percent..
  - SFY10, acute inpatient RSV-related admission rate was 2.0 percent.
  - SFY09, acute inpatient RSV-related admission rate was 1.7 percent.
- Claims data does not allow for analysis of how many members hospitalized would have met criteria for administration of plivizumab (Synagis®).
- However, claims data has provided information to indicate less than one percent of the members with a RSV-associated acute inpatient hospitalization had received palivizumab (Synagis®) during the same season as the acute inpatient hospitalization.
- Additionally, prior authorization data indicates less than one percent of the members with a RSV-related acute inpatient hospitalization were denied prior authorization for palivizumab (Synagis®).
  - All members who had both a RSV-related acute inpatient hospitalization and a denied prior authorization for palivizumab (Synagis®) did not meet the gestational or chronological age criterion for the year requested.
- The data studied suggest the current method of calculating the start date for administration of palivizumab (Synagis®) for Iowa Medicaid members is appropriate to provide protection during the annual RSV season.

- The current method of determining administration of palivizumab (Synagis®) results in protection beyond the end date for administration.
- As supported by the graphs on the next two pages, the majority of hospitalizations for RSV-related diagnoses occur during the administration time frame. Outlier hospitalizations historically have occurred more frequently after the administration season has ended.

## Recommendations

- Continue to utilize IDPH epidemiological data to define start date for authorization of palivizumab (Synagis®) for Iowa Medicaid using the median start date of the past five seasons using Iowa virological data.
  - The dates of administration may be adjusted based on epidemiological prevalence of RSV.
- The data studied suggests the method of calculating the palivizumab start date is adequate.
  - Graphs located on pages five through eight of this report identify the RSV-related hospitalizations and date of occurrence for SFYs 2009 through 2013.
- Continued further evaluation of acute inpatient RSV-related hospitalizations with corresponding RSV anticipated season.
- Continue to monitor benefit coverage for application of best practices/standard of care.
- Collaborate with IDPH utilizing match data for Medicaid premature births to follow trends for these infants throughout the first year of life.

## Appendix

Weekly Acute Inpatient RSV-related Hospitalizations SFYs 2012 and 2013.

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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

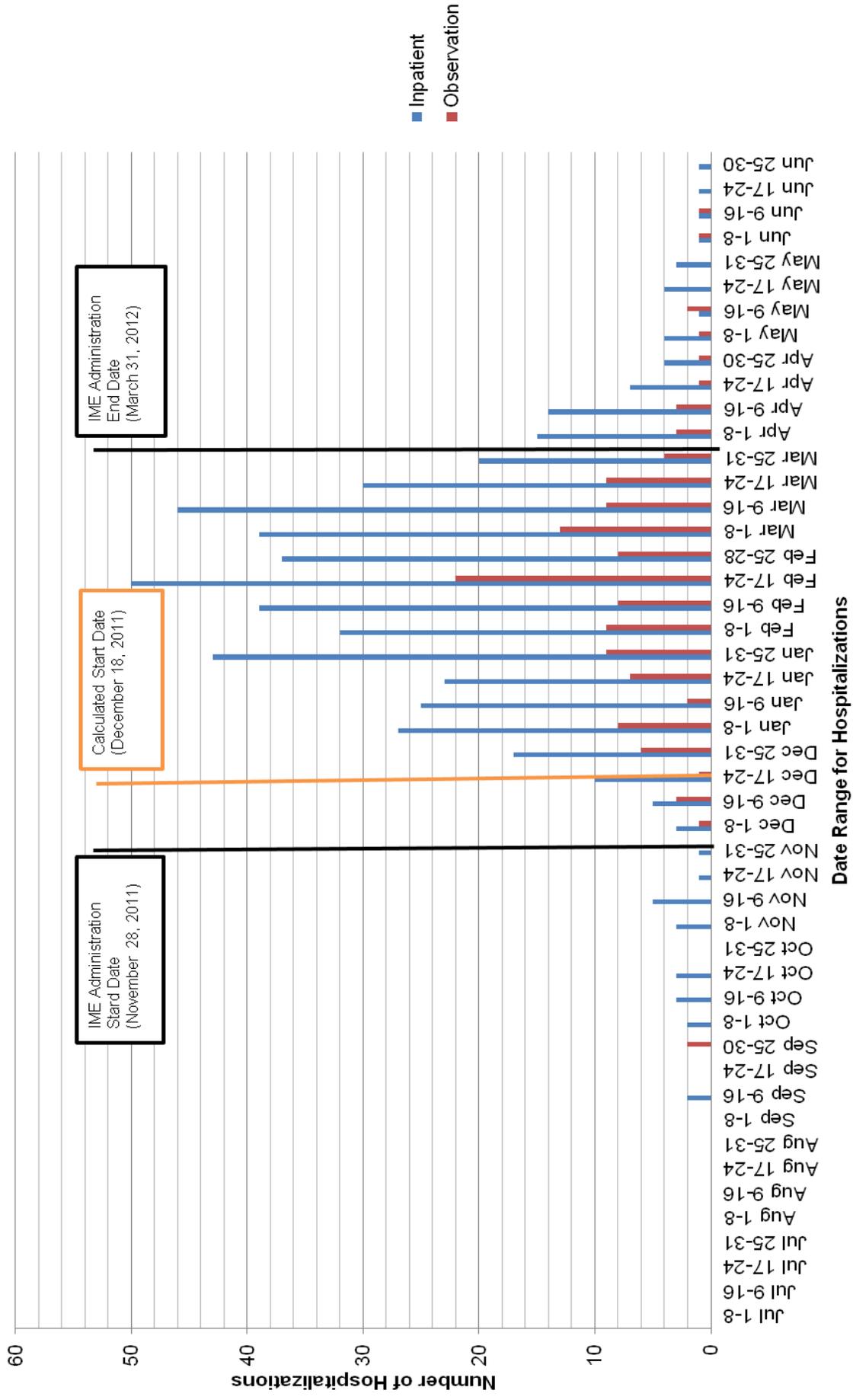
Iowa Medicaid Enterprise, prior authorization and claims data.  
Iowa Department of Public Health, Bureau of Health Statistics. Percent and number of Iowa Medicaid reimbursed births for SFYs 2009 through December 2013.

## **Respiratory Syncytial Virus (RSV)-related Hospitalizations**

### **Appendix**

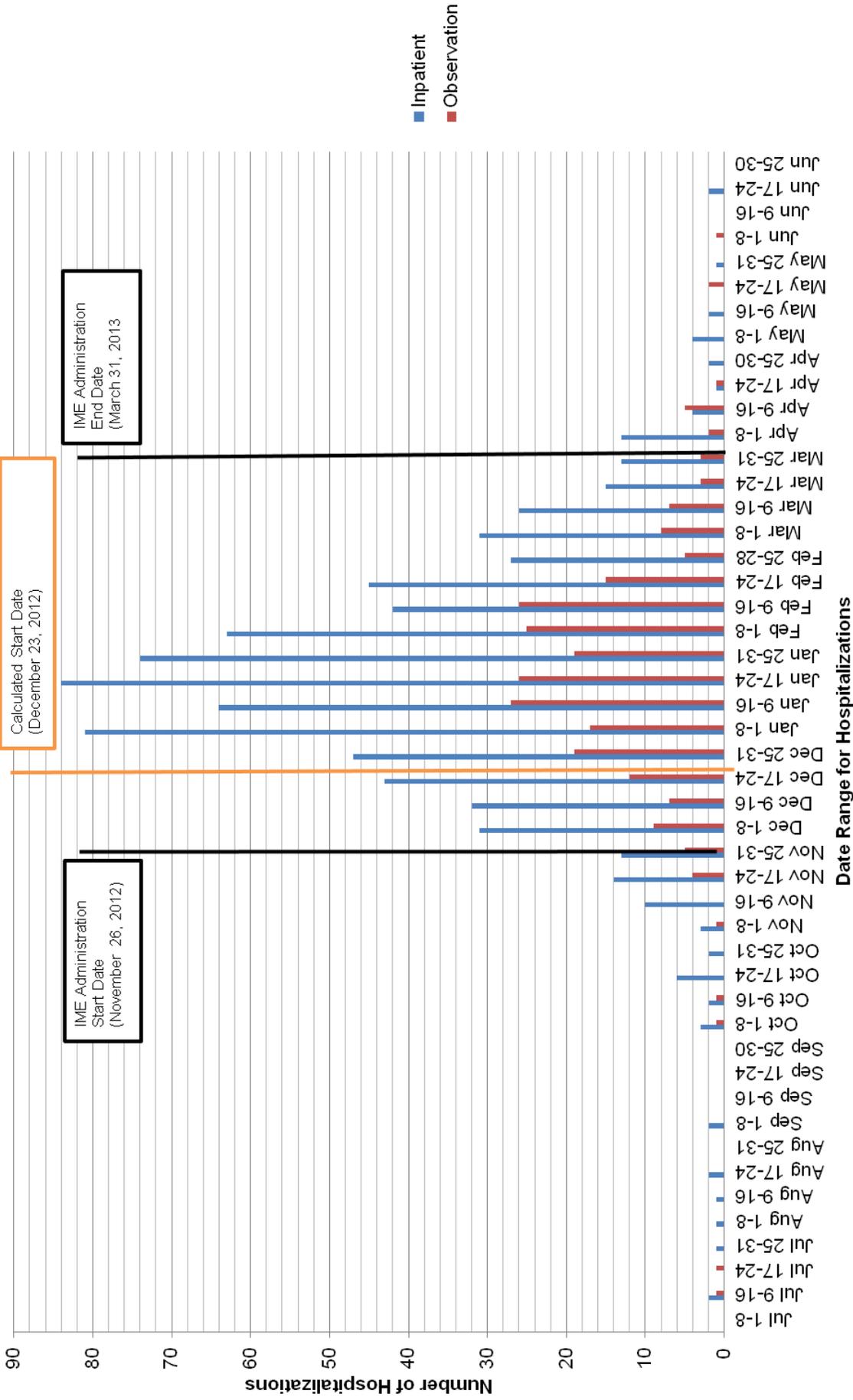
Weekly Acute Inpatient RSV-related Hospitalizations SFYs 2012 and 2013.

## RSV-related Hospitalizations, SFY12 (Iowa Medicaid members aged birth to two years)



- 86.3 percent of all RSV-related hospitalizations occurred during the time frame authorized for administration of palivizumab (Synagis®).
- 10.5 percent of all RSV-related hospitalizations occurred after the IME administration end date.
- 3.2 percent occurred prior to the IME administration start date.

## RSV-related Hospitalizations, SFY13 (Iowa Medicaid members aged birth to two years)



- 90.8 percent of all RSV-related hospitalizations occurred during the time frame authorized for administration of palivizumab (Synagis®).
- 3.8 percent of all RSV-related hospitalizations occurred after the IME administration end date.
- 5.4 percent occurred prior to the IME administration start date