



April 2014

## Choosing Wisely®: Iowa Medicaid Utilization of DXA Scans

3rd Qtr, SFY14

Point of interest:

- 51 Specialty Societies have published Choosing Wisely® lists.

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### The Choosing Wisely Initiative

“Choosing Wisely® is an initiative of the ABIM [American Board of Internal Medicine] Foundation to help physicians and patients engage in conversations to reduce overuse of tests and procedures, and support physician efforts to help patients make smart and effective care choices.” (Choosing Wisely, 2014)

Medical specialty societies have identified tests or procedures commonly used in their fields, who necessity should be questioned and discussed. The resulting lists of “Things Physicians and Patients Should Question” (Choosing Wisely, 2014) are intended to spark a discussion about the true need for many frequently ordered tests or treatments.

Choosing Wisely lists are available from the following specialty societies.

- [American Academy of Neurology](#)
- [American Academy of Ophthalmology](#)
- [American Academy of Orthopaedic Surgeons](#)
- [American Academy of Otolaryngology–Head and Neck Surgery](#)
- [American Academy of Pediatrics](#)
- [The American Academy of Physical Medicine and Rehabilitation](#)
- [American Association of Critical-Care Nurses/American College of Chest Physicians/American Thoracic Society/Society of Critical Care Medicine \(Critical Care\)](#)
- [American Association of Clinical Endocrinologists/Endocrine Society](#)
- [American Association for Pediatric Ophthalmology and Strabismus](#)
- [American College of Cardiology](#)
- [American College of Chest Physicians/American Thoracic Society \(Pulmonary\)](#)
- [American College of Emergency Physicians](#)
- [American College of Medical Toxicology](#) and the [American](#)
- [American Academy of Allergy, Asthma & Immunology](#)
- [American Academy of Dermatology](#)
- [American Academy of Family Physicians](#)
- [American Academy of Hospice and Palliative Medicine](#)

Dual-energy X-ray Absorptiometry (DXA) scans was one of the five choosing wisely initiatives selected by the American College of Rheumatology for physicians and patients to question.

- [Academy of Clinical Toxicology](#)
  - [American College of Obstetricians and Gynecologists](#)
  - [American College of Occupational and Environmental Medicine](#)
  - [American College of Physicians](#)
  - [American College of Radiology](#)
  - [American College of Rheumatology](#)
  - [American College of Surgeons](#)
  - [American Gastroenterological Association](#)
  - [American Headache Society](#)
  - [American Geriatrics Society](#)
  - [AMDA – Dedicated to Long Term Care Medicine](#)
  - [American Psychiatric Association](#)
  - [American Society of Anesthesiologists](#)
  - [American Society of Clinical Oncology](#)
  - [American Society for Clinical Pathology](#)
  - [American Society of Hematology](#)
  - [American Society of Echocardiography](#)
  - [American Society of Nephrology](#)
  - [American Society of Nuclear Cardiology](#)
  - [American Society for Radiation Oncology](#)
  - [American Urological Association](#)
  - [Commission on Cancer – a multidisciplinary program of the American College of Surgeons](#)
  - [Heart Rhythm Society](#)
  - [North American Spine Society](#)
  - [Society of Cardiovascular Computed Tomography](#)
  - [Society for Cardiovascular Magnetic Resonance](#)
  - [Society of General Internal Medicine](#)
  - [Society of Gynecologic Oncology](#)
  - [Society of Hospital Medicine](#)
  - [Society for Maternal-Fetal Medicine](#)
  - [Society of Nuclear Medicine and Molecular Imaging](#)
  - [Society of Thoracic Surgeons](#)
  - [Society for Vascular Medicine](#)
- Additional scheduled Choosing Wisely lists are to be released from the following specialty societies.
- [American Medical Society for Sports Medicine](#)

- [American Association of Blood Banks](#)
- [American Association of Neurological Surgeons](#)
- [American Association for the Study of Liver Diseases](#)
- [American Society of Colon and Rectal Surgeons](#)
- [American Society of Plastic Surgeons](#)
- [Society of Cardiovascular Angiography and Interventions](#)

### Dual-energy X-ray Absorptiometry (DXA) Scans

Dual-energy X-ray Absorptiometry (DXA) scans was one of the five choosing wisely initiatives selected by the American College of Rheumatology for physicians and patients to question.

**“Don’t routinely repeat DXA scans more often than once every two years.**

Initial screening for osteoporosis should be performed according to National Osteoporosis Foundation recommendations. The optimal interval for repeating Dual-energy X-ray Absorptiometry (DXA) scans is uncertain, but because changes in bone density over short intervals are often smaller than the measurement error of most DXA scanners, frequent testing (e.g., <2 years) is unnecessary in most patients. Even in high-risk patients receiving drug therapy for osteoporosis, DXA

changes do not always correlate with probability of fracture. Therefore, DXAs should only be repeated if the result will influence clinical management or if rapid changes in bone density are expected. Recent evidence also suggests that healthy women age 67 and older with normal bone mass may not need additional DXA testing for up to ten years provided osteoporosis risk factors do not significantly change.” (Choosing Wisely, 2013)

### Iowa Medicaid DXA Scan Utilization

Claims data was queried for state fiscal years (SFYs) 2011 through 2013 to determine DXA scan utilization patterns for Iowa Medicaid members. During the time frame studied, 255 members were noted to have had more than one DXA scan. DXA scans were performed on 3,765 unique members during SFYs 2011 through 2013.

The average age of Iowa Medicaid members receiving DXA scans was 52.

Three procedure codes were billed.

- **77080** -- Dual Energy X-Ray Absorptiometry (DXA), Bone Density Study, 1 or More Sites; Axial Skeleton (e.g., Hips, Pelvis, Spine)
  - Current Fee Schedule of \$73.12
  - In SFY11, \$33,386 was paid by IME for this procedure.
  - In SFY12, \$34,593 was paid by IME for this procedure.
  - In SFY13, \$28,214 was paid by IME for this procedure.

DXA scans were performed on 3,765 unique members during SFYs 2011 through 2013.

- **77081** -- Dual Energy X-Ray Absorptiometry (DXA), Bone Density Study, 1 or More Sites; Appendicular Skeleton (e.g., Radius, Wrist, Heel)
  - Current Fee Schedule of \$34.83
  - In SFY11, \$490 was paid by IME for this procedure.
  - In SFY12, \$322 was paid by IME for this procedure.
  - In SFY13, \$200 was paid by IME for this procedure.
- **77082** -- Dual Energy X-Ray Absorptiometry (DXA), Bone Density Study, 1 or More Sites Vertebral Fracture Assessment
  - Current Fee Schedule of \$30.02
  - In SFY11, \$819 was paid by IME for this procedure.
  - In SFY12, \$900 was paid by IME for this procedure.
  - In SFY13, \$941 was paid by IME for this procedure.
- The average age for Iowa Medicaid members receiving DXA scans is 52 years.
- Claims data does not indicate over utilization of DXA scans for Iowa Medicaid members aged 67 or older. However, appropriateness of testing is not clear from the claims data alone and would require review of the members' clinical records.
- Combined, \$99,866 was reimbursed by Iowa Medicaid for DXA scans for SFYs 2011 through 2013.
- Three of the top four primary diagnoses submitted on claims for the DXA scan are related to osteoporosis or other disorder of the bone. The fourth primary diagnosis is one that may predispose women to reduced bone mass.

The four most common primary diagnosis codes billed were as follows:

- **256.39** -- Other Ovarian Failure (2.1%)
- **733.00** -- Osteoporosis Unspecified (17.1%)
- **733.01** -- Senile Osteoporosis (7.0%)
- **733.90** -- Disorder of Bone and Cartilage, Unspecified (19.7%)

A total of 363 different diagnoses have been billed as primary on DXA scan claims.

## Summary

In summary, the data queried revealed the following:

- During the three year date span of claims data studied, 6.8 percent of the unique members identified received more than one DXA scan.

## Recommendations

- Continue to monitor topics identified in the Choosing Wisely lists for application to Iowa Medicaid.
- Proceed with medical necessity review sample of members who received DXA scans to determine appropriateness of procedure.
- Limit coverage for DXA scans to once every two years as recommended by the American College of Rheumatology.

## References

- Choosing Wisely. (2014) Advancing Medical Professionalism to Improve Health Care. Retrieved from <http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx>
- Choosing Wisely. (2013) Five Things Physicians and Patients Should Question. Retrieved from <http://www.choosingwisely.org/wp-content/uploads/2013/02/Choosing-Wisely-Master-List.pdf>

## 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

IME Claims Data



April 2014

Health Home Enrollee Demographics

3rd Qtr, SFY14

### Points of Interest:

- On July 1, 2013, 20,041 unique members were enrolled in Iowa Medicaid Health Homes.

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## Iowa Medicaid Health Home

The Iowa Medicaid Health Home consists of two programs--Chronic Conditions Health Home (CCHH) and the Integrated Health Home (IHH).

Enrollees within the CCHH are identified by tiers based on the chronic conditions present and/or the chronic conditions the member is at risk for.

Enrollees in the IHH are assigned to a tier based age (child or adult) coupled with a diagnosis of a serious mental illness or serious emotional disturbance with the intent to promote an optimal outcome for the member through coordinated care.

Covered services for both the CCHH and IHH programs include:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care following move from one care setting to another
- Member and family support
- Referral to community and social support services.

## Chronic Conditions Health Home

Members may be eligible for health home services if they meet one of the following criteria:

- Has at least two chronic conditions;
- Has one chronic condition and is at risk for developing a second chronic condition;
- Has a serious mental illness; or
- Has a serious emotional disturbance.

The following qualifying chronic conditions have been identified for to determine eligibility for the health home.

- Hypertension
- Overweight (Adults with a BMI of 25 or greater /children in the 85 percentile)
- Heart Disease
- Diabetes
- Asthma
- Substance Abuse
- Mental Health

Once eligibility has been determined, the severity of other diagnoses are considered to establish the appropriate health home tier to assign for the member. A list of Expanded Diagnosis Clusters (EDCs) used in conjunction with eligibility diagnoses has been identified to assist with tier assignment.

A complete list of EDCs can be obtained from <http://>

[www.health.state.mn.us/healthreform/homes/payment/expandeddiagnosisclusters.pdf](http://www.health.state.mn.us/healthreform/homes/payment/expandeddiagnosisclusters.pdf)

CCHH Tiers are based on the number of chronic conditions the member is diagnosed with or is at risk for acquiring.

- **Tier 1 – Chronic Conditions** (1-3 chronic conditions)
- **Tier 2 – Chronic Conditions** (4-6 chronic conditions)
- **Tier 3 – Chronic Conditions** (7-9 chronic conditions)
- **Tier 4 – Chronic Conditions** (10 or more chronic conditions)

## Integrated Health Home

The following qualifying serious mental illness conditions have been identified for the integrated health home.

- A Psychotic Disorder;
- Schizophrenia;
- Schizoaffective Disorder;
- Major Depression;
- Bipolar Disorder;
- Delusional Disorder; or
- Obsessive-Compulsive Disorder

Qualifying serious emotional disturbance conditions for the integrated health home have been defined as "...A diagnosable mental, behavioral, or emotional disorder (not including substance abuse disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and results in a functional impairment." (IAC 441--78.53)

The IHH program distinguishes the child population as members aged 18 years or younger. The adult population is defined as members aged 19 years or older.

- **Tier 5 – Integrated Health Home** (Adult)
- **Tier 6 - Integrated Health Home** (Child)
- **Tier 7 – Integrated Health Home** (Adult with Intensive Care Management)
- **Tier 8 - Integrated Health Home** (Child with Intensive Care Management)

Effective April 1, 2014, an additional tier was added for the IHH program to accommodate time needed for member outreach.

- **Tier 9 - Integrated Health Home** (Member Outreach Adults and Children - allowed for three months only)

**Note:** *The defined ages for child and adult for the IHH program differs from other Iowa Medicaid programs which follow the age parameters identified for the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program defines children as age birth through 20 years.*

## MVM Purpose

This MVM report is intended to provide a high-level overview of the health home enrolled members, including demographics, as they appeared on the anchor date. To keep in line with other MVM studies, the anchor date of the start of the fiscal year was used for this report.

Iowa Medicaid claims data were queried with an anchor date of July 1, 2013, to determine unique members enrolled in a health home. The claims data indicated 20,060 members were enrolled on this date with one of 21 different health home provider entities.

Nineteen members were assigned to a health home but had not yet been assigned a tier in either the chronic conditions or integrated health home programs.

The information contained within the remainder of this MVM report will relate to the remaining 20,041 members who had been assigned a tier in a health home on July 1, 2013.

## Data Query Results

On July 1, 2013, Fremont County was the only county without any Iowa Medicaid residents enrolled in either a chronic condition or integrated health home.

A total of 35 counties did not have Iowa Medicaid members enrolled in a CCHH.

Only Fremont County did not have any Iowa Medicaid members enrolled in an IHH. *No Iowa Medicaid members were enrolled in the IHH for the seventh or eighth IHH tiers.*

It is important to note that the IHH program services began on July 1, 2013; the anchor date for this report. The members identified in tiers five and six for the IHH were identified by Iowa Medicaid and the IHH and assigned a tier accordingly based on age and diagnosis(es). Enrollment fluctuations are expected and should be measurable for comparison at a future date.

The chart beginning on page three identifies the number of unique members, for each tier, residing in each of the corresponding counties. The total volume of members residing in each county that have been assigned to a CC health home and IHH are also identified.

**NOTE:** *The chart beginning on page three identifies the members enrolled in a health home on July 1, 2013, and the members' re-siding counties within the state of Iowa. Both the CCHH and IHH are represented on these charts.*

*Barriers with member engagement have prevented a significant number of the members who had been assigned to a health home on July 1, 2013, from participating in the program and maintaining enrollment.*

*Current health home enrollment demographics may vary.*

County Name / Number		CCHH Tier 1	CCHH Tier 2	CCHH Tier 3	CCHH Tier 4	IHH Tier 5	IHH Tier 6	Resident County Health Home Enrollee Total	Resident County Total Chronic Conditions (CC) Health Home	Resident County Total Integrated Health Home (IHH)
		No. of Unique Members								
Adair	1	0	0	0	0	2	7	9	0	9
Adams	2	0	0	0	0	2	6	8	0	8
Allamakee	3	0	0	0	0	0	8	8	0	8
Appanoose	4	0	0	1	0	2	16	19	1	18
Audubon	5	0	0	0	0	1	1	2	0	2
Benton	6	3	1	0	0	2	145	151	4	147
Black Hawk	7	264	246	103	18	16	92	739	631	108
Boone	8	7	6	2	1	9	78	103	16	87
Bremer	9	4	2	1	1	3	11	22	8	14
Buchanan	10	1	3	1	0	0	115	120	5	115
Buena Vista	11	3	1	0	0	0	11	15	4	11
Butler	12	0	3	3	1	1	4	12	7	5
Calhoun	13	0	0	0	0	1	5	6	0	6
Carroll	14	1	1	0	1	6	4	13	3	10
Cass	15	0	0	0	0	3	5	8	0	8
Cedar	16	0	0	0	0	8	32	40	0	40
Cerro Gor-	17	1	2	11	2	11	63	90	16	74
Cherokee	18	2	14	1	0	0	4	21	17	4
Chickasaw	19	2	0	1	0	1	8	12	3	9
Clarke	20	1	0	0	0	8	14	23	1	22
Clay	21	1	0	0	0	3	7	11	1	10
Clayton	22	0	0	0	0	2	18	20	0	20
Clinton	23	6	2	1	1	11	11	32	10	22
Crawford	24	0	1	0	0	4	7	12	1	11
Dallas	25	15	8	2	0	26	92	143	25	118
Davis	26	0	0	0	0	1	4	5	0	5
Decatur	27	0	1	0	0	0	11	12	1	11
Delaware	28	3	0	0	0	5	96	104	3	101

County Name / Number		CCHH Tier 1	CCHH Tier 2	CCHH Tier 3	CCHH Tier 4	IHH Tier 5	IHH Tier 6	Resident County Health Home Enrollee Total	Resident County Total Chronic Condi- tions (CC) Health Home	Resident County Total In- tegrated Health Home (IHH)
		No. of Unique Members								
Des Moines	29	10	31	7	1	2	110	161	49	112
Dickinson	30	1	2	1	0	5	4	13	4	9
Dubuque	31	0	1	0	1	13	121	136	2	134
Emmet	32	0	0	0	0	0	17	17	0	17
Fayette	33	0	2	1	0	5	68	76	3	73
Floyd	34	0	2	0	0	2	16	20	2	18
Franklin	35	0	0	0	0	1	8	9	0	9
Fremont	36	0	0	0	0	0	0	0	0	0
Greene	37	1	1	0	1	1	2	6	3	3
Grundy	38	0	0	0	0	0	13	13	0	13
Guthrie	39	1	0	0	0	1	12	14	1	13
Hamilton	40	1	0	1	1	3	17	23	3	20
Hancock	41	0	0	0	1	1	12	14	1	13
Hardin	42	6	1	0	0	0	17	24	7	17
Harrison	43	1	0	0	0	3	2	6	1	5
Henry	44	0	0	0	1	0	48	49	1	48
Howard	45	0	0	0	0	0	9	9	0	9
Humboldt	46	0	0	0	0	0	6	6	0	6
Ida	47	2	0	0	0	1	5	8	2	6
Iowa	48	0	0	0	1	8	23	32	1	31
Jackson	49	0	0	0	0	8	5	13	0	13
Jasper	50	8	1	3	0	21	66	99	12	87
Jefferson	51	0	0	0	1	2	15	18	1	17
Johnson	52	1	1	1	6	33	215	257	9	248
Jones	53	3	0	0	0	2	88	93	3	90
Keokuk	54	0	0	0	0	3	11	14	0	14
Kossuth	55	0	0	0	0	1	2	3	0	3
Lee	56	1	0	1	0	7	28	37	2	35

County Name / Number		CC Tier 1	CC Tier 2	CC Tier 3	CC Tier 4	IHH Tier 5	IHH Tier 6	Resident County Health Home Enrollee Total	Resident County Total Chronic Conditions (CC) Health Home	Resident County Total Integrated Health Home (IHH)
		No. of Unique Members								
Linn	57	65	22	4	6	2,075	1,836	4,008	97	3,911
Louisa	58	3	2	2	0	1	25	33	7	26
Lucas	59	0	0	0	0	7	9	16	0	16
Lyon	60	0	0	0	0	2	1	3	0	3
Madison	61	7	3	0	0	4	27	41	10	31
Mahaska	62	2	2	0	0	3	21	28	4	24
Marion	63	3	3	0	0	12	37	55	6	49
Marshall	64	48	13	20	3	6	29	119	84	35
Mills	65	0	0	0	0	1	3	4	0	4
Mitchell	66	0	0	0	0	1	2	3	0	3
Monona	67	0	0	0	0	0	13	13	0	13
Monroe	68	1	1	0	0	2	2	6	2	4
Montgomery	69	0	0	0	0	2	0	2	0	2
Muscatine	70	1	2	2	1	3	40	49	6	43
O'Brien	71	1	2	0	0	3	5	11	3	8
Osceola	72	0	1	0	0	0	3	4	1	3
Page	73	0	0	0	0	3	32	35	0	35
Palo Alto	74	0	0	0	0	4	2	6	0	6
Plymouth	75	35	34	19	7	13	6	114	95	19
Pocahontas	76	0	0	0	0	3	3	6	0	6
Polk	77	686	366	95	17	3,408	4,233	8,805	1,164	7,641
Pottawattamie	78	2	0	1	0	15	43	61	3	58
Poweshiek	79	2	0	2	0	4	23	31	4	27
Ringgold	80	2	1	0	0	0	5	8	3	5
Sac	81	0	0	0	0	0	1	1	0	1
Scott	82	186	109	8	0	16	76	395	303	92

County Name / Number		CC Tier 1	CC Tier 2	CC Tier 3	CC Tier 4	IHH Tier 5	IHH Tier 6	Resident County Health Home Enrollee Total	Resident County Total Chronic Conditions (CC) Health Home	Resident County Total Integrated Health Home (IHH)
		No. of Unique Members								
Shelby	83	0	1	0	0	0	1	2	1	1
Sioux	84	8	7	1	1	0	7	24	17	7
Story	85	12	40	19	5	19	57	152	76	76
Tama	86	6	4	2	0	2	18	32	12	20
Taylor	87	0	0	0	0	1	2	3	0	3
Union	88	0	3	0	0	5	19	27	3	24
Van Buren	89	0	0	0	0	0	7	7	0	7
Wappello	90	2	2	0	0	8	64	76	4	72
Warren	91	4	11	1	0	193	281	490	16	474
Washing-	92	0	0	0	0	1	84	85	0	85
Wayne	93	1	1	0	0	1	0	3	2	1
Webster	94	1	1	0	0	9	35	46	2	44
Winnebago	95	0	0	0	0	0	1	1	0	1
Winnishiek	96	0	0	0	0	2	9	11	0	11
Woodbury	97	394	471	134	20	702	557	2,278	1,019	1,259
Worth	98	0	0	0	0	2	2	4	0	4
Wright	99	0	0	0	0	6	7	13	0	13
<b>Tier Totals</b>		<b>1,822</b>	<b>1,435</b>	<b>452</b>	<b>99</b>	<b>6,790</b>	<b>9,443</b>			

For geographical reference, a map of Iowa counties is located at the top of page eight.

Although all but one county in the state of Iowa had at least one Iowa Medicaid member identified as enrolled in the IHH, only five counties implemented the IHH on July 1, 2013. Geo Access software was used to identify a 40 mile radius around each of the five counties included in phase one of the IHH roll out on July 1, 2013. All postal zip codes assigned to each of the five counties were applied to the software program to capture the coverage radius from the borders of each county.

The five counties included in phase one of the IHH were Dubuque, Linn, Polk, Warren, and Woodbury.

The 40 mile coverage radius is identified by the red circles on the map on page eight.

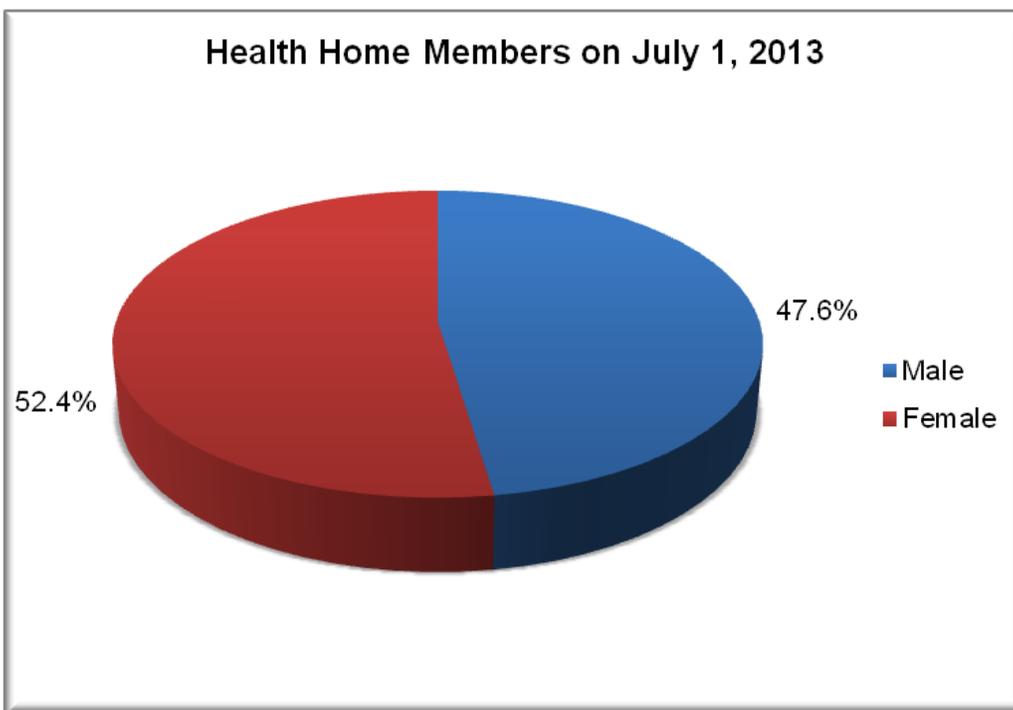


## Health Home Enrollee Demographics

Overall, health home enrollment are fairly evenly distributed between males and females. The discrepancy shifts when health home enrollment is looked at more closely based on age, comparing adults aged 19 and older to children defined as ages birth to 18 years. A second shift in the demographics of male versus female is noticeable when health homes for chronic conditions are isolated from the integrated health homes and vice versa.

The graphs below and on the next several pages will further demonstrate the shifts of the home health population demographics.

The graph below represents the enrollees for both the CCHH and IHH programs.

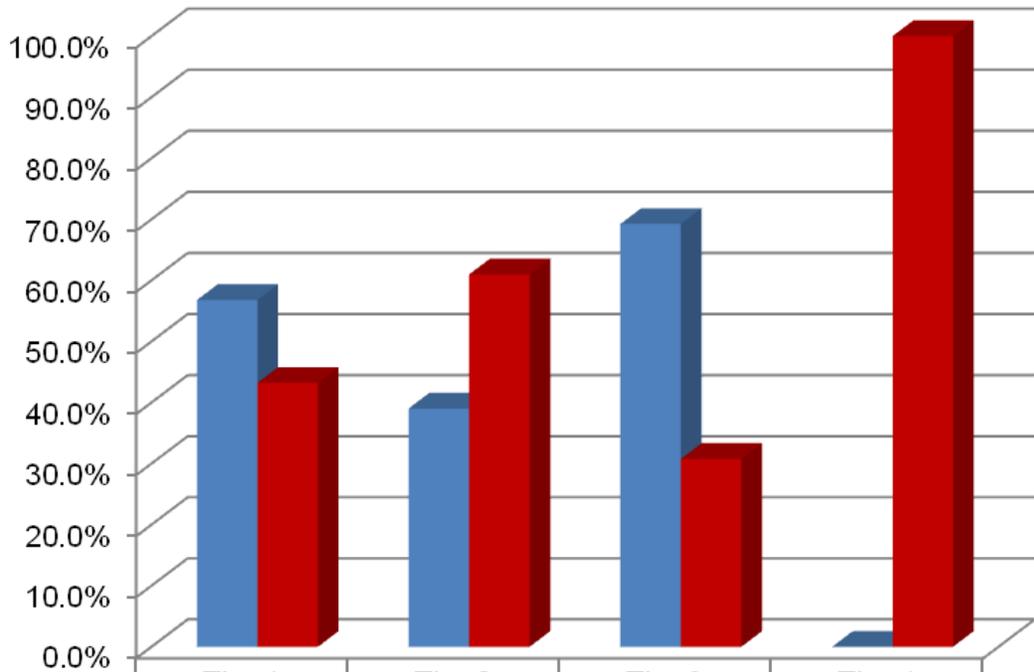


On July 1, 2013, slightly under five percent more female Iowa Medicaid members enrolled in either a health home for chronic conditions or an integrated health home than males.

The age of the member significantly alters this distribution pattern.

The graphs on the next several pages will look more closely at the enrollee demographic proportions, gender and age, for CCHH and IHH programs.

## Chronic Conditions Health Home

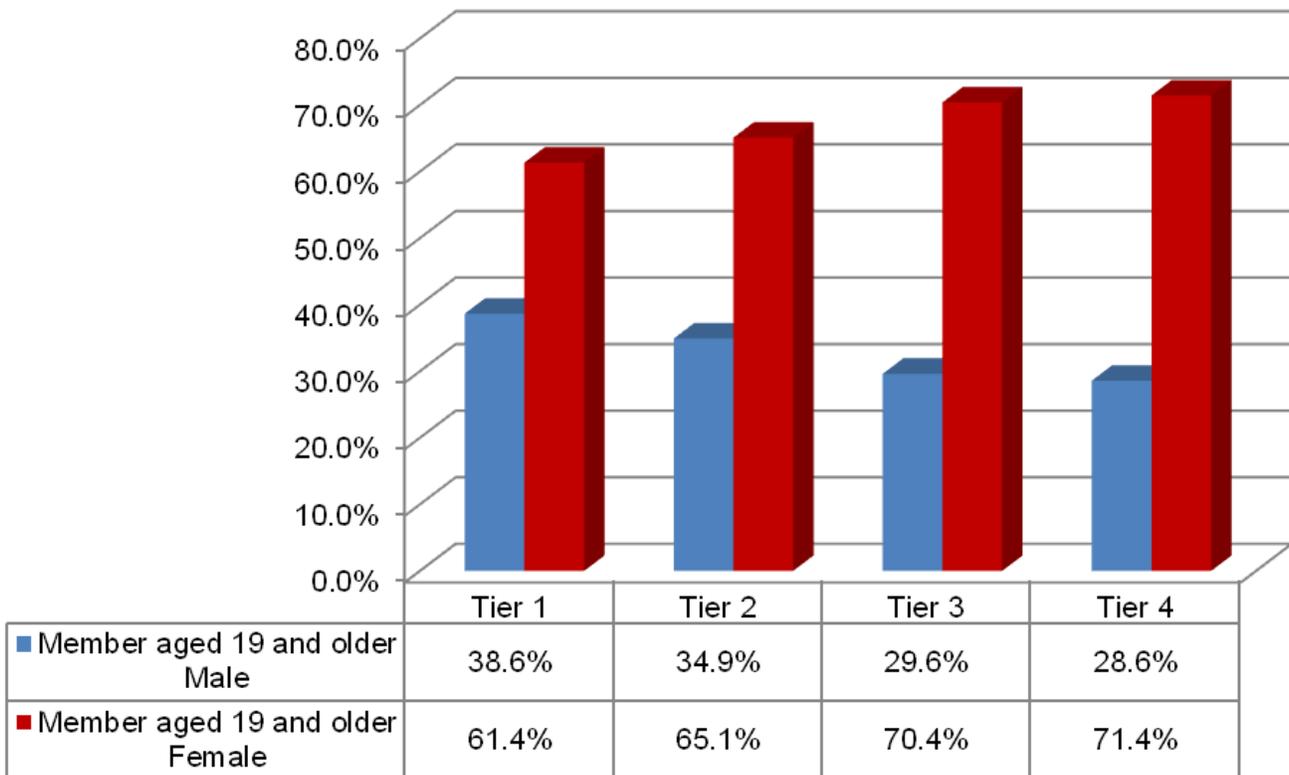


	Tier 1	Tier 2	Tier 3	Tier 4
Members age 0-18 Male	56.8%	39.0%	69.2%	0.0%
Members age 0-18 Female	43.2%	61.0%	30.8%	100.0%

The graph above reflects the percentage of members, by gender, aged birth to 18 enrolled in tiers one through four of the CCHH. Although 100 percent of tier four was identified as female, this accounted for only one member. The unique member count for each tier for this age group in the CCHH on July 1, 2013, was as follows:

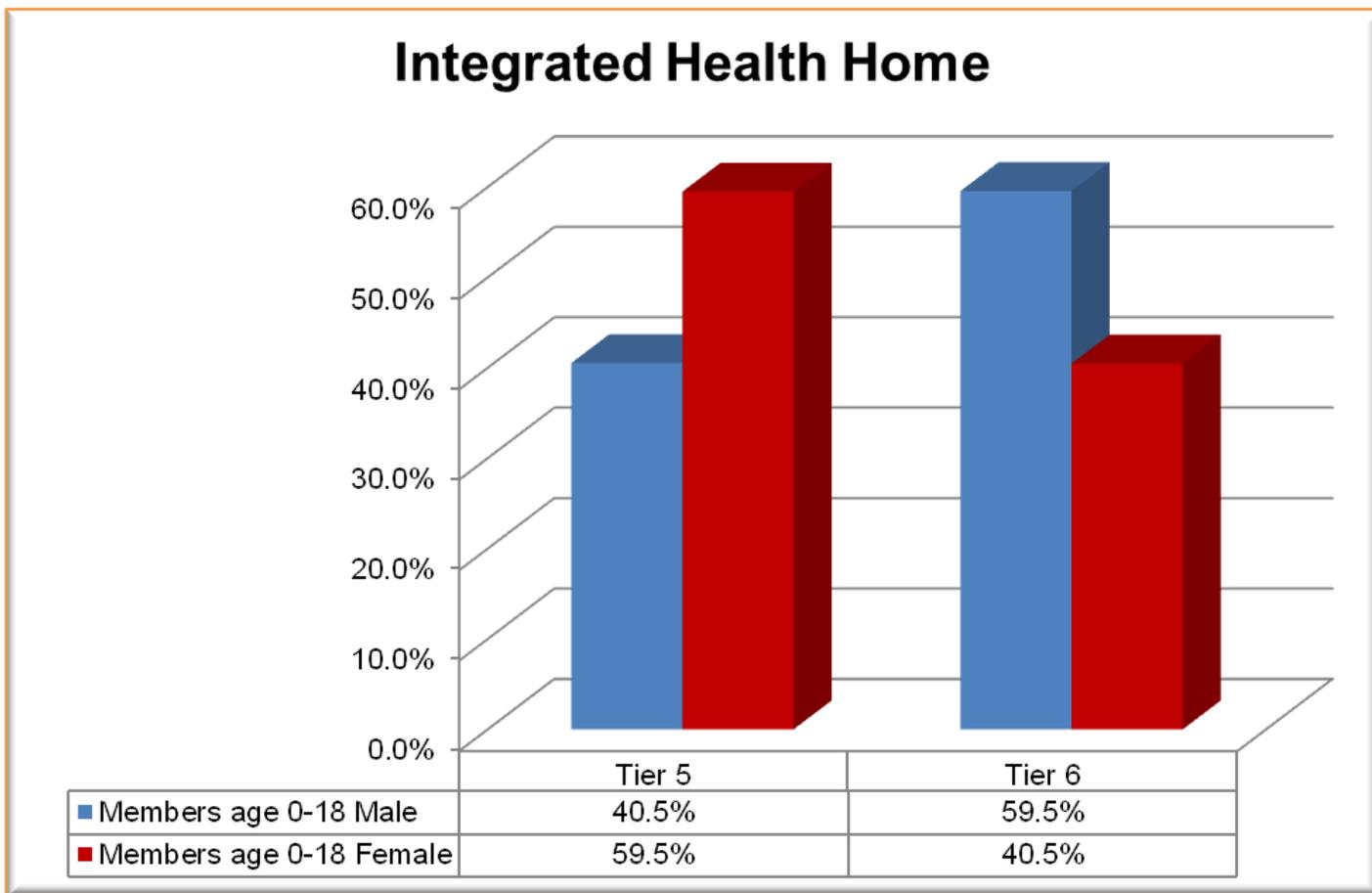
Tier	Members age 0-18		
	Total No. of Members	Male	Female
Tier 1	310	176	134
Tier 2	123	48	75
Tier 3	13	9	4
Tier 4	1	0	1

## Chronic Conditions Health Home



The graph above reflects the percentage of members, by gender, aged 19 and older enrolled in tiers one through four of the CCHH. The unique member count for each tier for this age group in the CCHH on July 1, 2013, was as follows:

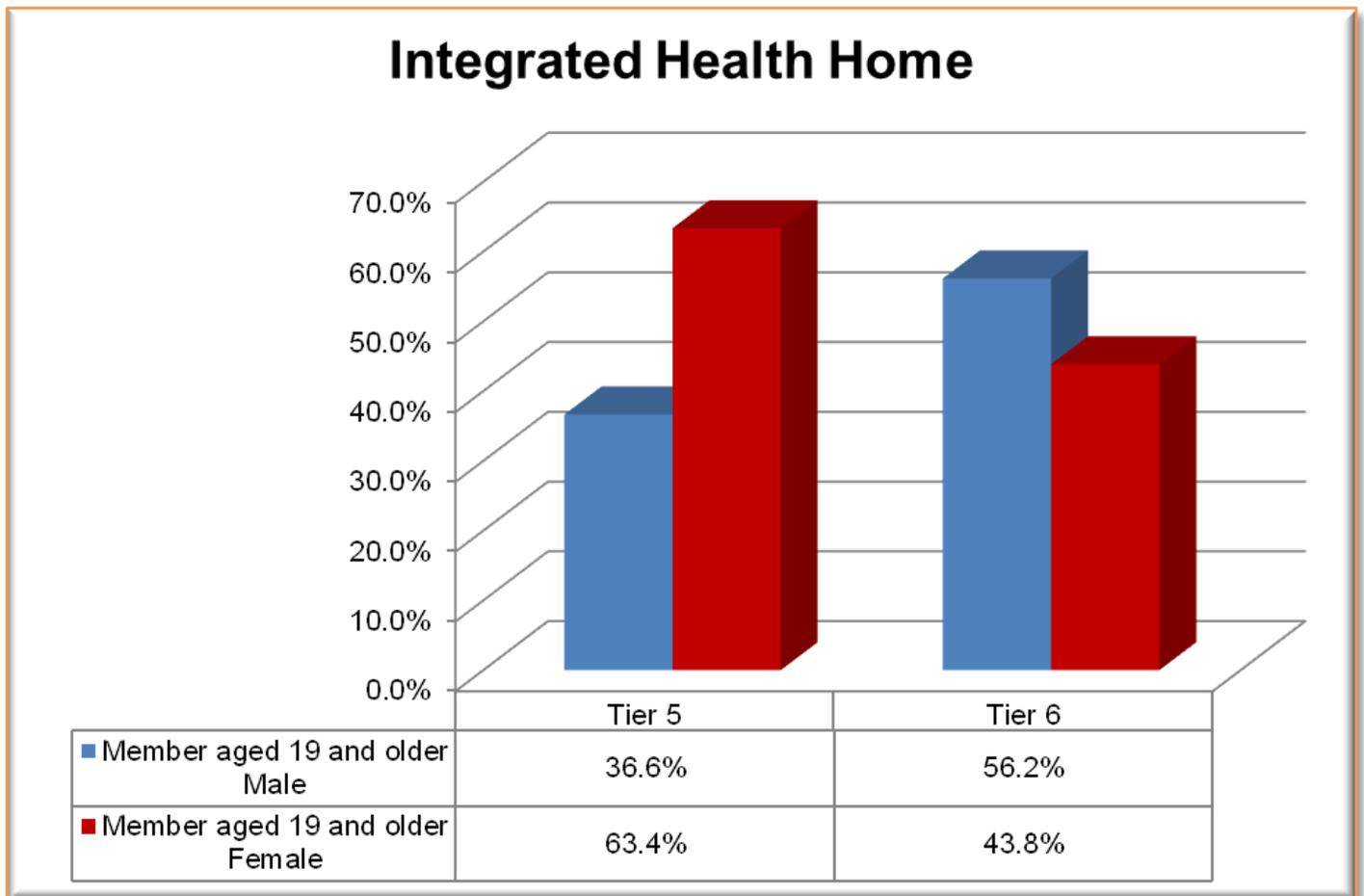
Tier	Members age 18 and Older		
	Total No. of Members	Male	Female
Tier 1	1,511	584	927
Tier 2	1,312	458	854
Tier 3	439	130	309
Tier 4	98	28	70



The graph above reflects the percentage of members, by gender, aged birth to 18 enrolled in tiers five and six of the IHH. The unique member count for each tier for this age group in the IHH on July 1, 2013, was as follows:

Tier	Members age 0-18		
	Total No. of Members	Male	Female
Tier 5	232	94	138
Tier 6	9,313	5,545	3,768

Note: Tier five is inclusive of members aged 19 and older. It is unknown why on July 1, 2013, members aged birth to 18 years were assigned to this tier. On July 1, 2013, there were no members aged birth to 18 years enrolled in IHH tiers seven or eight.



The graph above reflects the percentage of members, by gender, aged 19 and older enrolled in tiers five and six of the IHH. The unique member count for each tier for this age group in the IHH on July 1, 2013, was as follows:

Tier	Members aged 19 years and older		
	Total No. of Members	Male	Female
Tier 5	6,558	2,403	4,155
Tier 6	130	73	57

Note: Tier six is inclusive of members birth to 18 years. It is unknown why on July 1, 2013, members aged 19 years and older were assigned to this tier. On July 1, 2013, there were no members aged 19 years and older enrolled in IHH tiers seven or eight.

## Health Home Providers

As noted previously in this report, on July 1, 2013, 20,060 Iowa Medicaid members were assigned to a health home. The chart below identifies the health home providers and the number of unique members enrolled to each on July 1, 2013. **Note:** All IHH Members were assigned to Magellan Behavioral Health Care of IA.

Provider Name	Provider City (Billing Address)	Provider County (Billing Address)	Number of Unique Members Enrolled
AKRON MERCY MEDICAL CLINIC	Akron	Plymouth	100
COMMUNITY HEALTH CARE, INC	Davenport	Scott	317
COMMUNITY HEALTH CENTERS OF SE IO-WA	West Burlington	Des Moines	56
EAST DES MOINES FAMILY CARE CENTER	Des Moines	Polk	77
FAMILY HEALTHCARE INDIAN HILLS	Sioux City	Woodbury	69
HEALTH HOME BROADLAWNS MEDICAL CENT	Des Moines	Polk	700
HIAWATHA PEDIATRIC CLINIC	Hiawatha	Linn	78
LINN COMMUNITY CARE	Cedar Rapids	Linn	19
MADISON COUNTY MEDICAL ASSOC PC	Winterset	Madison	10
MAGELLAN BEHAVIORAL CARE OF IA (Tiers 5 and 6 only)	West Des Moines	Polk	16,233
MCFARLAND CLINIC PC AFTER HOURS CLI	Ames	Story	66
MCFARLAND CLINIC PC FAM MEDICINE NO	Ames	Story	10
MERCY FAMILY MEDICINE RESIDENCY	Mason City	Cerro Gordo	15
NORTHEAST IA MED EDUCATION	Waterloo	Black Hawk	234
PEOPLES COMMUNITY HEALTH CLINIC INC	Waterloo	Black Hawk	440
PRIMARY HEALTH CARE INC	Des Moines	Polk	609
PRIMARY HEALTH CARE INC	Des Moines	Polk	2
PRIMGHAR MERCY MEDICAL CENTER	Primghar	O'Brien	1
SIouxLAND COMMUNITY HEALTH CENTER	Sioux City	Woodbury	977
STEPHEN J VEIT MDPC	Cherokee	Cherokee	22
UNIVERSITY OF IOWA HOSPITAL AND CLI	Iowa City	Johnson	25

## Summary

The data within this report used an anchor date of July 1, 2013. Barriers with member engagement have prevented a significant number of the members who had been assigned to a health home on July 1, 2013, from participating in the program and maintaining enrollment. The member's county of residence in relation to a participating county for the IHH program may have contributed to the barriers experienced with member engagement.

The information contained within this report may prove to be more beneficial if compared to a future anchor date to identify shifts in the population of health home enrollees and expansion of the health home provider community.

## Appendix

- Health Care Homes Payment Methodology, Expanded Diagnosis Clusters (EDCs)

## Recommendations

- Repeat with an anchor date of July 1, 2014, for comparison.
- Develop editing within the eligibility system around the age parameters for IHH tiers five through eight.

## References

Johns Hopkins. (n.d) Health Care Homes Payment Methodology Expanded Diagnosis Clusters (EDCs), Adpated from the Johns Hopkins ACG System Reference Manual, Version 8.2. Retrieved from <http://www.health.state.mn.us/healthreform/homes/payment/expandeddiagnosisclusters.pdf>

State of Iowa. (2014). Iowa Administrative Code Rule 441--78.53. Retrieved from [http://www.dhs.iowa.gov/policyanalysis/PolicyManualPages/Manual\\_Documents/Rules/441-78.pdf](http://www.dhs.iowa.gov/policyanalysis/PolicyManualPages/Manual_Documents/Rules/441-78.pdf)

## Medicaid Value Management (MVM)

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### Query Facts

Iowa Medicaid Claims Data for Health Home Enrollees



April 2014

Health Home:  
Major Diagnostic Category Roll-Up

3rd Qtr, SFY14

### Points of Interest:

- In SFY13, the total Medicaid expenditure was \$3,736,569,870.
- Health home enrollees accounted for \$18,048,967 of the total Iowa Medicaid expenditure.

### In this issue:

Proportion of claims by type	3
Major Diagnostic Categories	5
Cost per utilizing member	4
Invalid diagnoses	5
Recommendations	7

## Major Diagnostic Category (MDC) Roll-Up History

Each year an analysis is completed of expenditures by Major Diagnostic Category (MDC) and claim type. Review of expenditures by MDC and claim type gives Iowa Medicaid a snapshot view of how Medicaid money is spent. It supports transparency for the public to know how tax payer dollars are being spent by the Medicaid agency. It informs policy makers of potential concerns relative to specific populations.

MVM began reviewing expenditures in 2007 and obtained data on claims beginning 2002. While there are complete data for SFY02 through SFY12, this analysis is limited to Iowa Medicaid health home enrollees for SFY13.

## Medicaid Expenditures

Medicaid membership and expenditures have been gradually increasing. In SFY13, the total Medicaid expenditure was \$3,736,569,870. **Health home enrollees accounted for \$18,048,967 of the total Iowa Medicaid expenditure.**

The following claim types have been submitted and paid by Medicaid:

- CMS 1500

- Inpatient
- Outpatient
- Inpatient Crossover
- Outpatient Crossover
- Part B Crossover
- Long Term Care
- Waiver
- Pharmacy
- Dental
- Capitation
- Gross Adjustments

Expenditures by claim type are listed in the table at the top of [page two](#).

Claim types identified on page two are displayed with distinct members receiving services and costs for health home enrollees.

## Iowa Medicaid Health Home Enrollee Expenditures

Claim Type	SFY123	
	Distinct Members	Procedure Amount
<b>CMS 1500</b>	3,091	\$3,944,149
<b>Inpatient</b>	157	\$1,899,852
<b>Outpatient</b>	1,211	\$2,263,783
<b>Inpatient Crossover</b>	175	\$209,127
<b>Outpatient Crossover</b>	890	\$369,283
<b>Part B Crossover</b>	1,046	\$462,449
<b>Long Term Care</b>	126	\$2,575,216
<b>Waiver</b>	178	\$1,625,154
<b>Pharmacy</b>	2,348	\$3,100,387
<b>Dental</b>	746	\$272,677
<b>Capitation</b>	3,429	\$1,327,656
<b>Gross Adjustments</b>	4	\$-766
<b>Total</b>		\$18,048,967

The largest proportion of Medicaid expenditures for Health Home enrollees is paid on CMS 1500s, or professional claims. The next highest was pharmacy claims.

The chart at the top of [page 3](#) displays the relative proportion of costs per claim type. Professional claims comprised 21.9 percent of the total expenditures associated with health home enrollees.

Claim Type	SFY13	
	Procedure Amount	% of Total
<b>CMS 1500</b>	\$3,944,149	21.9%
<b>Inpatient</b>	\$1,899,852	10.5%
<b>Outpatient</b>	\$2,263,783	12.5%
<b>Inpatient Crossover</b>	\$209,127	1.2%
<b>Outpatient Crossover</b>	\$369,283	2.0%
<b>Part B Crossover</b>	\$462,449	2.6%
<b>Long Term Care</b>	\$2,575,216	14.3%
<b>Waiver</b>	\$1,625,154	9.0%
<b>Pharmacy</b>	\$3,100,387	17.2%
<b>Dental</b>	\$272,677	1.5%
<b>Capitation</b>	\$1,327,656	7.4%
<b>Gross Adjustments</b>	\$-766	0.0%
<b>Total</b>	\$18,048,967	

The chart at the top of [page four](#) provides details of costs by each MDC and counts of members who received services related to conditions within each MDC. Categories are listed in descending order of cost for SFY13.

Major Diagnostic Category	SFY13	
	Distinct Members	Procedure Amount
Mental Disorders	912	\$1,844,236
Symptoms, Signs, and Ill-defined Conditions	1,404	\$1,122,616
Diseases of the Circulatory System	1,347	\$1,264,421
Diseases of the Nervous System & Sense Organs	1,084	\$605,873
Diseases of the Musculoskeletal & Connective Tissue	1,195	\$1,020,361
Diseases of the Respiratory System	1,267	\$862,010
Injury & Poisoning	554	\$423,898
Complications of Pregnancy, Childbirth, & Puerperium	34	\$132,584
Diseases of the Digestive System	700	\$512,918
Endocrine, Nutritional & Metabolic & Immunity Disorders	1,350	\$899,422
Diseases of the Genitourinary System	567	\$422,379
Neoplasm	212	\$347,591
Congenital Anomalies	46	\$24,354
Infectious & Parasitic Diseases	449	\$789,733
Diseases of the Skin & Subcutaneous Tissue	463	\$314,962
Certain Conditions Originating in the Perinatal Period	4	\$474
Diseases of Blood & Blood-forming Organs	143	\$155,225
Supplementary Classification of External Causes of Injury & Poisoning	0	\$0

In SFY13, Mental Disorders category was the highest cost diagnostic category. The top five most costly diagnostic categories in descending order are:

- Mental Disorders
- Diseases of the Circulatory System
- Symptoms, Signs, and Ill-defined Conditions
- Diseases of the Musculoskeletal & Connective Tissue
- Endocrine, Nutritional & Metabolic & Immunity Disorders

Costs per utilizing member are examined in the [chart on page six](#). The highest diagnostic category costs per utilizing member are as follows:

- Complications of Pregnancy, Childbirth, & Puerperium
- Mental Disorders
- Infectious & Parasitic Diseases
- Neoplasm
- Diseases of the Blood & Blood-forming Organs

### Invalid Diagnoses

When a diagnosis is invalid or otherwise unavailable, claims and amounts are populated as an invalid, descriptive diagnosis (V01-V86), Missing, Null, or Unknown. The chart below notes the volume distinct members and subsequent cost to Medicaid for these categories.

Major Diagnostic Category	SFY13	
	Distinct Members	Procedure Amount
V01-V86	1,060	\$429,162
Missing	12	\$1,456
Null	3,437	\$5,225,845
Unknown	215	\$1,649,446

It is anticipated the implementation of ICD-10 will reduce the volume of null and usage of the v-codes (V01-V86).

### Iowa Medicaid Health Home Enrollees, Diagnostic Category Cost Per Utilizing Member

Major Diagnostic Category	SFY13
	Cost Per Utilizing member
Mental Disorders	\$2,022
Complications of Pregnancy, Childbirth, & Puerperium	\$3,900
Supplemental Classification of External Causes of Injury & Poisoning	\$0.00
Congenital Anomalies	\$529
Diseases of the Circulatory System	\$939
Neoplasm	\$1,640
Certain Conditions Originating in the Perinatal Period	\$119
Endocrine, Nutritional & Metabolic Immunity Disorders	\$666
Diseases of Blood & Blood-forming Organs	\$1,085
Symptoms, Signs, and Ill-defined Conditions	\$800
Diseases of the Musculoskeletal & Connective tissue	\$854
Injury & Poisoning	\$765
Diseases of the Digestive System	\$733
Diseases of the Genitourinary System	\$745
Diseases of the Nervous System & Sense Organs	\$559
Diseases of the Respiratory System	\$680
Infectious and Parasitic Diseases	\$1,759
Diseases of the Skin & Subcutaneous Tissue	\$680

## Summary

The largest proportion of Iowa Medicaid Health Home enrollees expenditures (21.9 percent) was paid on HCFA 1500, professional claims

The top five most costly diagnostic categories in descending order are:

- Mental Disorders
- Diseases of the Circulatory System
- Symptoms, Signs, and Ill-defined Conditions
- Diseases of the Musculoskeletal & Connective Tissue
- Endocrine, Nutritional & Metabolic & Immunity Disorders

Costs per utilizing member are examined in the [chart on page six](#). The highest diagnostic category costs per utilizing member are as follows:

- Complications of Pregnancy, Childbirth, & Puerperium
- Mental Disorders
- Infectious & Parasitic Diseases
- Neoplasm
- Diseases of the Blood & Blood-forming Organs

## Recommendations

-

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## Query Facts

Iowa Medicaid Claims Data



# Medicaid Value Management (MVM)

Realizing the fiscal value of quality care.

April 2014

Hospice

3rd Qtr, SFY14

### Point of Interest:

- 6 percent of the members accessing the hospice benefit did not meet hospice criteria.

### In this Report:

PIMN Review History	1
PIMN Hospital Review Outcome	2
PIMN Hospice Review Outcome	3
Summary	4
Recommendations	4

### MVM Project History:

The Program Integrity Medical Necessity (PIMN) team reviewed medical records of members who were receiving hospice benefits, for which the claims submitted to Iowa Medicaid Enterprise (IME) did not contain a primary diagnosis of a terminal condition. All members selected for review also had an acute inpatient hospitalization billed to IME within 60 days prior to admission to hospice services. To gain a better understanding of these members' medical conditions that lead to the hospice admission, the PIMN team requested and reviewed medical records for both the acute inpatient hospitalization as well as the hospice care.

This MVM report highlights a representative sample of the records reviewed by the PIMN team.

### PIMN Review History:

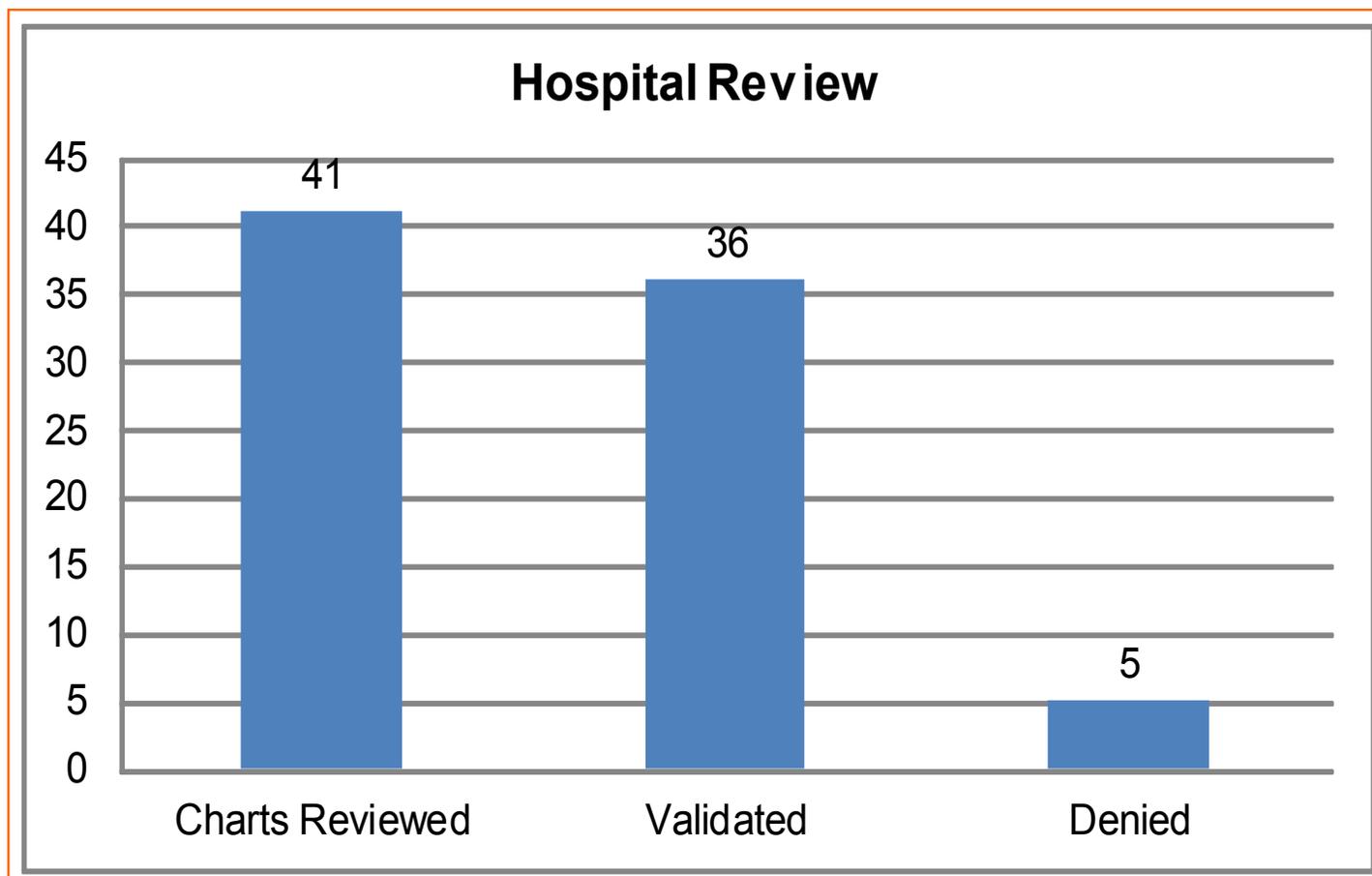
Records were requested for 20 hospital and 21 hospice providers. Milliman criterion was used to verify the appropriateness of the members' acute inpatient hospitalization. The Medicare Local Coverage Determination (LCD) for Hospice Determining Terminal Status (L32015) (Revision 7/2/11) was used to determine the requirements for hospice admissions.

The following hospice providers were reviewed:

- Amenity Hospice
- Care Initiative Hospice Greenfield
- Cedar Valley Hospice
- Cherokee Regional Medical Center
- Genesis Health System DBA
- Hospice of Dubuque
- Hospice of Mercy
- Hospice of North Iowa
- Hospice of Siouxland
- Hospice Preferred Choice, Inc. DBA
- Iowa City Hospice, Inc.
- Iowa Hospice by Harden Healthcare in Muscatine, Iowa
- Iowa Hospice by Harden Healthcare in Spirit Lake, Iowa
- Iowa Hospice by Harden Healthcare in Carroll, Iowa
- Iowa Hospice by Harden Healthcare in Marshalltown, Iowa
- Great River Hospice
- Lee County Health Department
- Mercy Home Care & Hospice-Clinton
- Skiff Hospice
- Unity Point at Home DBA in Fort Dodge, Iowa
- Unity Point at Home DBA in Urbandale, Iowa

### PIMN Hospital Review Outcome:

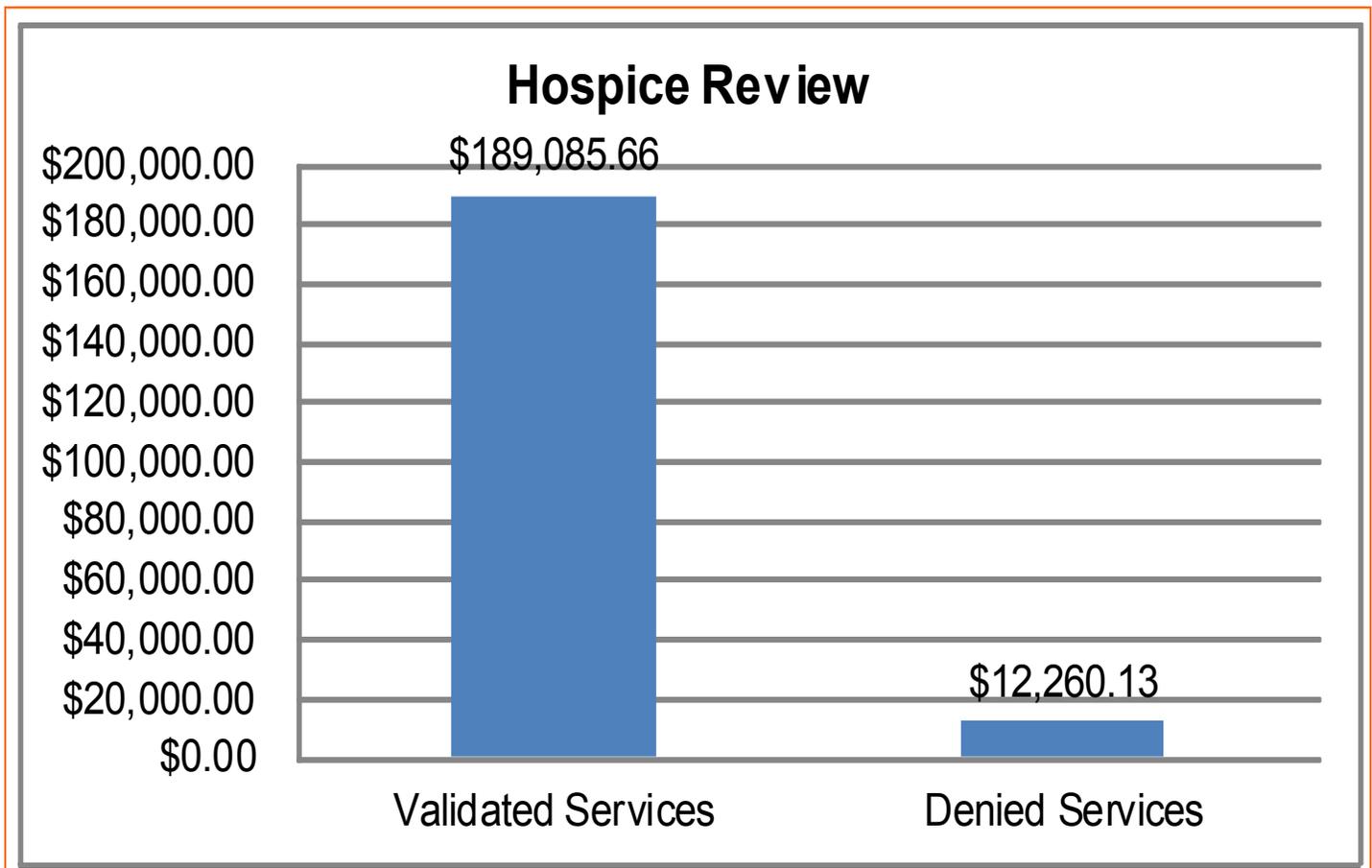
In the hospital review sample, a total of 41 dates of service (DOS) were billed, which 36 DOS were validated and five DOS were denied relating to the same issue. The denied hospitalization dates were readmissions within one to two weeks from the previous admission. These dates were combined with the previous hospital stay and reimbursement adjusted accordingly.



The graph above reflects the outcome review of the hospitalizations that occurred within 60 days prior to hospice admission.

### PIMN Hospice Review Outcome:

The sample of documentation reviewed encompassed DOS during SFY12 and SFY13. A total of 1,698 days were billed for the record sample which accounted for Medicaid reimbursement of \$201,345.79, for hospice care. All members' reviewed were admitted to hospice within 60 days of being discharged from a hospital. The members' length for hospice services had varied from a few hours up to two years.



The hospice review graph above reflects the dollar amount reimbursed by Medicaid or the tentative overpayment identified through the Program Integrity audit. The preliminary hospice review, resulted in 1582 days of hospice service validated totaling \$189,085.66, from Medicaid. Conversely, 102 days of hospice service were denied totaling \$12,260.13, from Medicaid.

The following issue was identified within the preliminary hospice review:

- Members did not meet the criteria for hospice services.
  - 102 days (6 percent) were denied for not meeting hospice criterion.

## Summary

- Records were requested for 20 hospital and 21 hospice providers.
- The sample of documentation reviewed encompassed DOS during SFY12 and SFY13. A total of 1,698 days were billed for the record sample which accounted for Medicaid reimbursement of \$201,345.79, for hospice care.
- The preliminary hospice review resulted in 1582 days of hospice service validated totaling \$189,085.66, from Medicaid.
- Conversely, 102 days of hospice service were denied totaling \$12,260.13, from Medicaid.
- In the preliminary hospice review, the following was identified:
  - Members did not meet the criteria for hospice services.
    - 102 days (6 percent) were denied for not meeting hospice criterion.

## Recommendations

- Conduct routine retrospective reviews for hospice providers.
- Implement a prior authorization process for members entering into hospice.
- Projected annual cost avoidance for 2.5 percent of members not hospice eligible based on the hospice claims is \$1,019,427\*

*\* Percentages based on the average of actual paid amount for claims submitted during SFYs 2011, 2012, and 2013 for hospice services.*

## References

Local Coverage Determination (LCD) for Hospice Determining Terminal Status (L32015). Revision July 2, 2011.

Milliman Criteria from <http://cgi.careguidelines.com/login-careweb.htm>

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### Query Facts

Iowa Medicaid Claims Data



April 2014

Major Diagnostic Category Roll-Up

3rd Qtr, SFY14

### Points of Interest:

- Medicaid membership and expenditures have been gradually increasing. In SFY13, the total Medicaid expenditure was \$3,736,569,870.

### In this issue:

Proportion of claims by type 3

Major Diagnostic Categories 5

Cost per utilizing member 6

Invalid diagnoses 8

Recommendations 10

## Major Diagnostic Category

Each year an analysis is completed of expenditures by Major Diagnostic Category (MDC) and claim type. Review of expenditures by MDC and claim type gives Iowa Medicaid a snapshot view of how Medicaid money is spent. It supports transparency for the public to know how tax payer dollars are being spent by the Medicaid agency. It informs policy makers of potential concerns relative to specific populations.

MVM began reviewing expenditures in 2007 and obtained data on claims beginning 2002. While there are complete data for SFY02 through SFY12, this analysis is limited to SFY11 through SFY13. Costs per diagnosis and claim type are presented. Members are duplicated in the counts within the charts as they likely had claims in multiple claim types. Costs are not duplicated.

## Medicaid Expenditures

Medicaid membership and expenditures have been gradually increasing. In SFY13, the total Medicaid expenditure was \$3,736,569,870.

The following claim types have been submitted and paid by Medicaid:

- CMS 1500
- Inpatient
- Outpatient

- Inpatient Crossover
- Outpatient Crossover
- Part B Crossover
- Long Term Care
- Waiver
- Pharmacy
- Dental
- Capitation
- Gross Adjustments

Expenditures by claim type are listed in the table at the top of page two.

Claim types identified on page two are displayed with distinct members receiving services and costs with the following notations:

- Despite a consistent increase in CMS 1500s, claims for professional services, from 2009 to 2011; 2012 showed a decrease of 5.3 percent. SFY13 reported an increase of 6.4 percent in costs for this claim type. A 3.1 percent increase in distinct members was noted in 2012 on CMS1500 claims.
- Dental claims both realized a decrease of more than three percent in the cost to the Medicaid program with a slight decrease in the number of unique members.
  - The decrease in dental claims may be related to changes implemented regarding coverage criteria for general dental and orthodontia services.

- Capitation claims had a 30.4 percent increase in 2013 from 2012. This was likely influenced by the transition of the habilitation program in July 2013.
- Gross adjustments decreased by 6.3 percent in 2013, reason unknown.

Claim Type	SFY11		SFY12		SFY123			
	Distinct Members	Procedure Amount	Distinct Members	Procedure Amount	Distinct Members	% Change from SFY12	Procedure Amount	% Change from SFY12
<b>CMS 1500</b>	460,530	\$583,408,975	<b>478,193</b>	<b>\$552,680,108</b>	<b>493,122</b>	3.1%	<b>\$587,921,825</b>	6.4%
<b>Inpatient</b>	51,322	\$411,156,029	<b>52,089</b>	<b>\$426,074,301</b>	<b>78,685</b>	51.1%	<b>\$429,358,634</b>	0.8%
<b>Outpatient</b>	274,814	\$410,631,101	<b>282,053</b>	<b>\$428,371,405</b>	<b>346,390</b>	22.8%	<b>\$477,833,486</b>	11.5%
<b>Inpatient Crossover</b>	19,586	\$24,480,256	<b>19,595</b>	<b>\$24,990,190</b>	<b>19,892</b>	1.5%	<b>\$25,665,943</b>	2.7%
<b>Outpatient Crossover</b>	52,093	\$39,348,643	<b>52,416</b>	<b>\$41,963,710</b>	<b>53,811</b>	2.7%	<b>\$45,939,805</b>	9.5%
<b>Part B Crossover</b>	66,966	\$43,760,351	<b>68,373</b>	<b>\$42,684,775</b>	<b>70,009</b>	2.4%	<b>\$45,051,576</b>	5.5%
<b>Long Term Care</b>	21,765	\$805,279,553	<b>21,793</b>	<b>\$840,312,913</b>	<b>21,919</b>	0.6%	<b>\$849,881,298</b>	1.1%
<b>Waiver</b>	29,608	\$470,796,924	<b>29,746</b>	<b>\$499,400,549</b>	<b>30,422</b>	2.3%	<b>\$544,806,394</b>	9.1%
<b>Pharmacy</b>	338,709	\$255,923,287	<b>350,913</b>	<b>\$275,769,464</b>	<b>430,809</b>	22.8%	<b>\$268,032,017</b>	-2.8%
<b>Dental</b>	182,792	\$64,586,208	<b>187,959</b>	<b>\$63,136,525</b>	<b>187,862</b>	-0.1%	<b>\$60,888,260</b>	-3.6%
<b>Capitation</b>	518,052	\$150,209,240	<b>570,319</b>	<b>\$216,464,875</b>	<b>598,569</b>	5.0%	<b>\$282,338,844</b>	30.4%
<b>Gross Adjustments</b>	13,542	\$79,881,698	<b>13,818</b>	<b>\$126,871,203</b>	<b>9,727</b>	-29.6%	<b>\$118,851,788</b>	-6.3%
<b>Total</b>	<b>\$3,339,462,266</b>		<b>\$3,538,720,018</b>				<b>\$3,736,569,870</b>	<b>5.6%</b>

The largest proportion of Medicaid expenditures (22.7 percent) is paid on Long Term Care claims to facilities. Although the unique members served has increased, the percentage of the total Medicaid expenditure for this claim type has continued to slightly decline over the past three years.

The next highest is CMS 1500s or professional claims at 15.7 percent. The proportions of other claim types have remained relatively steady over the past three years.

The chart below displays the relative proportion of costs per claim type.

Claim Type	SFY11		SFY12		SFY13	
	Procedure Amount	% of Total	Procedure Amount	% of Total	Procedure Amount	% of Total
<b>CMS 1500</b>	\$583,408,975	17.5%	<b>\$552,680,108</b>	15.6%	<b>\$587,921,825</b>	15.7%
<b>Inpatient</b>	\$411,156,029	12.3%	<b>\$426,074,301</b>	12.0%	<b>\$429,358,634</b>	11.5%
<b>Outpatient</b>	\$410,631,101	12.3%	<b>\$428,371,405</b>	12.1%	<b>\$477,833,486</b>	12.8%
<b>Inpatient Crossover</b>	\$24,480,256	0.7%	<b>\$24,990,190</b>	0.7%	<b>\$25,665,943</b>	0.7%
<b>Outpatient Crossover</b>	\$39,348,643	1.2%	<b>\$41,963,710</b>	1.2%	<b>\$45,939,805</b>	1.2%
<b>Part B Crossover</b>	\$43,760,351	1.3%	<b>\$42,684,775</b>	1.2%	<b>\$45,051,576</b>	1.2%
<b>Long Term Care</b>	\$805,279,553	24.1%	<b>\$840,312,913</b>	23.7%	<b>\$849,881,298</b>	22.7%
<b>Waiver</b>	\$470,796,924	14.1%	<b>\$499,400,549</b>	14.1%	<b>\$544,806,394</b>	14.6%
<b>Pharmacy</b>	\$255,923,287	7.7%	<b>\$275,769,464</b>	7.8%	<b>\$268,032,017</b>	7.2%
<b>Dental</b>	\$64,586,208	1.9%	<b>\$63,136,525</b>	1.8%	<b>\$60,888,260</b>	1.6%
<b>Capitation</b>	\$150,209,240	4.5%	<b>\$216,464,875</b>	6.1%	<b>\$282,338,844</b>	7.6%
<b>Gross Adjustments</b>	\$79,881,698	2.4%	<b>\$126,871,203</b>	3.6%	<b>\$118,851,788</b>	3.2%
<b>Total</b>	<b>\$3,339,462,266</b>		<b>\$3,538,720,018</b>		<b>\$3,736,569,870</b>	

The chart at the top of page four provides details of costs by each MDC and counts of members who received services related to conditions within each MDC. Categories are listed in descending order of cost for SFY13.

Trends are consistent over the past three years, except a proportional increase in capitation claims.

Major Diagnostic Category	SFY11		SFY12		SFY13	
	Distinct Members	Procedure Amount	Distinct Members	Procedure Amount	Distinct Members	Procedure Amount
Mental Disorders	92,556	\$399,807,503	91,365	\$407,675,387	90,987	\$409,312,737
Symptoms, Signs, and Ill-defined Conditions	214,943	\$204,527,833	218,924	\$221,523,616	248,872	\$231,925,216
Diseases of the Circulatory System	59,116	\$174,559,459	63,310	\$177,104,931	68,941	\$175,030,096
Diseases of the Nervous System & Sense Organs	204,344	\$164,487,488	209,657	\$168,890,924	219,680	\$182,841,123
Diseases of the Musculoskeletal & Connective Tissue	133,067	\$121,928,095	141,198	\$136,594,192	153,486	\$148,624,918
Diseases of the Respiratory System	201,013	\$119,359,280	194,079	\$118,267,472	214,614	\$132,631,289
Injury & Poisoning	118,263	\$109,490,284	122,071	\$114,734,166	140,530	\$116,230,823
Complications of Pregnancy, Childbirth, & Puerperium	29,531	\$92,770,653	30,174	\$96,302,905	38,904	\$114,631,429
Diseases of the Digestive System	108,118	\$86,882,624	117,760	\$95,626,477	132,022	\$104,664,997
Endocrine, Nutritional & Metabolic & Immunity Disorders	60,460	\$77,833,010	65,051	\$77,453,256	72,619	\$79,981,430
Diseases of the Genitourinary System	74,186	\$58,830,923	76,889	\$61,944,988	87,171	\$66,215,788
Neoplasm	21,795	\$54,543,671	23,126	\$56,496,657	24,417	\$57,446,675
Congenital Anomalies	12,925	\$39,978,794	13,577	\$40,226,007	14,543	\$44,143,696
Infectious & Parasitic Diseases	80,701	\$38,518,611	80,254	\$40,727,709	87,172	\$43,705,969

Major Diagnostic Category	SFY11		SFY12		SFY13	
	Distinct Mem- bers	Procedure Amount	Distinct Mem- bers	Procedure Amount	Distinct Members	Procedure Amount
Diseases of the Skin & Subcu- taneous Tissue	80,253	\$26,686,926	83,273	\$27,581,183	90,713	\$29,022,023
Certain Conditions Originating in the Perinatal Period	9,322	\$24,927,498	9,444	\$22,766,626	10,516	\$19,981,759
Diseases of Blood & Blood- forming Organs	13,822	\$13,568,109	14,296	\$14,592,839	16,203	\$15,405,077
Supplementary Classification of External Causes of Injury & Poi- soning	21	\$80,233	27	\$85,879	20	\$3,038

Again in SFY13, Mental Disorders category was the highest cost category, despite moving Remedial, PMIC, and Habilitation services to managed care. This is likely due to diagnoses on long term care and waiver claims. The top five most costly categories in descending order are:

- Mental Disorders
- Symptoms, Signs, and Ill-defined Conditions
- Diseases of the Circulatory System
- Diseases of the Nervous System & Sense Organs
- Diseases of the Respiratory System

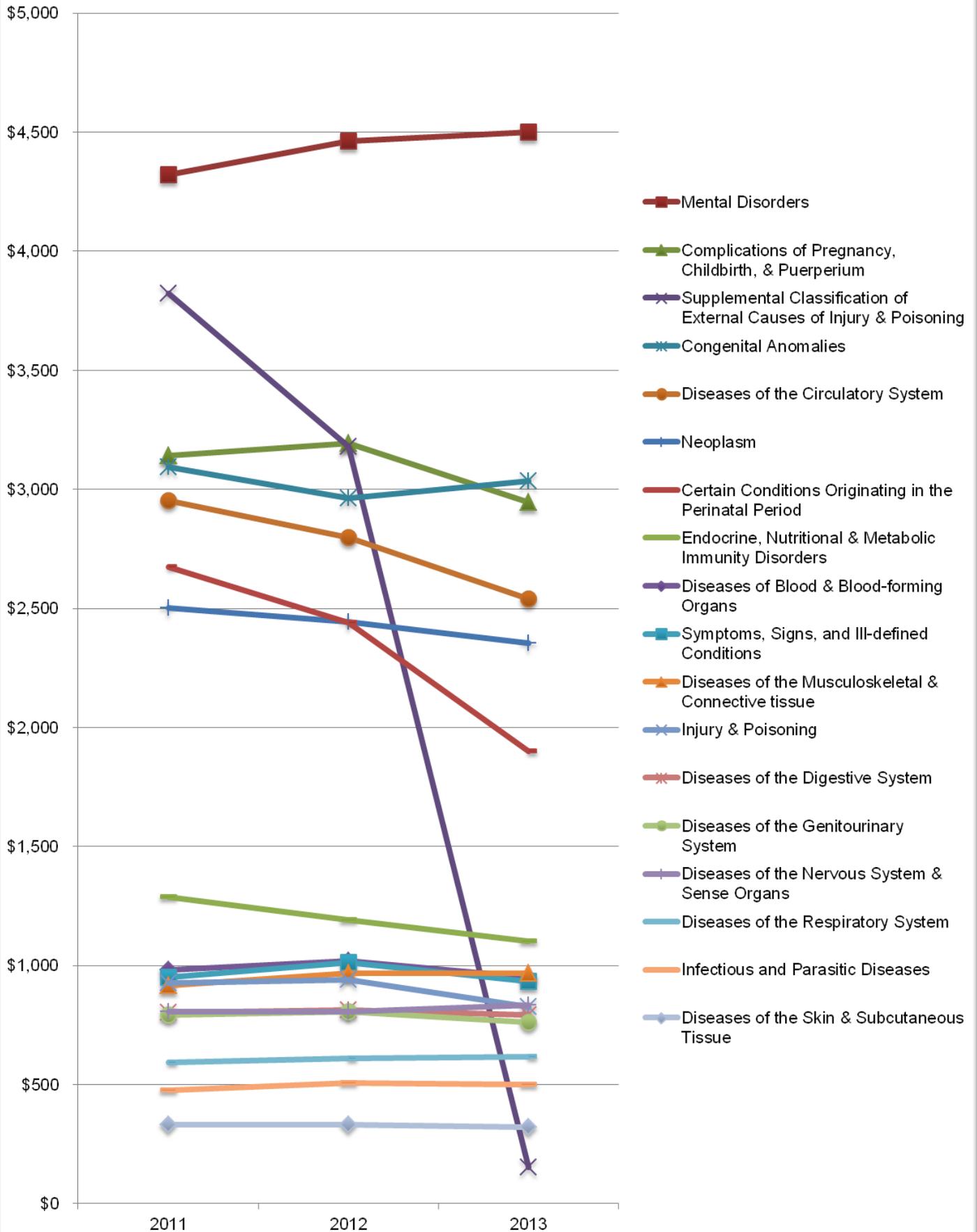
The largest increases in costs over the past three years were in the following categories:

- Symptoms, Signs, and Ill-defined Conditions
- Diseases of the Musculoskeletal & Connective Tissue
- Complications of Pregnancy, Childbirth, & Puerperium
- Diseases of the Nervous System & Sense Organs
- Diseases of the Digestive System

Costs per utilizing member are examined in the chart on page six. The highest costs per utilizing member are as follows:

- Mental Disorders
- Congenital Anomalies
- Complications of Pregnancy, Childbirth, & Puerperium
- Diseases of the Circulatory System
- Neoplasm

### Cost Per Utilizing Member, Per SFY, Per MDC



Major Diagnostic Category	SFY11		SFY12		SFY13	
	Cost Per Utilizing Member	% of Change	Cost Per Utilizing Member	% of Change From SFY11	Cost Per Utilizing member	% of Change From SFY12
Mental Disorders	\$4,320	6.7%	\$4,462	3.3%	\$4,499	8.0%
Complications of Pregnancy, Child-birth, & Puerperium	\$3,141	9.0%	\$3,192	1.6%	\$2,947	-7.7%
Supplemental Classification of External Causes of Injury & Poisoning	\$3,821	1647%	\$3,181	-16.7%	\$152	-97.2%
Congenital Anomalies	\$3,093	5.3%	\$2,963	-4.2%	\$3,035	2.4%
Diseases of the Circulatory System	\$2,953	4.9%	\$2,797	-5.3%	\$2,539	-9.2%
Neoplasm	\$2,502	5.1%	\$2,443	-2.4%	\$2,353	-3.7%
Certain Conditions Originating in the Perinatal Period	\$2,674	20.0%	\$2,441	-8.7%	\$1,900	22.2%
Endocrine, Nutritional & Metabolic Immunity Disorders	\$1,287	5.8%	\$1,191	-7.5%	\$1,101	-7.6%
Diseases of Blood & Blood-forming Organs	\$982	2.5%	\$1,021	4.0%	\$951	-6.9%
Symptoms, Signs, and Ill-defined Conditions	\$952	11.7%	\$1,012	6.3%	\$932	-7.9%
Diseases of the Musculoskeletal & Connective tissue	\$916	7.6%	\$967	5.6%	\$968	0.1%
Injury & Poisoning	\$926	13.2%	\$940	1.5%	\$827	-12.0%
Diseases of the Digestive System	\$804	8.1%	\$812	1.0%	\$793	-2.3%
Diseases of the Genitourinary System	\$793	8.2%	\$806	1.6%	\$760	-5.7%
Diseases of the Nervous System & Sense Organs	\$805	2.7%	\$806	-0.1%	\$832	3.2%
Diseases of the Respiratory System	\$594	4.9%	\$609	2.5%	\$618	1.5%
Infectious and Parasitic Diseases	\$477	11.4%	\$507	6.3%	\$501	-1.2%
Diseases of the Skin & Subcutaneous Tissue	\$333	12.5%	\$331	-0.6%	\$320	-3.3%

The average cost per utilizing member has decreased in 12 categories, identified above in green. This may be indicative of more efficient care being provided to Iowa Medicaid members.

Major Diagnostic Category	SFY12		SFY13	
	Procedure Amount	% of Change From SFY11	Procedure Amount	% of Change From SFY12
Diseases of the Musculoskeletal & Connective Tissue	\$136,594,192	12.0%	\$148,624,918	8.8%
Diseases of the Digestive System	\$95,626,477	10.1%	\$104,664,997	9.5%
Symptoms, Signs, and Ill-defined Conditions	\$221,523,616	8.3%	\$231,925,216	4.7%
Diseases of Blood & Blood-forming Organs	\$14,592,839	7.6%	\$15,405,077	5.6%
Supplementary Classification of External Causes of Injury & Poisoning	\$85,879	7.0%	\$3,038	-96.5%
Infectious & Parasitic Diseases	\$40,727,709	5.7%	\$43,705,969	7.3%
Diseases of the Genitourinary System	\$61,944,988	5.3%	\$66,215,788	6.9%
Injury & Poisoning	\$114,734,166	4.8%	\$116,230,823	1.3%
Complications of Pregnancy, Childbirth, & Puerperium	\$96,302,905	3.8%	\$114,631,429	19.0%
Neoplasm	\$56,496,657	3.6%	\$57,446,675	1.7%
Diseases of the Skin & Subcutaneous Tissue	\$27,581,183	3.4%	\$29,022,023	5.2%
Diseases of the Nervous System & Sense Organs	\$168,890,924	2.7%	\$182,841,123	8.3%
Mental Disorders	\$407,675,387	2.0%	\$409,312,737	0.4%
Diseases of the Circulatory System	\$177,104,931	1.5%	\$175,030,096	-1.2%
Congenital Anomalies	\$40,226,007	0.6%	\$44,143,696	9.7%
Endocrine, Nutritional & Metabolic & Immunity Disorders	\$77,453,256	-0.5%	\$79,981,430	3.3%
Diseases of the Respiratory System	\$118,267,472	-0.9%	\$132,631,289	12.1%
Certain Conditions Originating in the Perinatal Period	\$22,766,626	-8.7%	\$19,981,759	-12.2%

Areas showing the highest percentage of increase in costs are:

- Complications of Pregnancy, Childbirth, & Pureperium
- Diseases of the Respiratory System
- Congenital Anomalies
- Diseases of the Digestive System

The number of distinct members treated for endocrine diagnoses has increased 11.6 percent, the cost of these services also increased 3.3 percent from SFY12. In SFY12, the number of distinct members treated for endocrine diagnoses had increased 8.6 percent, while the cost of these services had nominally decreased from SFY11.

The cost per utilizing member for endocrine diagnoses has continued to nominally decrease each year from SFY11 through SFY13.

## Invalid Diagnoses

When a diagnosis is invalid or otherwise unavailable, claims and amounts are populated as an invalid, descriptive diagnosis (V01-V86), Missing, Null, or Unknown. The chart below notes the volume distinct members and subsequent cost to Medicaid for these categories.

Major Diagnostic Category	SFY11		SFY12			SFY13		
	Distinct Members	Procedure Amount	Distinct Members	Procedure Amount	% of Change	Distinct Members	Procedure Amount	% of Change
V01-V86	300,849	\$211,094,597	306,414	\$222,940,018	5.6%	329,600	\$247,122,207	10.8%
Missing	1,300	\$328,033	1,656	\$468,331	42.8%	2,719	\$588,867	25.7%
Null	532,566	\$799,436,237	\$584,134	\$901,403,816	12.8%	637,319	\$948,456,548	5.2%
Unknown	35,926	\$519,904,082	35,482	\$535,479,646	3.0%	35,975	\$568,604,167	6.2%

Claims submitted with missing diagnoses are likely indicative of waiver claims not requiring a diagnosis code.

It is anticipated the implementation of ICD-10 will reduce the volume of null and usage of the v-codes (V01-V86).

Follow up review has been completed of claims with diagnoses in the Missing, Unknown and Null categories as expenditures are not transparent. In SFY06, 48 percent of Medicaid dollars were paid on claims without a valid diagnosis. With increased emphasis on electronic billing and changes in crossover claim processing, decreases of paid claims without a valid diagnosis became evident with in most claim types and by SFY2010 40.5 percent of Medicaid dollars were paid on claims without a valid diagnosis. Unfortunately, an increase was noted in SFY12. SFY13 remained stable with SFY12 in that 47.2 percent of Medicaid dollars were paid on claims without a valid diagnosis.

The top five claim types per percentage of Medicaid expenditures for SFY13 are as follows:

- Long Term Care – 22.7 percent
- CMS 1500 – 15.7 percent
- Waiver – 14.6 percent
- Outpatient – 12.8 percent
- Inpatient – 11.5 percent

## Summary

The largest proportion of Medicaid expenditures (22.7 percent) is paid on Long Term Care claims to facilities.

The top five most costly categories in descending order are:

- Mental Disorders
- Symptoms, Signs, and Ill-defined Conditions
- Diseases of the Circulatory System
- Diseases of the Nervous System & Sense Organs
- Diseases of the Respiratory System

Costs per utilizing member are examined in the chart on page six. The highest costs per utilizing member are as follows:

- Mental Disorders
- Congenital Anomalies
- Complications of Pregnancy, Childbirth, & Puerperium
- Diseases of the Circulatory System
- Neoplasm

Areas showing the highest percentage of increase in costs are:

- Complications of Pregnancy, Childbirth, & Puerperium
- Diseases of the Respiratory System
- Congenital Anomalies

The number of distinct members treated for endocrine diagnoses has increased 11.6 percent, the cost of these services also increased 3.3 percent from SFY12. In SFY12, the number of distinct members treated for endocrine diagnoses has increased 8.6 percent, the cost of these services nominally decreased from SFY11.

## Recommendations

- Continue to monitor MDCs for trends.
- Continue to compare overall Medicaid population trends for impact from the chronic conditions and integrated health homes.



## Medicaid Value Management (MVM)

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Realizing the fiscal value of  
quality care.

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 over-all impact on our Medicaid population; MVM also looks at individual programs within Iowa Medicaid. Ultimately MVM looks for ways to promote improved health out-comes within the constraints of Medicaid budget limits and with this information, MVM makes recommendations for policy and program changes.

## Query Facts

Iowa Medicaid Claims Data