

Medicaid

Medicaid



SCHIP

State Children's Health Insurance Program



**Assessment of Medicaid and
SCHIP
Quality Improvement
Activities for the
State of Iowa
September 2008**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

September 18, 2008

Eugene Gessow, Medicaid Director
Division of Medical Services
Department of Human Services
100 Army Post Road
Des Moines, Iowa 50315

Dear Mr. Gessow:

We are pleased to share with you this packet of information intended to support quality improvement efforts in your State Medicaid program.

Background

CMS has established the Medicaid Quality Improvement Program (MQIP) which serves to fulfill the objectives of the Medicaid Quality goal established through the Federal Government Performance and Results Act (GPRA). One of the objectives of the goal calls for the Centers for Medicare & Medicaid Services (CMS) to work in partnership with State Medicaid Directors to develop a National Medicaid Quality Framework that will articulate broad principles and a common vision of quality for the program. The other objective of the GPRA goal seeks to enhance the ability of States to assess improvements in access and quality of health care under their Medicaid programs. Both objectives were discussed in a letter sent to all State Medicaid Directors on April 25, 2007 (<http://www.cms.hhs.gov/SMDL/SMD/list.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&intNumPerPage=10>).

Focusing on the latter of these two objectives, this packet presents an array of information about access and quality of care in your Medicaid and State Children's Health Insurance Program (SCHIP) program. We have compiled information on many of Iowa's activities across settings and delivery systems in an effort to provide a comprehensive assessment of activities, which in their totality, work to achieve the quality improvement goals of your State. We are providing this information to you to establish a baseline that can help you assess the current state of access and quality in your program, identify opportunities for improvement, and provide a basis for future collaborative efforts. In conducting this analysis, you may wish to supplement the contents of this Report with information available from your own internal sources, as well as information disseminated by external organizations, such as the Commonwealth Fund report, U.S. Variations in Child Health System Performance: A State Scorecard,

http://www.commonwealthfund.org/usr_doc/site_docs/slideshows/ChildScorecard/ChildScorecard.html.

Some of your State's efforts referenced in this packet also advance the four cornerstones of the Department of Health and Human Services' Value Driven Health Care initiative:

- Interoperable Health Information Technology (HIT)
- Transparency of Quality Information (measuring and publishing quality information)
- Transparency of Price Information (measuring and publishing price information)
- Incentives for High-Value Care (creating positive incentives for high quality health care purchasers)

Activities undertaken in support of these cornerstones help achieve multiple goals:

- Improve health outcomes through the exchange of clinical data among payers and providers,
- Reduce costs through increased administrative efficiencies,
- Enhance the ability of consumers to make informed health care decisions,
- Help providers and plans identify opportunities for quality improvement,
- Encourage providers to deliver high value care and consumers to adopt healthy behaviors,
- Support research into the effectiveness of alternative clinical approaches, and
- Reduce national health care expenditures.

Secretary Leavitt has asked governors, county executives and mayors to support the four cornerstones of value-driven health care and to encourage the health insurance plans, third party administrators, providers, and others with which they contract to take consistent actions to achieve these goals. The VDHC website (www.hhs.gov/transparency/government/index.html) indicates that four Iowa cities (Ames, Burlington, Cedar Rapids, and Des Moines) have endorsed the principles of this initiative. For practical steps that your State can take to further advance these goals, we suggest that you refer to "Value-Driven Health Care: A Guide for State Medicaid Agencies, Version 1.0-May 2007"

(http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/07_Tools_Tips_%20and_Protocols.asp#TopOfPage).

Components of Packet and Summary

This packet consists of the following components:

- Tab A - Quality Summary:
Performance measures, other data, and descriptions of current State initiatives that provides a snapshot of quality in your Medicaid program.
- Tab B - Data Reflective of Iowa's Broad Quality Efforts:
2007 State Snapshot for Iowa developed by the Agency for Healthcare Research and Quality

- Tab C – Data Reflective of Iowa’s Quality Efforts Related to Children’s Health
 - CMS Analyses and Initiatives:
 - CMS Analysis of Data on the State of Iowa’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program
 - CMS Analysis of Immunization Status of Iowa’s Medicaid Children ages 19 – 35 months
 - CMS Childhood Obesity Initiatives and link to Childhood Obesity Report Card for Iowa by the Childhood Obesity Action Network of the National Initiative for Children’s Healthcare Quality (NICHQ).
 - Analyses and Initiatives Developed by Other Organizations:
 - Snapshot of Child Health Needs and System Performance: Findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children’s Health - Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) Data Resource Center for Child and Adolescent Health (June 15, 2006)
 - Commonwealth Fund: 2008 State Scorecard on Child Health System Performance
 - Maternal and Child Health Bureau – Iowa’s State Priority Needs
 - Title V Maternal and Child Health Block Grant Performance Measures – Iowa
- Tab D - CMS Comments on the Iowa’s 2007 Quality Strategy for Managed Care
- Tab E - Comments on Iowa’s 2006-7 External Quality Review Annual Technical Report;
- Tab F - Medicaid Information Technology Architecture (MITA): An Opportunity to Improve Medicaid Quality
- Tab G - Quality-Related Initiatives Recognized by CMS and Other Health-Related Organizations – Iowa
- Tab H - CMS Regional Office Reviews of Iowa Home and Community Based Services Waiver Programs
- Tab I - Data from CMS Hospital Compare and Nursing Home Compare Databases
- Tab J - 2007 State Children’s Health Insurance Program (SCHIP) Data: Iowa

Summary of Findings from Review of Information

The CMS Medicaid and SCHIP Quality Strategy published in 2005 and revised in 2006 (see Appendix D of Tab D) was used as the primary assessment framework to analyze the State’s progress in moving towards the Strategy pillars listed below. Additionally, considerable attention was given to the State’s EPSDT screening rates and regulatory activity related to State Quality Strategies and External Quality Reviews for managed care delivery systems. In this regard the overall assessment was primarily based on the State’s use of:

- Evidenced Based Guidelines and Performance Measures to improve the quality of care delivered to beneficiaries;

- Health Information Technology to support quality and efficiency;
- Value-Base Purchasing strategies to align payment and quality;
- Activities designed to reduce health care disparities;
- Partnerships and collaborations to promote care coordination and leverage resources;
- Information Dissemination/Transparency (e.g. public reporting);
- The State Quality Strategy, External Quality Review (EQR) activities, and HCBS Quality Management Plans to achieve stated goals; and
- EPSDT services as reflected in the State reported CMS-416.

Collectively, these efforts, as well as many others referenced throughout the document, should enhance the State's ability to provide safe, effective, person-centered, timely, efficient and equitable care.

Selected Accomplishments

Iowa is actively involved in quality improvement efforts and has activities underway in many of the above referenced assessment areas. The State covers telemedicine services and exchanges information with registries for immunizations and several chronic conditions. We note that the State uses nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS[®]) performance measures and measures similar to HEDIS to track 14 of the 39 performance measures captured in Section IV of the attached *Quality Summary*. Iowa also uses a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument to assess member satisfaction, access and utilization of services.

The State publishes nursing facility accountability measures, as well as HEDIS measures for the Iowa Plan section 1915(b) mental health/substance abuse carve out., on its website. The Iowa Department of Public Health also publishes EPSDT participation, dental, and blood lead screening rates by county to enable providers and planners to compare local performance to statewide rates.

Incentive payment systems have been implemented for hospitals, managed care plans, and nursing facilities. Evidence based guidelines are utilized in disease management and case management efforts and in support of high-quality long term care services. Iowa's Primary Care Case Management program and 2008 legislation support the establishment of medical homes for beneficiaries. Medicaid has developed a Congestive Health Failure monitoring program using telemedicine technology. We also note that the State reports that it was an early adopter of Medicaid Information Technology Architecture principles and has completed the self assessment requested by CMS. Iowa has received a multiple CMS grants and has been an early adopter of several home and community based services initiatives.

Iowa ranks sixth best in the percent of overweight or obese children in the State. The State has received an Agency for Healthcare Research and Quality rating of "strong", compared to other States, based on a summary of over 100 measures in the National

Healthcare Quality Report (NHQR). Iowa's overall 2006 immunization rate of 78.9 percent exceeds the national average of 77.5 percent.

The Iowa Quality Strategy is a thoughtful and well-drafted document. The physical and behavioral health components of Iowa's Quality Strategy adequately meet all regulatory requirements for State quality strategies

Several of the State's more innovative quality efforts have been recognized by CMS and national organizations. The CMS Home and Community Based Services (HCBS) promising practices website profiles the Certified Nursing Assistants Recruitment and Retention Project, an effort to address turnover among support staff in Iowa nursing homes that may be adapted to HCBS services. Iowa is one of several States that has implemented a Cash and Counseling project to provide Medicaid-eligible frail elderly persons and disabled individuals of all ages with an annual budget that participants may use to pay for the combination of goods and services that best meets their personal care needs.

Iowa reported data for all four core measures on the 2007 SCHIP annual report. The rate for well child visits in the first 15 months increased by 8.5 percentage points between 2006 and 2007. The percent of children in each age group measured who used appropriate asthma medications rose consistently and considerably over the three-year period, 2005-2007.

Recommendations for Continuous Improvement

Iowa may wish to consider expanding the number of performance measures indicated in Section IV of the Quality Summary (Tab A) for which the State collects data. For example, reporting on infection rates is a key indicator used in identifying Never Events. Reporting on neonatal care, prenatal care, and obesity can facilitate necessary interventions to assure optimal infant and child health. Your State's Early and Periodic Screening Diagnoses and Treatment (EPSDT) participation rate declined 3 percentage points from 71 percent in fiscal year (FY) 2006 to 68 percent for FY 2007. We urge Iowa to continue its efforts to reach the national participation goal of 80 percent. We also encourage Iowa to enhance its efforts to improve its EPSDT dental service and blood lead screening rates, which are 43 percent and 9 percent, respectively. While the State ranks among the top States in the percent of overweight and obese children overall, its rates for children with low family incomes and on public insurance are about average. We encourage Iowa to explore new strategies for addressing this health problem among Medicaid-eligible children.

The most recent External Quality Review Annual Technical Report for Iowa that CMS has received is for the years 2006-7. We look forward to seeing future reports that show enhanced documentation and data analysis associated with Performance Improvement Plans, as well as initiation of improvement strategies based on the results of performance measurement.

With regard to Iowa's 2007 Quality Strategy, we recommend that the State integrate the two Quality Strategies for physical and behavioral health into a single document that incorporates quantified, measurable performance targets. CMS would also appreciate more information from Iowa in the Quality Strategy on its participation in pay for performance, health information technology, Never Events, and other value-based purchasing initiatives.

We note that, while various organizations have recognized practices undertaken by the State to advance quality, Iowa has not submitted profiles of any such efforts for posting on the Medicaid/SCHIP Promising Practices website hosted by CMS (<http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp#TopOfPage>). We encourage you to review the process for nominating a practice (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/10_Promising%20PracticesConceptNomination%20Process.asp#TopOfPage) and to submit your nominations so that beneficiaries in other States can benefit from the progress that is being made through your efforts.

We encourage Iowa to continue to incorporate HIT-related goals and refer to national standards in its Quality Strategy and next ATR. We have included a concept paper on quality and CMS's Medicaid Information Technology Architecture (MITA) initiative and would appreciate your feedback on the State's intentions to adopt MITA principles in its Medicaid information systems. We would also like to learn more about current efforts to address health care disparities in the State, as this continues to be a priority area.

Given that the Iowa Department of Human Services administers both the Medicaid and SCHIP programs, we offer several recommendations to improve the completeness of the data reported via the SCHIP Annual Report Template System (SARTS) and to clarify the data submitted on the 2007 report. We encourage the State to examine the reasons for the decline in the number of 4- and 5-year olds who received well child visits between 2005 and 2007 and for the low percentages of 6-year olds receiving well child visits in each of these years. We would appreciate the State's efforts to provide the percent of children in the first 15 months who receive specific numbers of visits. We will be glad to provide technical assistance to enhance the State's reporting of each of these measures.

We have included more specific comments related to the above summary in attachment A of this letter. Detailed information regarding each item can be found in the subsequent attachments.

Requested Follow-up Actions

Please provide written acknowledgement of receipt of this information as well as any necessary corrections and additions to the information to ensure accuracy. We would like to particularly call your attention to the *Quality Summary* that can be found in Tab A as that portion of this assessment will eventually be available for public review.

We would also like to request feedback indicating how the Iowa Medicaid and SCHIP programs intend to use the information presented in this packet as well as other sources of information to improve access and quality to Medicaid services. We would appreciate receiving your feedback by November 7, 2008 as this will help as we further develop the State Quality Assessment Process for other States. Your feedback should be sent to the attention of James Scott, Associate Regional Administrator for Medicaid and Children's Health Operations in the CMS Kansas City Regional Office, at James.Scott1@cms.hhs.gov.

Additionally we are interested in learning the extent to which Iowa has found this information to be useful, and what other information CMS could supply or help the State develop to support its Medicaid quality improvement efforts.

We appreciate your commitment to improving quality for the children, families, aged, blind and disabled beneficiaries covered through your Medicaid and SCHIP programs and look forward to working with you in these efforts. Please feel free to contact me or any member of my staff to discuss this information in more detail. I can be reached at 410-786-0505 or john.young@cms.hhs.gov.

Sincerely,

John M. Young
Acting Director, Division of Quality, Evaluation, and Health Outcomes

Executive Summary:
Information to Support the Assessment of Quality Improvement
by the State of Iowa's Medicaid Program

Following is a summary analysis of the key documents included in this packet:

- Quality Summary (Tab A) – The *Quality Summary* is designed to serve as a quick reference of quality improvement activities in the State of Iowa. We ask that you carefully review this document as this information in the *Quality Summary* will eventually be made public.
 - In Section II, Iowa reports activity in all four principal areas of Value Driven Health Care: Interoperable Health Information Technology, Measurement and Publication of Quality Information (Quality Standards), Measurement and Publication of Price Information (Price Standards), and Promoting Quality and Efficiency of Care (Incentives/Pay for Performance).
 - In Section III, Iowa indicates that it promotes quality in all six areas identified in the CMS Medicaid/SCHIP Quality Strategy: Evidence Based Guidelines/Performance Measures, Value-Based Purchasing/P4P, Health Information Technology, Racial/Ethnic Disparities Projects, Medical Home Models, and Partnerships/Collaboration. The State is engaged in various local and Federal collaborative efforts to advance health information technology and child health.
 - The State collects and reports 14 of the 39 nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS[®]) performance measures and measures similar to HEDIS identified in Section IV.
 - Some of the State's more innovative quality efforts have been recognized by CMS and national organizations. The CMS Home and Community Based Services (HCBS) promising practices website profiles the Certified Nursing Assistants Recruitment and Retention Project, and the Agency for Healthcare Research and Quality profiles Iowa's Cash and Counseling project. The State has also identified several other noteworthy initiatives.
- Data Reflective of Iowa's Broad Quality Efforts (Tab B) –
 - Agency for Healthcare Research and Quality 2007 State Snapshot – Iowa: This AHRQ analysis indicates that your State has a strong overall rating in comparison to other States on a series of quality measures. It highlights measures in which Iowa performed best in comparison to other States and identifies other measures that provide opportunities for improvement.

- Information Reflective of Iowa's Quality Efforts Related to Children's Health (Tab C) –
 - CMS Analyses and Initiatives:
 - CMS Analysis of Data on the State of Iowa's Early and Periodic Screening, Diagnostic, and Treatment Program: Data on the State of Iowa's Early and Periodic Screening, Diagnostic, and Treatment Program: The State's form CMS-416, the EPSDT annual reporting form, indicates that for FY 2007 Iowa's participation ratio was 68 percent, its dental services rate was 43 percent, and its lead screening rate was 9 percent.
 - CMS Analysis of Immunization Status of Iowa Medicaid Children ages 19 – 35 months: Iowa's overall rate for 2006 is 78.9 percent, compared to a national average of 77.5%. The number of Medicaid children was not specifically measured, but the number of children in the Vaccines for Children Program (VFC) in Iowa with full immunizations was 77.0 percent, compared to a national VFC coverage rate of 79.8%. The majority of VFC participants are Medicaid children, and VFC is the primary source of Medicaid immunizations.
 - CMS Childhood Obesity Initiatives: The State ranks sixth best among all States in percentage of children ages 10-17 who are considered overweight or obese according to Body Mass Index-for-age standards. The State's overall prevalence of childhood obesity is about five percentage points lower than the national average. The percentage of overweight or obese children is comparable to national averages for children in low-income families and those covered by public insurance.
 - Analyses and Initiatives Developed by Other Organizations:
 - Snapshot of Child Health Needs and System Performance: Findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health - Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) Data Resource Center for Child and Adolescent Health (June 15, 2006): This resource indicates Iowa's performance on various indicators in the domains of Health Needs and Health Outcomes and in Performance and Improvement Opportunities in comparison to its region and the nation.
 - Maternal and Child Health Bureau – Iowa State Priority Needs: Through a Statewide maternal and child health needs assessment

required by Title V legislation, the State of Iowa has established 10 priority needs. Priority needs of particular relevance to the Medicaid-eligible children relate to the provision of developmental evaluations, access to pediatric specialty care, quality of primary care, access to oral health care, reduction of infant mortality, and access to necessary mental health services for pregnant and parenting women. We would appreciate information concerning the State's participation in activities to address these priorities with regard to Medicaid populations.

- Title V Maternal and Child Health Block Grant Performance Measures – Iowa: The State reports on six performance measures that represent selected indicators of statewide quality, as required by the Title V Maternal and Child Health Block Grant program. Those of particular relevance to the Medicaid-eligible children generally correspond to the priority needs discussed above.
- CMS Comments on the Iowa 2007 Quality Strategy (Tab D):
 - The Iowa Quality Strategy is a thoughtful and well-drafted document. The physical and behavioral health components of Iowa's Quality Strategy adequately meet all regulatory requirements for State quality strategies.
 - CMS recommends that the State integrate the two Quality Strategies for physical and behavioral health into a single document that incorporates quantified, measurable performance targets.
 - CMS would also appreciate more information from Iowa in the Quality Strategy on its participation in pay for performance, health information technology, and other value-based purchasing initiatives.
- Iowa External Quality Review Organization (EQRO) 2006-7 Annual Technical Report (ATR) (Tab E):
 - CMS views the External Quality Review process as a mechanism that can be more effectively used to help the State reach its quality goals as stated in the State Quality Strategy. We continue to explore best practices in how to use the process more effectively and would appreciate your feedback in this area.
 - CMS encourages the State to submit a single EQRO report that provides summary and comparative information for all participating MCOs and PIHPs in the future.
- Medicaid Information Technology Architecture (MITA): An Opportunity to Improve Medicaid Quality Medicaid Information Technology Architecture

(MITA): An Opportunity to Improve Medicaid Quality (Tab F) – This paper is intended to provide an overview of MITA and Quality for MMIS and Quality professionals.

- The Medicaid Information Technology Architecture (MITA) framework seeks to move the MMIS toward a greater focus on the beneficiary, integration of clinical and administrative data, support of program analysis and decision making, and an enhanced capacity for Medicaid to communicate with other programs and payers.
- The MITA initiative can support quality improvement by providing a more comprehensive base of information on individual beneficiaries and real-time data on changes in the delivery of services in real time.
- A July 2007 report issued by the DHHS Office of Inspector General cited numerous examples of State Medicaid HIT and HIE initiatives intended to serve these aims.
- CMS intends to take a series of concrete actions to explore opportunities for using MITA principles to advance quality goals for Medicaid beneficiaries
- Quality-Related Initiatives Recognized by CMS and Other Health-Related Organizations – Iowa (Tab G):
 - CMS-Posted Promising Practices:
 - Iowa has no promising practices on the CMS Medicaid/SCHIP Quality Website. CMS encourages Iowa to submit descriptions of any innovative initiatives undertaken through your Medicaid managed care plans that advance quality for Medicaid beneficiaries or SCHIP enrollees using the guidelines and format found on the CMS Medicaid/SCHIP Quality website (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/10_Promising%20PracticesConceptNominationProcess.asp#TopOfPage). See examples of promising practices for other States already posted to this site (<http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp#TopOfPage>).
 - The Home and Community Based Services promising practices website (<http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp#TopOfPage>) profiles the State's Certified Nursing Assistant (CNA) Recruitment and Retention Project, which seeks to address the need for direct support professionals in both institutional and community settings.

- CMS-Posted Promising Practices: National organizations have recognized Iowa's quality-related efforts as well: AHRQ's Health Care Innovations Exchange website (<http://www.innovations.ahrq.gov/content.aspx?id=1800>) profiles Iowa's Cash and Counseling project, which provides frail elderly and disabled individuals of all ages with Medicaid coverage with an annual budget, which the participant uses to pay for the combination of goods and services that best meets their personal care needs.
- CMS Regional Office (RO) Reviews of Iowa Home and Community Based Services (HCBS) Waiver Programs (Tab H) – Summaries of RO reviews of the five following HCBS waiver programs are furnished:
 - Elderly
 - Physically Disabled
 - Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)
- Data from CMS Hospital Compare and Nursing Home Compare Databases (Tab J) - We have included national averages and averages for Iowa hospitals from the CMS Hospital Compare website (<http://www.hospitalcompare.hhs.gov/Hospital/Home2.asp?version=alternate&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home>) for 24 measures in four areas (i.e., Myocardial Infarction, Health Failure, Pneumonia, Surgery). Also included are national averages and averages for Iowa nursing homes from the CMS Nursing Home Compare website (<http://www.medicare.gov/NHCompare/Home.asp?version=alternate&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True>) for 19 measures. These measures reflect the quality of care received by Medicaid and beneficiaries and SCHIP enrollees as a part of the overall population.

We encourage you to review these data and the facility-specific rates on the CMS websites. Iowa can obtain information about Medicaid hospitalizations using HCUPNet (www.hcupnet.ahrq.gov). By providing information on hospital discharges (e.g. length of stay, charges) for a variety of diagnoses and procedures, HCUPNet would enable the State to compare Medicaid versus other payers.

- 2007 State Children's Health Insurance Program (SCHIP) Data: Iowa (Tab J) – CMS requires State SCHIP programs to report annually on four core child health performance measures:
 - Well Child Visits in the First 15 Months of Life
 - Well Child Visits in the Third, Fourth, and Sixth Years of Life
 - Use of Appropriate Medications for Children with Asthma
 - Children's Access to Primary Care Practitioners

- Iowa reported data for all four core measures on the 2007 SCHIP annual report. The rate for well child visits in the first 15 months increased by 8.5 percentage points between 2006 and 2007. The percent of children in each age group measured who used appropriate asthma medications rose consistently and considerably over the three-year period, 2005-2007.
- The number of 4- and 5-year olds who received well child visits declined between 2005 and 2007. Relatively low percentages of six-year olds received well child visits in each of these years. The State indicated the percent of children in the first 15 months who received any well child visits but not the number who received a specific numbers of visits (i.e., 0, 1, 2, 3, 4, 5, 6).

Tab A
Quality Summary

Quality Summary for the State of Iowa

I. State Contact Information:

Name/Title: Jennifer Vermeer, Assistant Medicaid Director
 Organization: Iowa Medicaid Enterprise
 Street Address: 100 Army Post Road
 City/State/Zip Code: Des Moines, IA 50315
 Telephone: 515-725-1144
 Email Address: Jvermee@dhs.state.ia.us

II. Value Driven Health Care:

1. Interoperable Health Information Technology (HIT Standards)

Yes No (if yes, see checked box below)

Adoption of Medicaid Information Technology Architecture (MITA)

Early adopter – self assessment completed

Remote Monitoring/Telemedicine

Underlying service payable – not transmission/hardware

Used considerably for mental health delivery

Remote evaluations for enclosed bed therapy - nighttime video evaluated remotely to determine tolerance by the patient for an enclosed bed used to promote safety.

Electronic Medical Record (EMR)

Electronic Health Record (EHR)

The Iowa Medicaid Electronic Records System (IMERS) is a web-based tool that organizes and displays information from the State's claims data warehouse for the provider in an EHR format to support patient care.

Patient/Disease Registries

Used by the State's medical reviewer contractor to support diagnosis-based medical/disease/care management for:

Diabetes

Congestive Heart Failure

Asthma

Individuals with multiple, complex care needs

Information Exchange/Collaboration

Immunization Registry with Iowa Department of Public Health (IDPH)

2. Measure and Publish Quality Information (Quality Standards)

Yes No

How/where are these measures published? On State website?

The State publishes:

(1) HEDIS measures published at <http://www.ime.state.ia.us/ManagedCare/ManagedCareDocs.html>

(2) Iowa Plan 1915(b) mental health/substance abuse program performance measures published at <http://www.ime.state.ia.us/ManagedCare/ManagedCareDocs.html>

(3) Nursing facility accountability measures published – You can find the last posted Acct Measures at: <http://www.ime.state.ia.us/Providers/Forms/NursingFacilityRates.html>

3. Measure and Publish Price Information (Price Standards)

Yes No

All fee schedules are published on http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

4. Promote Quality and Efficiency of Care (Incentives/Pay for Performance)

Hospital Physician Home Health MCO Other Nursing Facility

(1) **Iowa Plan (Incentives)** – Additional payments for benchmark practices. Under the Iowa Plan (managed behavioral health contract) funds are set aside for community reinvestment programs. Community reinvestment is a specified portion of the monthly capitation payment that is intended to pay for innovative practices that become required services and self-supporting. The program contains extra payments by the Iowa Plan for benchmark practices. These can include paying providers contracted with the Iowa Plan for achieving specific goals relative to the project that impact the quality of care provided.

(2) **Iowa Plan (Incentives)** - In addition, the Iowa Department of Human Services holds the contract with the current Iowa Plan contractor and has agreed to make incentive payments to the contractor for the achievement of specific performance measures. These measures are developed by the Clinical Advisory Committee and sent to the Iowa Plan Advisory Committee, consisting of consumers, advocates, providers and others. The Iowa Plan Advisory Committee makes a recommendation to DHS as to whether or not to accept, amend or drop any specific measures.

(3) **Nursing facility accountability measures (P4P)** - State legislation required Iowa Medicaid to initiate a system to measure a variety of elements to determine a NF capacity to provide quality of life and appropriate access to medical assistance program beneficiaries in a cost-effective manner. To do so, Iowa Medicaid was to implement a process to collect data for measurements and develop procedures to increase NF payments based on achievement of multiple favorable outcomes. Iowa's NF Accountability Measures were developed to be objective and measurable NF characteristics that indicated either quality care, efficiency, or commitment to care for special resident populations. The Accountability Measure is calculated by facility (if the criteria are met) and then is an add on to their rate.

(4) **Hospital participation in Diagnosis Related Groups (DRG)/Ambulatory Patient Groups (APG) (General promotion of efficiency of care)** – Iowa has adopted hospital reimbursement methodologies that are dependent upon the specific condition of the individual. DRGs were developed by Medicare to promote efficiency of care.

III. CMS Medicaid / CHIP Quality Strategy Pillars

Evidenced Based Guidelines/ Performance Measures (See Section IV)

HEDIS Measures

AHRQ Learning Project to encourage information

Value-Based Purchasing/P4P – (See Section II – Incentives)

Refer to #4 – Section II

See comment in Section II,

Health Information Technology (See Section II)

Medicaid has joined other payers and providers on an Information Technology Commission established by State legislation

IMERS electronic health record (Section II)

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| <p>sharing among States regarding strategies for developing and implementing disease management programs</p> <p>Used for prior authorization, disease management, utilization management, and case management programs</p> <p>Quality Assurance programs for Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded</p> | <p>subsection 4.</p> | |
| <p><input checked="" type="checkbox"/> Racial/Ethnic Disparities Projects</p> <p>Community Reinvestment project for Urban Dreams funded as a pilot project under Iowa Plan section 1915(b) program</p> | <p><input checked="" type="checkbox"/> Medical Home Models</p> <p>Primary Care Case Management program</p> <p>2008 Legislation for establishment of medical home</p> <p>Care Management program</p> <p>Disease Management program</p> <p>Iowa safety net provider collaboration</p> <p>Health Care Reform bill (2008) – House File 2539 contains a number of measures designed to advance coverage of the uninsured and improve the health care system in Iowa.</p> | <p><input checked="" type="checkbox"/> Partnerships/Collaborations</p> <p>The State has joined Des Moines University in a partnership to monitor Congestive Heart Failure patients via telephone. Started as a grant program. Now Medicaid-funded.</p> <p>Medicaid has a partnership with the Department of Public Health on a number of initiatives included the states smoking cessation programs, EPSDT services, and dental access issues.</p> <p>Medicaid collaborates with the University of Iowa in developing HEDIS data to monitor and report on EPSDT participation.</p> <p>The State was one of five States selected to participate in the ABCD II Consortium, which began its work in early 2004. With funding from the Commonwealth Fund, the National Academy for State Health Policy administers the ABCD II initiative, a three-year project designed to build state capacity to deliver care that supports children’s healthy mental development. Iowa Medicaid works with the University of Iowa on this initiative.</p> <p>Medicaid works with various partners on the Medical Assistance Advisory Committee in reviewing program performance.</p> |

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| | <p>One of these measures is implementation of a medical home model. There is a workgroup that has been appointed to design the program. Medicaid and SCHIP will be the first phase of implementation, per the legislation.</p> | <p>Medicaid works with private clinicians on the Clinical Advisory Committee to review utilization of acute care, prior authorization, and utilization trends.</p> <p>Medicaid convenes a Pharmaceutical and Therapeutic Committee to make recommendations on the Preferred Drug List and a Drug Utilization Review Committee to make recommendations on clinical prior authorization requirements. Both groups consist of community physicians and pharmacists.</p> <p>Medicaid works with the State Department of Inspections and Appeals on fraud and abuse investigation and survey and certification.</p> |
|--|--|--|

Comments:

IV. Performance Measures: **HEDIS** **HEDIS-Like** **Hospital Quality Alliance (HQA)** **Other (See comments)**

| | | | |
|---|--|---|--|
| <input checked="" type="checkbox"/> Access | <input checked="" type="checkbox"/> Dental | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Acute Myocardial Infarction (AMI) | <input checked="" type="checkbox"/> Depression | <input type="checkbox"/> Intensive Care Unit (ICU) Care | <input type="checkbox"/> Patient Safety |
| <input type="checkbox"/> Ambulatory | <input checked="" type="checkbox"/> Diabetes | <input type="checkbox"/> Infection | <input checked="" type="checkbox"/> Pediatric |
| <input checked="" type="checkbox"/> Asthma | <input type="checkbox"/> Efficiency | <input type="checkbox"/> Health Literacy | <input type="checkbox"/> Pediatric Intensive Care Unit (PICU) Care |
| <input type="checkbox"/> Bone Conditions | <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pneumonia Care |
| <input checked="" type="checkbox"/> Cancer Screenings | <input type="checkbox"/> End Stage Renal Disease (ESRD) | <input checked="" type="checkbox"/> Medication | <input type="checkbox"/> Prenatal Care |
| <input checked="" type="checkbox"/> Care Coordination | <input checked="" type="checkbox"/> Heart Failure | <input checked="" type="checkbox"/> Mental Health | <input checked="" type="checkbox"/> Prevention |
| <input checked="" type="checkbox"/> Children with Special Health Care Needs (CSHCN) | <input type="checkbox"/> Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) | <input type="checkbox"/> Neonatal Care | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Coronary Artery Disease (CAD) | <input type="checkbox"/> Home Health | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Surgical Infection Prevention (SIP) | <input checked="" type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other |

Comments:

(1) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for member satisfaction, access and utilization of services.

(2) Measurement information collected and published by University of Iowa Public Policy Center.

V. Early and Periodic, Screening, Diagnostic and Treatment (EPSDT)

Participation Rate:

Dental Service Rate:

Lead Screen Rate:

Comments:

Iowa's EPSDT annual reporting form (CMS-416) for fiscal year 2007 indicates the following:

Participation Goal: The State of Iowa's FY 2007 participation ratio is 68%, a decrease of 3% from FY 2006. The national participation goal continues to be 80%.

Dental Services: For FY 2007, the data shows that the State provided some dental service to approximately 43% of eligible EPSDT individuals, an increase of 1% from FY 2006.

Lead Screening: For FY 2007, the data shows the State has provided a lead screening test to just 9% of the eligible EPSDT population under the age of 6 who should have had a screening blood lead test. This is a decrease of 2% from FY 2006. Blood lead screening continues to be a requirement under the federal Medicaid program for all children ages 1 and 2 as well as a blood test for any child under the age of 6 for whom no record of a test is available.

The IDPH publishes the above rates by county so that providers and planners can get a picture of the rates locally in addition to the statewide rates.

The State has set performance measures in the current year's IDPH contract for dental rates.

VI. Recognition of Promising / Innovative Practices

Recognition by CMS

Recognition by Other Health-Related Organization

Comments:

- **The Certified Nursing Assistants Recruitment and Retention Project:** This Project is profiled on the CMS Home and Community Based Services (HCBS) promising practices website.
- **Iowa Plan:** Iowa has received requests for information regarding the Iowa Plan, contract and performance measures.
- **Lock-In Program:** CMS, during the MIG visit recognized Iowa Medicaid's Lock-in program for making four provider types eligible for Lock-in status (including hospital and specialty physicians).
- **Nursing home accountability measures:** Iowa's NF Accountability Measure program has been recognized by other states and provider associations as the first in the nation and model program that focuses increased nursing facility payments based on provider performance.
- **Habilitation:** Iowa was the first state in the nation to implement a 1915i HCBS State Plan, which is a new option available under the Deficit Reduction Act to provide Home and Community Based Services under the State Plan
- **Care Management Coordination:** AHRQ Care Management Learning Network and the Medicaid Medical Director's Association have both recognized Iowa Medicaid's integration of behavioral and physical medicine through the completion of depression screening and its impact on chronic care.

- **Consumer Choices Option under HCBS waivers:** This self-direction option was initially awarded a Robert Wood Johnson Real Choices grant to add the service to six of Iowa's HCBS waivers. This option allows Medicaid members to have control over a targeted amount of HCBS funding to develop an individual budget. The individual budget plan allows the member to hire employees and/or purchase other goods and services. The project is profiled on AHRQ's Health Care Innovations website.
- **Money Follows the Person grant:** Iowa received a five-year grant from the Centers for Medicare and Medicaid Services (CMS) to provide opportunities for 528 people to move out of Iowa's ICF/MR facilities to independent settings of their choice. Grant funds provide the transition services and extra supports needed for the first year after they transition into the community.
- **Medicaid Infrastructure Grant:** The purpose Iowa's grant program people with disabilities and advocates working together with state government to enhance opportunities for Iowans with disabilities to work and live in the community of their choice.

VII. State Quality Strategy

Document Title: Quality Assessment and Improvement Strategy

Date of Last Quality Strategy: 2007

Comments:

VIII. External Quality Review

EQRO: Iowa Foundation for Medical Care

Date of Last EQRO Report: 2006-2007

Comments:

IX. Other Quality Initiatives

Childhood Health Initiatives

Other Quality-Related Studies

Comments:

(1) SCHIP focused study on health status improvement. The Health Assessment Survey project under which the State works with researchers and the SCHIP Clinical Advisory Committee to develop survey instruments that are used to evaluate the effect of the SCHIP participating health and dental plans on access to care, health status and family environment of enrolled children is used. Parents respond to a survey given at the time the child joins the SCHIP program (the baseline survey). These responses are compared with their responses to a survey given after their child had been enrolled for about a year (the

follow-up survey) to determine if there are differences in the perceived ability to receive health services or their child's health status.

(2) Coordination with immunization registry.

(3) The State is working to educate physicians and other primary care providers on the need for developmental surveillance and standardized screening according to the American Academy of Pediatrics guidelines.

(4) Title V has a developmental screening performance measure that is reported annually. Assures developmental evaluations are provided to Medicaid enrolled children 0-3 years. A development evaluation is periodic reviews of a child's development as an integrated part of a well-child examination to include a review of developmental milestones, behavior, family risk factors, and parent concerns. This measure is completely for the Medicaid population and the Expansion population under S-CHIP.

(5) Beginning in March 2007 Iowa Medicaid began a comprehensive approach to improving quality healthcare with a vision to maximize the value of the program to Medicaid members within the fiscal limitations of the state and federal budget. The 3 primary categories of comparison review include a norm for Iowa Medicaid spending, benchmarks for industry standards, and benchmarks for quality. Expert analysis of integrated information was used to formulate recommendations for the Iowa Medicaid program. Recommendations take into consideration: reach, long-term sustainability, operational and administrative implications, projected health outcomes, return on investment, and performance metrics. The project "checklist" supports a systematic review of claims-related information and is reported on monthly to the Department's Director and policy staff. The "checklist" includes the selected performance indicator and rationale for selection, data collected and description and overview of the assessment and analysis, outcomes, actions and recommendations.

X. Quality in Home and Community Based Services Programs

Assessed by CMS?

Number of Waiver Programs: 7 – The Quality Improvement system also includes the State plan Habilitation and Remedial services

Comments:

Over the past several years, Iowa has worked closely with the CMS Regional Office in the course of the waiver renewal process to assure that the State's Quality Improvement plan meets CMS requirements. Iowa has submitted a waiver renewal using the 3.5 version of the waiver application, which requires the State to clearly spell out its quality improvement strategies. The application has been reviewed and approved by CMS.

At the recommendation of CMS regional office, the State has consulted with Beth Jackson of Thompson-Reuters (a CMS contractor on quality) to further develop our quality improvement plan. Iowa will work with Ms. Jackson to craft performance measures to make use of the information and data on quality that the State currently gathers and to articulate the performance measures and improvement strategies to fulfill CMS requirements.

Tab B

Data Reflective of Iowa's Broad Quality Efforts

- Agency for Healthcare Research and Quality 2007 State Snapshot –
Iowa (as of April 29, 2008) – See
http://statesnapshots.ahrq.gov/snaps07/strongest_weakest.jsp?menuid=6&state=IA
and
<http://statesnapshots.ahrq.gov/snaps07/dashboard.jsp?menuid=4&state=IA&level=0>

Iowa

Strongest and Weakest Measures

Iowa's Strongest Measures

Strongest Measures are those in which the State performed above the all-State average and are strongest among their measures relative to all reporting States. This State may be leading the way in quality in these measures.

Note: The best result for each measure can be either the highest or lowest value. The direction representing best is noted in the "Best" column.

| Measure Short Name | Measure Long Name | Best |
|--|--|-------------|
| Diabetes eye exams | Percent of adults age 40 and over with diabetes who had a retinal eye examination in the past year | highest |
| Infant deaths - very low birth weight | Infant deaths per 1,000 live births, birth weight < 1,500 grams | lowest |
| HIV deaths | HIV-infection deaths per 100,000 population | lowest |
| Nursing home long-stay residents - with too much weight loss | Percent of long-stay nursing home residents who lose too much weight | lowest |
| Nursing home long-stay residents - bed/chair bound | Percent of long-stay nursing home residents who spent most of their time in bed or in a chair | lowest |

Iowa's Weakest Measures

Weakest Measures are those in which the State performed below the all-State average and are weakest among their measures relative to all reporting States. These measures highlight some of the opportunities for improvement.

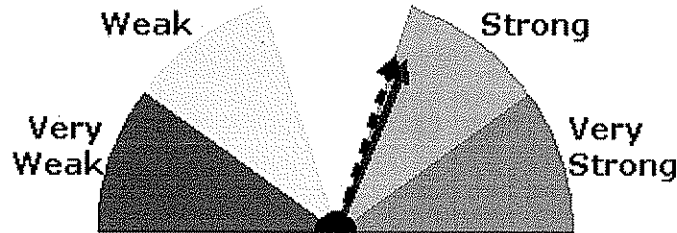
Note: The best result for each measure can be either the highest or lowest value. The direction representing best is noted in the "Best" column.

| Measure Short Name | Measure Long Name | Best |
|---|--|-------------|
| Home health care - improved oral drug management | Percent of home health care patients who get better at taking their medicines correctly (by mouth) | highest |
| Home health care - improved mobility | Percent of home health care patients who get better at walking or moving around | highest |
| Home health care - incontinence | Percent of home health care patients who have less urinary incontinence | highest |
| Nursing home short-stay residents - with delirium | Percent of short-stay nursing home residents with delirium | lowest |
| Home health care - plus urgent care | Percent of home health care patients who needed urgent, unplanned medical care | lowest |

Iowa

Dashboard on Health Care Quality Compared to All States

Overall Health Care Quality Average



Performance Meter: All Measures

The meters above and below are summaries of measures reported in the National Healthcare Quality Report (NHQR) for Iowa. The above meter is a summary of over 100 measures in the NHQR reported at the State level, while the 12 meters below describe specific types of care, settings of care, and care in clinical areas.

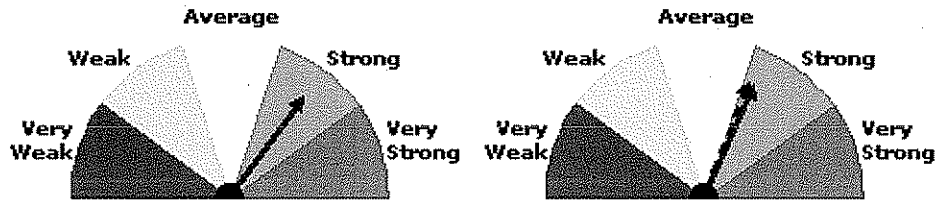
Each meter shows a State's balance of below average, average, and above average measures compared to all States reporting such data in the United States. The performance meter has five categories: very weak, weak, average, strong, and very strong. An arrow pointing to "very weak" means all or nearly all included measures for a State are below average within a given data year. An arrow pointing to "very strong" indicates that all or nearly all available measures for a State are above average within a given data year. A solid arrow describes results for the most recent data year; a dashed arrow describes the baseline year. A missing arrow means there were insufficient data to create the summary measure for this State.

Compared to all States, for the most recent data year, the performance for Iowa for all measures is in the strong range. For the baseline year, performance is in the strong range.

Click on any meter to find the underlying measures.

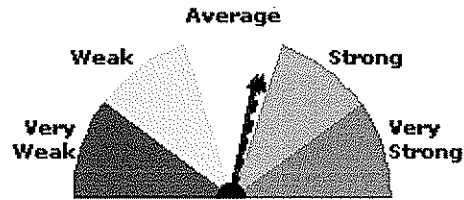
[How are measures represented by a performance meter? \(select this link or Methods\)](#)

Types of Care



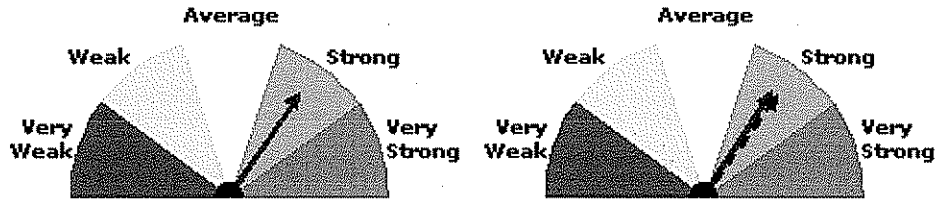
Performance Meter:
Preventive Measures

Performance Meter:
Acute Care Measures



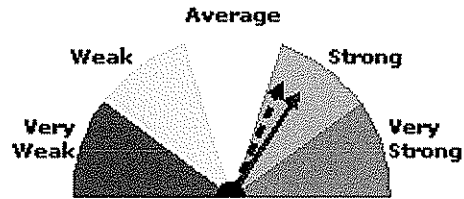
Performance Meter:
Chronic Care Measures

Settings of Care

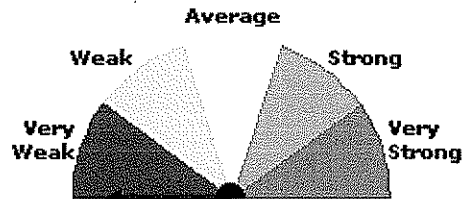


Performance Meter:
Hospital Care Measures

Performance Meter:
Ambulatory Care Measures

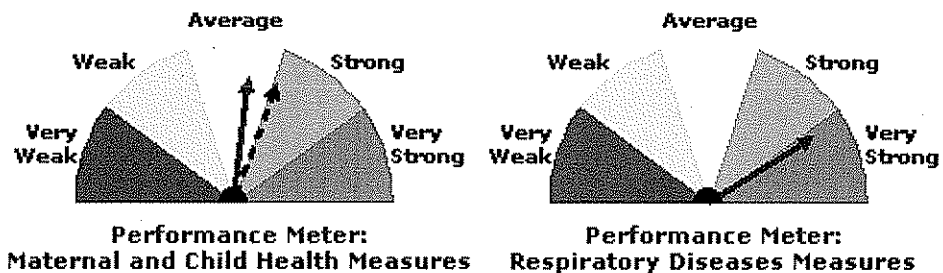
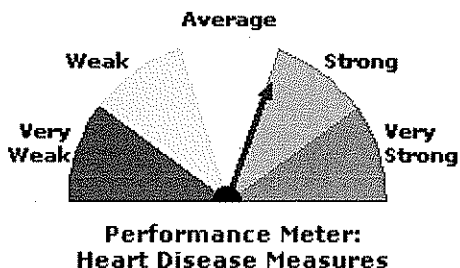
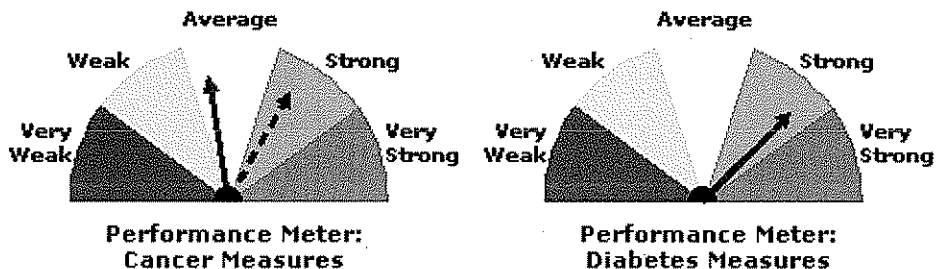


Performance Meter:
Nursing Home Care Measures



Performance Meter:
Home Health Care Measures

Care by Clinical Area



—————▶ = Most Recent Data Year
 - - - - -▶ = Baseline Year

(Baseline year may vary across measures)

[How are measures represented by a performance meter? \(select this link or Methods\)](#)

Tab C

Data Reflective of Iowa's Quality Efforts Related to Children's Health

CMS Analyses and Initiatives:

- CMS Analysis of Data on the State of Iowa's Early and Periodic Screening, Diagnostic, and Treatment Program
- CMS Analysis of Immunization Status of Iowa Medicaid Children ages 19 – 35 months
- CMS Childhood Obesity Initiatives

Analyses and Initiatives Developed by Other Organizations:

- Snapshot of Child Health Needs and System Performance: Findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health - Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) Data Resource Center for Child and Adolescent Health (April 13, 2006)
- Maternal and Child Health Bureau – Iowa State Priority Needs
- Title V Maternal and Child Health Block Grant Performance Measures – Iowa

CMS Analyses and Initiatives:

CMS Analysis of Data on the State of Iowa's Early and Periodic Screening, Diagnostic, and Treatment Program

As part of the State Improvement Package implementing the Medicaid Quality Improvement Program, we are providing an analysis of the most recent submittal of form CMS-416, the EPSDT annual reporting form, for fiscal year 2007 for your State. The following information is noted.

Participation Goal: The State of Iowa's FY 2007 participation ratio is 68%, a decrease of 3% from FY 2006. The national participation goal continues to be 80%.

Dental Services: For FY 2007, the data shows that the State provided some dental service to approximately 43% of eligible EPSDT individuals, an increase of 1% from FY 2006.

Lead Screening: For FY 2007, the data shows the State has provided a lead screening test to just 9% of the eligible EPSDT population under the age of 6 who should have had a screening blood lead test. This is a decrease of 2% from FY 2006. Blood lead screening continues to be a requirement under the federal Medicaid program for all children ages 1 and 2 as well as a blood test for any child under the age of 6 for whom no record of a test is available.

CMS Analyses and Initiatives:

CMS Analysis of Immunization Status of Iowa Medicaid Children ages 19 – 35 months

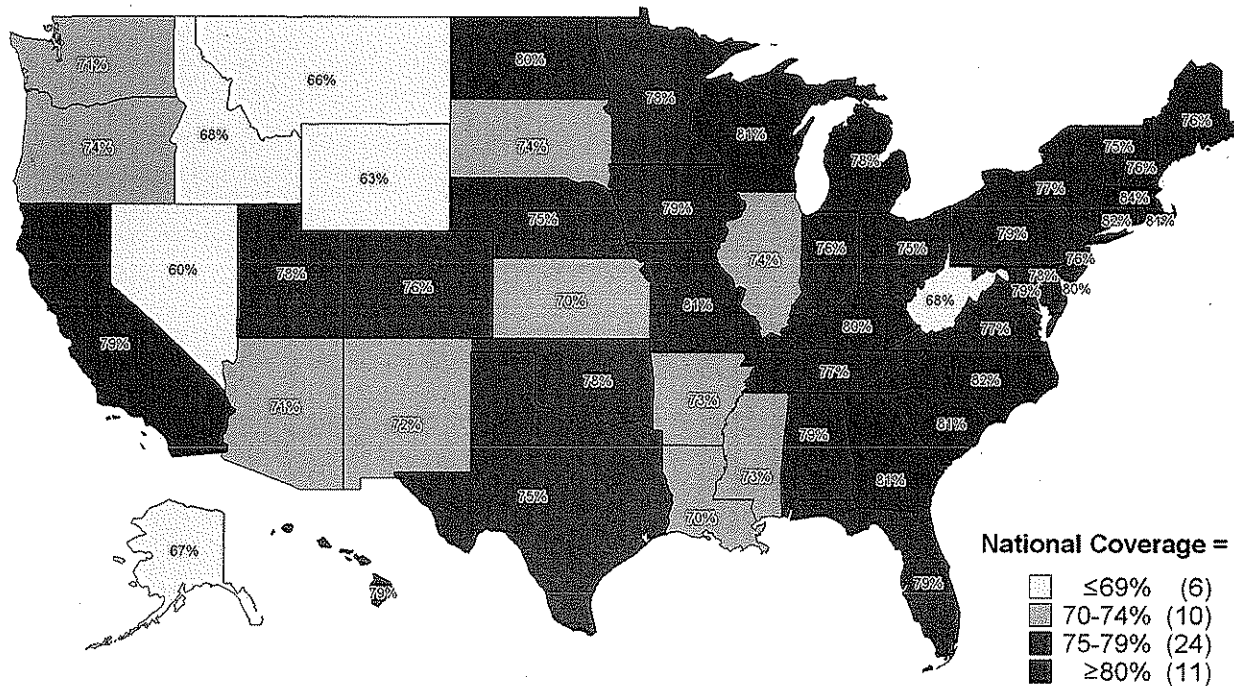
According to Healthy People 2010, the nation's objective for immunization status of children is to increase and maintain the vaccination coverage levels among children age 19 to 35 months. The goal is 90% fully immunized for the nation or any one state. To achieve herd immunity, a population must reach a goal of at least 80% of a population to be fully immunized to prevent outbreak of a vaccine preventable disease.

One way to measure the effort of a population is through the National Immunization Survey (NIS). The NIS is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The NIS is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers that began data collection in April 1994 to monitor childhood immunization coverage.

The target population for the NIS is children between the ages of 19 and 35 months living in the United States at the time of the interview. Data from the NIS are used to produce timely estimates of vaccination coverage rates for all childhood vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP). Estimates are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. The official estimates of vaccination coverage rates from the NIS are rates of being up-to-date with respect to the ACIP recommended numbers of doses of vaccines. Vaccinations included in the survey are: 4 diphtheria and tetanus toxoids, and acellular pertussis vaccine (DTaP); 3 poliovirus vaccine (polio); 1 measles-containing vaccine (MCV); 3 Haemophilus influenzae type b vaccine (Hib); 3 hepatitis B vaccine (Hep B); 1 varicella zoster vaccine for the series plus pneumococcal conjugate vaccine (PCV), 3 hepatitis A vaccine (Hep A), and influenza vaccine (FLU) included in the single vaccination rates reported. The series is referred to as 4:3:1:3:3:1. This is the measure most States use to report their HEDIS measures.

Iowa's overall rate for 2006 is 78.9% with a national average of 77.5%. The number of Medicaid children was not specifically measured but the number of children in the Vaccines for Children Program (VFC) in Iowa with full immunizations was 77.0% with a national VFC coverage rate of 79.8%. The majority of VFC participants are Medicaid children and is the primary source of Medicaid immunizations. More information may be obtained at <http://cdc.gov/nis/>.

4:3:1:3:3:1* Series Coverage: Children 19-35 Months, 2006



National Coverage = 77%

- ≤69% (6)
- ▒ 70-74% (10)
- 75-79% (24)
- ≥80% (11)

Note 1: *4+DTP, 3+Polio, 1+MMR, 3+HIB, 3+HepB, 1+Varicella
 Note 2: Includes children born between 01/06/2003 and 07/18/2005
 Source: National Immunization Survey (NIS)
 Revised April 2008



CMS Analyses and Initiatives:

CMS Childhood Obesity Initiatives

Background Information

- One of the national health objectives for 2010 is to reduce the prevalence of overweight or obesity (BMI equal to or > than 95th percentile) among children aged 6-19 years from the NHANES III baseline of 11 percent.
- Currently the percentage of young people who are overweight/obese has more than tripled since 1980 and estimated to be over 9 million young people (CDC and AAP)
- Obesity Trends
 - In 1991 four states had obesity prevalence rates of 15-19 percent and no states had rates at or above 20 percent (BMI > 30 or ~ 30 lbs overweight for a 5'4" person)
 - In 1995, obesity prevalence in each of the 50 states was less than 20 percent.
 - In 2000, 28 states had obesity prevalence rates less than 20 percent
 - In 2005 only 4 states had obesity prevalence rates less than 20 percent; 17 states had rates equal to or > 25 %; 3 of those equal to or > 30%
- Obesity Data
 - Recent data indicates prevalence of overweight children 6-11 years has quadrupled, from 4 percent to 16 percent.
 - The prevalence among adolescents aged 12 -19 years increased more than three-fold from approximately 5 percent to 16 percent.
 - Among boys, prevalence was significantly higher among Mexican Americans (25.5%) than non-Hispanic blacks (17.9%) or non-Hispanic whites (14.3%)
 - Among girls, the prevalence was significantly lower among non-Hispanic whites (12.9%) than non-Hispanic blacks (23.2%) or Mexican Americans (18.5%)
- Cost to the Nation
 - Children covered by Medicaid are nearly six times more likely to be treated for a diagnosis of obesity than children covered by private insurance.
 - Annual healthcare costs are about \$6,700 for children treated for obesity covered by Medicaid and \$3,700 billion for obese children with private insurance.
 - Children with obesity are roughly three times more expensive for the health system than the average insured child.

- Total healthcare spending for children who receive a diagnosis of obesity is approximately \$280 million per year for those with private insurance and \$470 million for those with Medicaid.
 - Children diagnosed with obesity are two to three times more likely to be hospitalized.
 - Children who receive Medicaid are less likely to visit the doctor and more likely to enter the hospital than comparable children with private insurance.
 - Obesity-associated annual hospital costs for children and youth more than tripled over 2 decades: from \$35 million in 1979-1981 to \$127 million in 1997-1999 (IOM)
- Medicaid Coverage and Reimbursement - Obesity related services can include:
 - Inpatient and outpatient hospital services, physician services (including medical visits and surgery) and clinic services.
 - Other licensed practitioners: States may elect to provide this optional benefit to include any medical and remedial care, other than a physician, such as licensed nutritionists, practicing within their scope of practice.
 - Obesity related services may also be covered as preventive services for individuals not eligible for EPSDT services. Such services must be provided by a physician or other licensed practitioner and provided when necessary to prevent disease, disability and other health conditions or their progression; prolong life; or promote physical and mental health and efficiency.
 - States are required to determine medical necessity for obesity related services.
 - States set their own reimbursement rates for services. Rates must be sufficient to enlist enough providers of services at least to the extent the services are available to the general population

Data Specific to the State of Iowa

The State ranks sixth best among all States in percentage of children ages 10-17 who are considered overweight or obese according to Body Mass Index-for-age standards. The State's overall prevalence of childhood obesity is about five percentage points lower than the national average. The percentage of overweight or obese children is comparable to national averages for children in low-income families and those covered by public insurance.

**Iowa's Childhood Obesity Action Network report card is available at
<http://childhealthdata.org/content/ObesityReportCards.aspx>**

Analyses and Initiatives Developed by Other Organizations:

Snapshot of Child Health Needs and System Performance:

Findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health - Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) Data Resource Center for Child and Adolescent Health (June 15, 2006)



Data Resource Center for Child & Adolescent Health
Your Data... Your story

Snapshot of Child Health Needs and System Performance:
Findings from the National Survey of Children with Special Health Care Needs
and the National Survey of Children's Health
June 15, 2006

Prepared by:
Child and Adolescent Health Care Initiative (CAHMI)
Data Resource Center for Child and Adolescent Health



Introduction

This report presents state-specific summaries of findings from two national surveys of children's health, highlighting 20 **Child Health Needs and Outcomes** measures and 25 measures of **Health System Performance and Improvement Opportunities**. These indicators were selected based on their relevance to Medicaid quality of care strategies and requirements for children and adolescents and are also relevant to several Healthy People 2010 objectives, including improving access to comprehensive, high-quality health care services and ensuring children with special health care needs (CSHCN) have a "Medical Home", as defined by the American Academy of Pediatrics.

Additional state specific data on the indicators represented are available on the online Data Resource Center for Child and Adolescent Health (DRC) at www.childhealthdata.org. This website delivers point-and-click, hands-on access to national, state, and regional data from the NSCH and the NS-CSHCN and downloadable, "print-and-go" data tables and graphs as well as easy-to-understand information about survey content and methods. The DRC features an easy-to-use interactive search feature that allows users to select, view, compare, and download results for every state and HRSA region and iteratively compare states and subgroups of children within and across each state (e.g. child's age, race, household income, insurance status and type, health status, family structure, etc.). The Data Resource Center is a project of the Child and Adolescent Health Measurement Initiative (CAHMI) in partnership with state and family leaders and is sponsored by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health & Human Services.

Data Sources

Data represented in the state data reports are from the most recent National Survey of Children with Special Health Care Needs (NS-CSHCN, 2001) and National Survey of Children's Health (NSCH, 2003). Both surveys were sponsored by the Maternal and Child Health Bureau and administered by the National Center for Health Statistics. The survey data was collected by means of computer assisted telephone interviews (CATI) with parents from randomly selected households throughout the nation.

The NSCH collected data on 102,353 children between the ages of 0-17 years, approximately 2000 per state (ranging from 1,483 – 2,241). The survey covers a wide range of topics, including children's physical and mental health and risk status, health insurance status and type of coverage, access to and use of health care services, medical home, additional age-specific information (0-5 years and 6-17 years), family health and activities, parents' health status, and more. This survey will be repeated in 2007.

The NS-CSHCN screened 372,174 children nationally to identify those with special health care needs (using the CAHMI CSHCN Screener) who received a more in-depth interview. In each state, 750 CSHCN were selected for the longer, more detailed CSHCN interview, resulting in a total of 38,866 CSHCN interviews. Survey topics include health and functional status of the child, type and adequacy of the child's health insurance coverage, access to health care, care coordination, family-centeredness of child's health care, and impact of child's health on family. This survey was repeated in 2005-2006 and will be available in late 2007.

The data in both surveys is based on parent report for a selected child within the household. The data is weighted to adjust for sampling error and was analyzed to adjust variance estimates for complex sampling methods. Data was also post-stratified to represent all children and youth age 0-17 nationally and in each state. Unknown values (“don’t know”, “refused”) were treated as missing. Table 1 below provides summary statistics of the characteristics of children upon which regional and national findings are based. Similar statistics for individual states may be obtained on the DRC website.

Indicators

State results tables for each survey list indicators in two groups: (1) **Child Health Needs and Outcomes**, and (2) **System Performance and Improvement Opportunities**. The indicators reported here were developed for use in the DRC using a multi-step process involving extensive technical, statistical, policy, and family input. Many are also included in national child health chartbooks produced and disseminated by the federal Health Resources and Services Administration’s Maternal and Child Health Bureau as well as by some states. Details about the surveys and documentation of the indicators may be accessed on the DRC website, www.childhealthdata.org.

Indicator results for each state are displayed in two one-page tables for each state in the CMS region. One table presents findings based on indicators from the NS-CSHCN and one for the NSCH. The NSCH table shows results for all non-institutionalized children ages 0-17 years.

* Results in the NS-CSHCN table apply ONLY to children with special health care needs (CSHCN). The title for each indicator describes the population that was queried (the denominator) and the relevant responses (the numerator). Specifically, some of the indicators apply only to certain age groups.

For each indicator, separate prevalence estimates are given for children whose parent or guardian reported that they had public insurance and for those reporting that the child had private sector insurance coverage. Within the two insurance groups, results are shown for the state, HRSA region and nation. For each indicator, population prevalence estimates are shown. In smaller type, the 95% confidence interval (CI) for that estimate is also displayed. This is the range within which the actual prevalence can be assumed to fall after taking into account possible sampling error. Results for children who were uninsured are not shown. For the NS-CSHCN data, children who had a combination of public and private insurance are also not shown in these reports. Tables that include these groups may be obtained from the DRC website.

Presentation of the indicators and results reflect their format in the DRC website, and the Indicator and Outcome numbers are the same as shown on the DRC website. Because desirable results may be reflected by either high or low prevalence rates, it is important to read the text of the indicator carefully. Most often higher rates reflect “better” health or performance. However, for several indicators higher rates represent higher levels of need or “lower” performance.

Resources and References

1. American Academy Of Pediatrics, "The Medical Home: Medical Home Initiatives for Children With Special Needs Project Advisory Committee," *Pediatrics* Vol. 110 No. 1 July 2002, pp. 184-186
2. Blumberg SJ, Olson L, Frankel M, et al. 2003. "Design and operation of the National Survey of Children with Special Health Care Needs 2001," *Vital Health Statistics* 1(41).
3. Blumberg SJ, Olson L, Frankel M, et al. 2005. "Design and operation of the National Survey of Children's Health 2003." *Vital Health Statistics* 1(43).
4. Blumberg SJ, Osborn L, Luke JV, et al. Estimating the prevalence of uninsured children: An evaluation of data from the National Survey of Children with Special Health Care Needs, 2001. National Center for Health Statistics. *Vital Health Stat* 2(136). 2004.
5. Child and Adolescent Health Measurement Initiative (CAHMI). Data Resource Center on Child and Adolescent Health, www.childhealthdata.org.
6. Child and Adolescent Health Measurement Initiative (2005). *National Survey of Children's Health*, Data Resource Center on Child and Adolescent Health website, www.nschdata.org.
7. Child and Adolescent Health Measurement Initiative (2005). *National Survey of Children' with Special Health Care Needs*, Data Resource Center on Child and Adolescent Health website, www.cshcndata.org.
8. Federal Register. June 14, 2002. Centers for Medicare and Medicaid Services. Medicaid program, Medicaid managed care; Final rules, Vol. 67, No. 115, p. 40988-41116.
9. U.S. Department of Health and Human Services (HHS) 2000. *Healthy People 2010*, 2nd edition, with "Understanding and improving health" and "Objectives for improving health," 2 vols. Washington, DC: Government Printing Office.

National Survey of Children's Health

AV w Data Resource Center — ybur Data... Your story

Child Health Indicators by Insurance Type

| | Public Insurance | | | Private Insurance | | |
|--|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|
| | Iowa | HRSA Region VII | National | Iowa | HRSA Region VII | National |
| | | | | | | |
| Health Needs and Outcomes | | | | | | |
| Indicator 1.1: % ages 0-17 whose overall health is excellent or very good | 84.3% 79.7% - 88.9% | 78.7% 76.0% - 81.4% | 73.3% 72.3% - 74.4% | 90.1% 88.3% - 91.9% | 91.4% 90.5% - 92.3% | 90.7% 90.3% - 91.1% |
| Indicator 1.2: % ages 1-17 whose teeth are in excellent or very good condition | 62.5% 55.7% - 69.3% | 63.0% 59.6% - 66.3% | 56.4% 55.2% - 57.6% | 76.8% 74.3% - 79.4% | 77.7% 76.4% - 79.1% | 76.3% 75.7% - 76.9% |
| Indicator 1.3: % ages 0-5 who were breastfed for any length of time | 48.6% 38.3% - 58.8% | 55.7% 50.3% - 61.2% | 63.3% 61.7% - 65.0% | 70.3% 65.3% - 75.2% | 75.3% 72.8% - 77.8% | 77.3% 76.3% - 78.2% |
| Indicator 1.4: % ages 10-17 who are within normal weight range for their age and height | 56.0% 44.9% - 67.2% | 54.1% 48.9% - 59.4% | 55.9% 54.1% - 57.8% | 72.1% 68.6% - 75.7% | 70.3% 68.3% - 72.3% | 68.2% 67.3% - 69.1% |
| Indicator 1.5: % ages 6-17 who exercised 4 or more days in the last week | 59.1% 50.2% - 68.0% | 58.7% 54.5% - 62.9% | 57.6% 56.1% - 59.1% | 61.4% 58.1% - 64.7% | 62.6% 60.8% - 64.4% | 60.1% 59.3% - 60.8% |
| Indicator 1.6: % school age children who missed 11 or more days of school in the past year due to illness or injury | 6.4% 2.7% - 10.0% | 7.9% 5.6% - 10.2% | 8.1% 7.3% - 8.8% | 4.6% 3.0% - 6.1% | 3.9% 3.2% - 4.7% | 4.2% 3.9% - 4.5% |
| Indicator 1.7: % ages 0-5 with injuries requiring medical attention during past year | 8.4% 3.8% - 13.4% | 9.6% 6.4% - 12.7% | 9.1% 8.6% - 10.1% | 13.0% 9.2% - 16.8% | 10.4% 8.6% - 12.1% | 10.0% 9.3% - 10.6% |
| Indicator 1.10: % ages 0-17 affected by asthma during past year | 6.2% 3.2% - 9.3% | 11.2% 9.1% - 13.3% | 10.8% 10.0% - 11.5% | 6.1% 4.8% - 7.5% | 7.0% 6.2% - 7.8% | 7.3% 7.0% - 7.7% |
| Indicator 2.1: % ages 0-5 whose parents have one or more concerns about child's learning, development, or behavior | 49.3% 39.0% - 59.6% | 42.4% 37.1% - 47.7% | 42.2% 40.4% - 44.0% | 32.5% 27.6% - 37.5% | 30.4% 27.8% - 33.1% | 33.2% 32.1% - 34.3% |
| Indicator 2.2: % ages 1-5 who are at moderate/high risk for developmental delay | 37.2% 25.8% - 48.6% | 28.5% 23.0% - 34.0% | 30.1% 28.2% - 31.9% | 21.7% 16.9% - 26.6% | 20.7% 18.2% - 23.3% | 21.6% 20.6% - 22.6% |
| Indicator 2.3: % ages 3-17 with moderate or severe difficulties in the area of emotions, concentration, behavior, or getting along with others | 15.6% 9.7% - 21.6% | 17.6% 14.9% - 20.4% | 14.9% 14.0% - 15.8% | 5.4% 3.9% - 6.8% | 6.0% 5.2% - 6.8% | 7.0% 6.6% - 7.3% |
| Indicator 2.7: % ages 2-17, ever told have ADD/ADHD, currently taking medication for ADD/ADHD | 11.4% 6.6% - 16.8% | 7.9% 6.1% - 9.7% | 5.2% 4.7% - 5.7% | 3.8% 2.7% - 5.0% | 3.4% 2.8% - 3.9% | 3.6% 3.4% - 3.9% |
| Indicator 6.3: % ages 0-17 whose mother's overall physical and mental health is excellent or very good | 45.9% 39.0% - 52.8% | 44.2% 40.7% - 47.6% | 42.1% 40.9% - 43.3% | 70.7% 68.0% - 73.4% | 70.1% 68.6% - 71.6% | 68.3% 67.7% - 68.9% |

Indicato

| | Public Insurance | | | Private Insurance | | |
|--|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|
| | Iowa | HRSA Region VII | National | Iowa | HRSA Region VII | National |
| | | | | | | |
| Performance and Improvement Opportunities | | | | | | |
| Indicator 3.2: % ages 0-17 currently uninsured or not insured for some period during the past year | 12.8% 8.6% - 17.0% | 11.2% 9.1% - 13.3% | 12.9% 12.2% - 13.7% | 3.6% 2.5% - 4.7% | 3.5% 2.9% - 4.1% | 4.0% 3.8% - 4.3% |
| Indicator 4.1: % ages 0-17 with a preventive medical care visit in the past year | 79.4% 74.1% - 84.8% | 81.4% 78.9% - 83.9% | 79.8% 78.8% - 80.7% | 77.4% 75.0% - 79.8% | 77.3% 76.0% - 78.6% | 79.8% 79.3% - 80.3% |
| Indicator 4.3: % ages 0-17 with both a preventive medical care visit and a preventive dental care visit in the past year | 59.5% 52.7% - 66.2% | 53.6% 50.3% - 56.9% | 55.8% 54.6% - 57.0% | 63.7% 61.0% - 66.5% | 62.2% 60.6% - 63.7% | 63.4% 62.8% - 64.1% |
| Indicator 4.5: % ages 1-17 with current emotional, developmental, or behavioral problems who received some type of mental health care during the past year | 82.0% 69.9% - 94.1% | 69.5% 61.3% - 77.8% | 58.6% 54.9% - 62.3% | 55.9% 41.2% - 70.6% | 61.5% 53.7% - 69.3% | 63.2% 60.4% - 66.0% |
| Indicator 4.8: % ages 0-17 whose medical care meets all six Medical Home criteria | 49.8% 43.1% - 56.3% | 43.6% 40.4% - 46.9% | 38.9% 37.7% - 40.0% | 53.5% 50.7% - 56.4% | 53.0% 51.5% - 54.6% | 52.6% 52.0% - 53.3% |
| Indicator 4.9: % ages 0-17 who have a personal doctor or nurse (PDN) | 88.1% 84.2% - 92.0% | 82.7% 80.1% - 85.3% | 78.0% 77.0% - 79.0% | 90.8% 89.1% - 92.5% | 90.9% 90.0% - 91.8% | 89.5% 89.1% - 89.9% |
| Indicator 4.10: % ages 0-17 who have a personal doctor or nurse who usually or always spends enough time and explains things well | 66.0% 59.7% - 72.4% | 61.0% 57.8% - 64.3% | 54.6% 53.5% - 55.8% | 78.1% 75.8% - 80.5% | 77.7% 76.4% - 79.0% | 74.7% 74.1% - 75.3% |
| Indicator 4.12: % ages 0-17 who have a PDN and needed specialized care or services and had few or no problems getting them | 87.5% 78.7% - 96.3% | 82.9% 78.1% - 87.7% | 78.3% 76.3% - 80.3% | 90.9% 87.3% - 94.5% | 90.6% 88.8% - 92.3% | 87.4% 86.6% - 88.3% |
| Indicator 4.13: % ages 0-17 who have a PDN and got specialized care or services, whose PDN usually or always follows up with them | 74.4% 64.4% - 84.4% | 62.9% 56.8% - 69.0% | 62.6% 60.4% - 64.9% | 61.8% 56.1% - 67.5% | 55.6% 52.6% - 58.7% | 55.8% 54.6% - 57.0% |
| Indicator 4.14: % ages 0-5 who had a doctor visit during which the doctor asked if parents have concerns about the child's learning, development or behavior | 36.2% 26.5% - 46.0% | 34.7% 29.6% - 39.9% | 32.4% 30.7% - 34.0% | 45.2% 39.9% - 50.5% | 45.6% 42.7% - 48.4% | 42.4% 41.2% - 43.3% |
| Indicator 6.4: % ages 0-17 who live in households where someone smokes | 51.5% 44.2% - 58.8% | 48.9% 45.3% - 52.5% | 38.4% 37.2% - 39.6% | 28.9% 26.1% - 31.7% | 27.7% 26.2% - 29.2% | 25.1% 24.5% - 25.7% |
| Indicator 6.7: % ages 0-5 who were read aloud to by family members every day during the past week | 51.2% 40.9% - 61.4% | 44.2% 38.9% - 49.5% | 41.4% 39.6% - 43.1% | 54.2% 48.9% - 59.4% | 52.4% 49.6% - 55.3% | 52.7% 51.5% - 53.8% |



National Survey of Children with Special Health Care Needs
Data Resource Center — Your Data... Your story

Child Health Indicators by Insurance Type

| | Public Insurance HRSA Region VII | | Iowa | | National | | Private Insurance HRSA Region VI | | National | |
|--|-------------------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|-------------------------------------|------------------------|------------------------|------------------------|
| | Iowa | HRSA Region VII | Iowa | HRSA Region VII | Iowa | HRSA Region VII | Iowa | HRSA Region VI | Iowa | HRSA Region VI |
| Health Needs and Outcomes | | | | | | | | | | |
| Indicator #1: % of CYSHCN ages 0-17 whose health conditions consistently and often greatly affect their daily activities | 20.9% 13.5% - 28.4% | 35.2% 30.0% - 40.3% | 11.8% 8.5% - 15.0% | 35.6% 33.5% - 37.7% | 11.8% 8.5% - 15.0% | 35.6% 33.5% - 37.7% | 13.7% 12.1% - 15.4% | 16.6% 15.7% - 17.5% | 13.7% 12.1% - 15.4% | 16.6% 15.7% - 17.5% |
| Prescription Medications: % of CYSHCN ages 0-17 who met screening criteria for prescription medication use for an ongoing condition | 74.7% 66.6% - 82.8% | 72.2% 67.7% - 76.7% | 82.4% 78.3% - 86.5% | 69.5% 67.4% - 71.5% | 82.4% 78.3% - 86.5% | 69.5% 67.4% - 71.5% | 82.1% 80.2% - 84.1% | 78.8% 77.8% - 79.8% | 82.1% 80.2% - 84.1% | 78.8% 77.8% - 79.8% |
| Service Use: % of CYSHCN ages 0-17 who met screening criteria for elevated use of medical or related services for an ongoing condition | 54.3% 44.3% - 64.2% | 54.5% 49.6% - 59.4% | 37.6% 32.6% - 42.6% | 54.7% 52.6% - 56.9% | 37.6% 32.6% - 42.6% | 54.7% 52.6% - 56.9% | 40.5% 38.2% - 42.9% | 41.0% 39.9% - 42.1% | 40.5% 38.2% - 42.9% | 41.0% 39.9% - 42.1% |
| Specialized Therapies: % of CYSHCN ages 0-17 who met screening criteria for specialized therapies for an ongoing condition | 11.9% 6.2% - 17.7% | 19.6% 15.9% - 23.3% | 7.4% 4.8% - 10.0% | 23.3% 21.5% - 25.0% | 7.4% 4.8% - 10.0% | 23.3% 21.5% - 25.0% | 10.7% 9.2% - 12.2% | 13.0% 12.2% - 13.7% | 10.7% 9.2% - 12.2% | 13.0% 12.2% - 13.7% |
| Mental Health: % of CYSHCN ages 0-17 who met screening criteria for ongoing emotional, developmental or behavioral conditions | 40.8% 30.9% - 50.7% | 41.4% 36.5% - 46.3% | 22.5% 17.9% - 27.2% | 40.4% 38.2% - 42.5% | 22.5% 17.9% - 27.2% | 40.4% 38.2% - 42.5% | 20.0% 18.0% - 21.9% | 22.4% 21.4% - 23.4% | 20.0% 18.0% - 21.9% | 22.4% 21.4% - 23.4% |
| Functional Limitations: % of CYSHCN ages 0-17 who met screening criteria for functional limitations due to ongoing condition | 23.9% 15.6% - 32.1% | 28.4% 23.7% - 33.1% | 12.5% 9.3% - 15.6% | 27.9% 26.2% - 29.7% | 12.5% 9.3% - 15.6% | 27.9% 26.2% - 29.7% | 14.2% 12.6% - 15.9% | 17.0% 16.1% - 17.8% | 14.2% 12.6% - 15.9% | 17.0% 16.1% - 17.8% |
| Indicator #2: % of CYSHCN ages 5-17 with 11 or more days of school absences due to illness | 23.5% 13.4% - 33.6% | 22.9% 18.1% - 27.7% | 8.3% 5.4% - 11.2% | 23.3% 21.2% - 25.5% | 8.3% 5.4% - 11.2% | 23.3% 21.2% - 25.5% | 9.3% 7.9% - 10.8% | 12.4% 11.6% - 13.3% | 9.3% 7.9% - 10.8% | 12.4% 11.6% - 13.3% |
| Performance and Improvement Opportunities | | | | | | | | | | |
| Indicator #5: % of currently insured CYSHCN ages 0-17 with health insurance coverage that is not adequate | 29.7% 20.0% - 39.8% | 31.3% 26.2% - 36.4% | 25.3% 20.9% - 29.8% | 37.6% 35.5% - 39.8% | 25.3% 20.9% - 29.8% | 37.6% 35.5% - 39.8% | 29.2% 27.1% - 31.4% | 31.7% 30.7% - 32.8% | 29.2% 27.1% - 31.4% | 31.7% 30.7% - 32.8% |
| Indicator #6: % of CYSHCN ages 0-17 with one or more unmet needs for specific health care services | 15.3% 7.4% - 23.2% | 24.3% 19.4% - 29.3% | 7.7% 5.1% - 10.3% | 25.2% 23.2% - 27.2% | 7.7% 5.1% - 10.3% | 25.2% 23.2% - 27.2% | 10.0% 8.6% - 11.5% | 12.2% 11.4% - 13.1% | 10.0% 8.6% - 11.5% | 12.2% 11.4% - 13.1% |
| Indicator #7b: % of CYSHCN ages 0-17 whose families were not able to get all the family support services they needed | 18.2% 4.2% - 32.1% | 29.3% 19.3% - 39.2% | 11.1% 3.3% - 18.8% | 23.3% 20.1% - 26.5% | 11.1% 3.3% - 18.8% | 23.3% 20.1% - 26.5% | 20.7% 15.2% - 26.2% | 18.7% 16.5% - 20.9% | 20.7% 15.2% - 26.2% | 18.7% 16.5% - 20.9% |
| Indicator #8: % of CYSHCN ages 0-17 who had problems getting referrals for specialty care | 13.2% 3.7% - 22.7% | 19.1% 13.6% - 24.5% | 10.4% 5.3% - 15.6% | 28.3% 25.5% - 31.1% | 10.4% 5.3% - 15.6% | 28.3% 25.5% - 31.1% | 14.4% 12.0% - 16.7% | 18.9% 17.6% - 20.1% | 14.4% 12.0% - 16.7% | 18.9% 17.6% - 20.1% |
| Indicator #9: % of CYSHCN ages 0-17 without a usual source of care or who rely on the emergency room | 14.5% 7.1% - 22.0% | 10.5% 7.9% - 13.1% | 12.3% 8.8% - 16.0% | 10.4% 9.1% - 11.7% | 12.3% 8.8% - 16.0% | 10.4% 9.1% - 11.7% | 8.2% 6.9% - 9.5% | 7.9% 7.3% - 8.4% | 8.2% 6.9% - 9.5% | 7.9% 7.3% - 8.4% |
| Indicator #10: % of CYSHCN ages 0-17 without a personal doctor or nurse | 10.4% 5.6% - 15.8% | 10.4% 7.4% - 13.3% | 6.4% 3.9% - 8.8% | 14.7% 13.0% - 16.4% | 6.4% 3.9% - 8.8% | 14.7% 13.0% - 16.4% | 5.6% 4.5% - 6.6% | 8.6% 7.9% - 9.3% | 5.6% 4.5% - 6.6% | 8.6% 7.9% - 9.3% |
| Indicator #11: % of CYSHCN ages 0-17 who had one or more doctor visits but did not have family-centered care | 36.8% 26.7% - 46.9% | 40.0% 35.0% - 45.0% | 25.1% 20.3% - 29.9% | 42.6% 40.4% - 44.8% | 25.1% 20.3% - 29.9% | 42.6% 40.4% - 44.8% | 26.1% 23.8% - 28.3% | 27.6% 26.5% - 28.6% | 26.1% 23.8% - 28.3% | 27.6% 26.5% - 28.6% |
| Indicator #13: % of CYSHCN ages 0-17 whose families experienced financial problems due to child's health needs | 14.4% 8.0% - 20.9% | 24.7% 19.9% - 29.5% | 17.9% 13.7% - 22.0% | 24.4% 22.5% - 26.4% | 17.9% 13.7% - 22.0% | 24.4% 22.5% - 26.4% | 17.2% 15.3% - 19.1% | 16.6% 15.8% - 17.5% | 17.2% 15.3% - 19.1% | 16.6% 15.8% - 17.5% |
| Indicator #15: % of CYSHCN ages 0-17 whose family members cut back and/or stopped working because of child's health needs | 35.1% 25.2% - 45.0% | 40.2% 35.2% - 45.2% | 19.8% 12.6% - 20.4% | 41.4% 39.3% - 43.6% | 19.8% 12.6% - 20.4% | 41.4% 39.3% - 43.6% | 19.8% 17.8% - 21.7% | 23.3% 22.3% - 24.3% | 19.8% 17.8% - 21.7% | 23.3% 22.3% - 24.3% |
| MCHB #1: % of CYSHCN ages 0-17 whose families are partners in decision-making and are satisfied with the services they receive | 41.2% 26.4% - 56.1% | 48.9% 42.0% - 55.8% | 67.2% 60.7% - 73.8% | 49.4% 45.9% - 53.0% | 67.2% 60.7% - 73.8% | 49.4% 45.9% - 53.0% | 64.5% 61.2% - 67.8% | 62.9% 61.1% - 64.6% | 64.5% 61.2% - 67.8% | 62.9% 61.1% - 64.6% |
| MCHB #2: comprehensive care within a medical home | 48.9% 38.6% - 59.3% | 48.1% 43.2% - 53.1% | 61.4% 56.2% - 66.6% | 43.8% 41.6% - 46.0% | 61.4% 56.2% - 66.6% | 43.8% 41.6% - 46.0% | 62.1% 59.7% - 64.5% | 58.1% 56.9% - 59.3% | 62.1% 59.7% - 64.5% | 58.1% 56.9% - 59.3% |
| MCHB #3: % of CYSHCN ages 0-17 who have adequate insurance to pay for Outcome the services they need | 57.2% 46.6% - 67.7% | 62.1% 57.1% - 67.0% | 72.6% 68.0% - 77.2% | 55.3% 53.1% - 57.5% | 72.6% 68.0% - 77.2% | 55.3% 53.1% - 57.5% | 69.4% 67.2% - 71.7% | 66.4% 65.3% - 67.3% | 69.4% 67.2% - 71.7% | 66.4% 65.3% - 67.3% |

Maternal and Child Health Bureau

State Priority Needs

Title V legislation directs States to conduct a Statewide maternal and child health needs assessment every 5 years to identify the need for preventive and primary care services for pregnant women, mothers, infants, children, and children with special health care needs. From this assessment, States select 7 to 10 priorities for focused programmatic efforts over the succeeding 5 years. States may adjust their priorities during the interim years as needs change.

| State | Priority Need | Keywords | Population/Race |
|-------|---|--|--|
| Iowa | Improve the quality of family support and parenting education programs and services | Health Promotion, Family Support Service, Quality Assurance | Families |
| Iowa | Assure children enrolled in early care and education programs are in quality environments. | Quality Assurance, Child Care | Children (1 through 21), Infants |
| Iowa | Assure developmental evaluations are provided to Medicaid enrolled children 0-3 years. | Primary/Preventive Health Care, Quality Assurance, Health Screening | Children (1 through 21), Infants, Newborns |
| Iowa | Assure access to pediatric specialty care for all children. | Access to Health Care, Specialized Care | Children (1 through 21), Infants, Newborns |
| Iowa | Minimize developmental delay through early intervention services for children 0-3 years. | Access to Health Care, Primary/Preventive Health Care, Mental Health, Health Screening | Children (1 through 21), Infants, Newborns |
| Iowa | All children and adolescents should be physically active for at least 30 minutes, limit screen time to no more than two hours, and eat five or more servings of fruits and vegetables each day. | Nutrition/Physical Activity | Adolescents (10 through 19), Children (1 through 21) |
| Iowa | Improve the quality of primary care for children in Iowa. | Primary/Preventive Health Care, Quality Assurance | Children (1 through 21), Infants, Newborns |
| Iowa | Assure access to oral health care for children in Iowa. | Oral Health, Access to Health Care | Children (1 through 21) |
| Iowa | Reduce infant mortality. | Birth Outcomes, | Infants, |

| | | Morbidity/Mortality | Newborns |
|-------------|--|---|-------------------------|
| Iowa | Assure pregnant and parenting women are screened and referred to appropriate mental health services. | Primary/Preventive Health Care, Mental Health, Health Screening, Specialized Care | Pregnant Women, Mothers |

**Title V Maternal and Child Health Block Grant
Performance Measures – Iowa**

Each State reports on 7 to 10 State Performance Measures that they develop and have approved by the Maternal and Child Health Bureau (MCHB). This procedure allows States to measure progress toward goals that are specific to a State. Each Measure in this table is linked to a detailed description of the Performance measure. The data below were reported by States in their Title V Block Grant FY2006 Annual Report and FY 2008 Application; Form 16.

The information on Performance Measures provided below can also be found at <https://perfddata.hrsa.gov/mchb/mchreports/Search/neg/negsch02p.asp>
All 2006 indicators we reported by States in their Title V Block Grant FY2006 Annual Report and FY 2008 Application; Form 16.

State Performance Measure #1

Percent of children served by family support programs, whose primary delivery method is a home visit, that are served through evidence-based programs. The goal is to increase the percent of Community Empowerment Areas that fund evidenced-based family support and parent education programs. Iowa is currently developing evidenced based criteria for Community Empowerment Areas. The data source is the Family Support Environmental Scan.

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|-----------|------|------|------|------|------|------|
| Indicator | 49.8 | | | | | |
| Objective | 12 | 55 | 60 | 65 | 68 | 70 |

State Performance Measure #2

Measures the number of early care and education providers who receive child care nurse consultant training or services. The goal is to improve the quality of health and safety in early care and education by increasing the number of early care and education providers receiving child care nurse consultant services. Through the Healthy Child Care Iowa Campaign, child care nurse consultants offer training and technical assistance to early learning providers. The data source is Healthy Child Care Iowa Encounter Data Child Care Resource and Referral Data. Early care and education providers are responsible for the well-being of children enrolled in their facility. The health and safety of children enrolled is a prime concern. Early care and education providers need accessible health care professionals as partners to improve the health and safety components of their business. Child care nurse consultants delivering direct services (on-site consultation, face-to-face services and training) to early care and education providers help providers improve the health and safety components.

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|-----------|------|------|------|------|------|------|
| Indicator | 1717 | | | | | |
| Objective | 1224 | 1750 | 1800 | 1850 | 1900 | 1950 |

State Performance Measure #3

Percent of Medicaid enrolled children 0-3 years who receive developmental evaluations. The goal is to assure developmental evaluations are provided to Medicaid enrolled children 0-3 years. A development evaluation is periodic reviews of a child's development as an integrated part of a well-child examination to include a review of developmental milestones, behavior, family risk factors, and parent concerns. This intervention is to identify and increase the proportion of children with mental health problems who receive treatment. The data source is the HCFA 4.16 Report Medicaid claims data: Fee for Service and

Encounter data. The significance of this performance measure is that behavioral, mental health, and social-emotional problems in children have gained increasing attention and priority in the national and state public health systems in the last several years. Recent studies indicate that 12 percent to 16 percent of children experience developmental problems, but that only one-third of those children are identified in pediatric practices prior to school entry. Using state and local collaborative relationships, Iowa's Title V program has the opportunity to foster the development of a seamless and comprehensive system of screening, assessment, and referral services.

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|-----------|------|------|------|------|------|------|
| Indicator | 10 | | | | | |
| Objective | 7 | 10 | 12 | 15 | 20 | 25 |

State Performance Measure #4

Measuring the percent of children who need care from a specialist and who receive the care without problem. The goal is to assure access to pediatric specialty care for all children. The data source is Iowa Child and Family Household Health Survey conducted by the Iowa Department of Public Health, Child Health Specialty Clinics, and University of Iowa Public Policy Center. Data Issues: The data for this performance measure is based on parent report of "need" and "problem" meeting the need. There are no descriptors offered to parent survey respondents to help standardize the concepts of "need" or "problem." That the survey uses a population-based, random sample design strengthens the assumption that the responses are a valid, unbiased representation of family experience. Specialty care is one essential component of a comprehensive system of care for all children. Concepts of systems, medical home, and collaborative partnership manifest prominently in discussions of quality improvement and cost-effectiveness. With estimates ranging as high as 30 percent of all children having a need at some time for specialty care, access to specialists is naturally a relevant concern. Geographical inaccessibility and higher cost of specialty care remain formidable problems.

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|-----------|------|------|------|------|------|------|
| Indicator | 85.1 | | | | | |
| Objective | 87 | 88 | 89 | 90 | 91 | 92 |

State Performance Measure #5

Measures the percent of children 0-3 years served by Early ACCESS (IDEA, Part C). The goal is to minimize developmental delay through early intervention services for children 0-3 years. The qualifying definition is that Early ACCESS serves children 0-3 years with a development delay of 25% or greater or a risk of development delays. The data source is Early ACCESS data - OSEP -- OSEP recommends that EA serve 2% of children 0-3 years of age and 1% of children 0-1. A future indicator will be the success with which premature infants and children with other qualifying health conditions are served by Early ACCESS. EA data cannot currently differentiate the condition for which the child was enrolled, but that may be a possibility in the future. The significance of this measure is for CHSC and the IDPH continue close collaboration with Early ACCESS to improve the early intervention system for children 0-3. Research has shown that for children with or at-risk for developmental delay, the earlier that intervention can be provided, the greater chance for the child's improved outcomes. By providing early intervention services to the child and family at the earliest possible time, potential later costs to society can be reduced.

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|-----------|------|------|------|------|------|------|
| Indicator | 2.7 | | | | | |
| Objective | 2.4 | 2.8 | 2.9 | 3 | 3.1 | 3.2 |

State Performance Measure #6

Measures the number of Iowa counties that have at least one participating targeted community in the CDC nutrition and physical activity obesity prevention project. The goal is to improve physical fitness of children and adolescents by achieving the following: 1. Seventy-five percent of Iowa children and adolescents in targeted communities will be physically active for 30 minutes daily and moderately active for 60 minutes daily by January 2010. 2. Seventy-five percent of Iowa children and adolescents in targeted communities will limit screen time to no more than two hours daily by January 2010. 3. Seventy-five percent of Iowa children and adolescents in targeted counties participating in the Fit for Life target interventions. The data source will be the evaluation component of the CDC nutrition and physical activity obesity prevention grant. This information will be collected in the targeted communities. According to the "2002 CDC Pediatric Nutrition Surveillance System," 30 percent of low-income children aged 2-5 years in Iowa are overweight or at risk of becoming overweight and 61 percent of Iowa adults are overweight or obese. In Iowa, the obesity rate in adults has increased by 70 percent from 1990 to 2002.

Tab D

**CMS Comments on the
Iowa's 2007 Quality Strategy**

CMS Response to Iowa's 2007 Quality Assessment & Improvement Strategy

8/27/08

CMS strives to work in partnership with States to fulfill the aims of safe, effective, timely, equitable, efficient, and person-centered care. The State's Quality Assessment & Improvement Strategy is one method of coordinating efforts to achieve these aims. Feedback provided here is intended for consideration in the next revision of the State's Quality Assessment & Improvement Strategy.

A state's Quality Assessment & Improvement Strategy should have, at a minimum, two basic purposes:

- (1) to ensure compliance with federal and state statutory and regulatory requirements on quality and
- (2) to go beyond compliance with the minimum regulatory requirements by implementing multiple methods for "continuous quality improvement" in order to raise the quality of care provided to, and received by, Medicaid beneficiaries in the state.

Attached to this response are two checklists which the Division of Quality, Evaluation, and Health Outcomes uses in its review of State Quality Strategies. One is entitled the "CMS Review List" (Appendix B) which we use to check your Quality Strategy for compliance with the regulations in 42 CFR 438, Subpart D (the "regulatory checklist") and the other is entitled "Components to Address in a Quality Assessment" (Appendix C) (the "quality checklist"). In general, you will find regulatory issues in the "Code of Federal Regulations" section of this report and the quality issues listed under "Specific Comments on the Quality Strategy". In these sections, we will reference the applicable checklist section for you to review. We do this so that the process of review can be transparent to the States.

One might well ask why the checklists are not combined. They could be, but we chose to separate them because we are doing two separate things in the review. In the first case, we are simply asking whether your Quality Strategy meets the minimal requirements set forth in the regulations. But the second checklist is really intended to ask a larger question, which is the question of whether your State has put into place a real strategy intended to produce continuous quality improvement. Legal minimums must be satisfied, but the real aim of continuous quality improvement is to ensure that you have put in place systems which will support your providers in their efforts to provide quality, cost-efficient care that goes beyond the minimums and incorporates within the system a mechanism which uses continuous feedback and review to help the provider to continue to improve. Quality care does not happen by accident, but rather by careful planning and work on the part of providers, States, and patients. It is this larger effort that will, in the long run, determine the success or failure of your State's Medicaid Quality Strategy.

Consequently, CMS has reviewed Iowa's "Medicaid Managed Care Quality Assurance System," dated 2007, in regard to the following:

- 1) Comprehensiveness of Strategy
- 2) Objectives
- 3) "Terms and Conditions" for compliance requirements
- 4) Code of Federal Regulations
- 5) Specific Comments on the Quality Strategy
- 6) CMSO Quality Initiative

The two separate documents dealing with physical health and behavioral health were both reviewed.

1) Comprehensiveness of Strategy

CMS would like each state to have a single, comprehensive, integrated Quality Strategy, covering managed care for both physical health and behavioral health. A comprehensive plan covering both physical health and mental health would facilitate achievement of the State's goals and objectives in managed care.

Iowa's Quality Strategy is divided into two documents, one dealing with Behavioral Health and Substance Abuse and one dealing with Physical Health. A single, comprehensive Quality Strategy would strengthen the effectiveness of the State's overall Strategy by addressing the interaction between the two systems.

2) Objectives

Iowa lists the following objectives for the State's Behavioral Quality Strategy:

- Inpatient 30-day readmission by children and adults shall be 15% or less.
- The Contractor shall arrange or participate in 450 JTP conferences per contract period with the consumer participating in at least 97% of the JTP conferences.
- The average time between mental health hospitalizations shall not fall below 60 days for children and adults.
- The percent of involuntary admissions for mental health treatment to 24-hour inpatient settings shall not exceed 15% of all children admissions and 10% of all adult admissions.
- At least 6% of mental health service expenditures will be used in the provision of integrated services and supports, including natural supports, consumer run programs, and services delivered in the home of the enrollee.
- 90% of persons discharged from mental health inpatient care will receive other treatment services within 7 days of discharge date.
- 60% of enrollees discharged from ASAM Levels III.5 and III.3 and receiving a follow-up substance abuse service within 14 days of discharge

- 90% of all discharge plans written for enrollees being released from a mental health inpatient hospitalization shall be implemented.
- A discharge plan shall be documented on the day of discharge for 90% of enrollees being discharged from the following mental health settings: inpatient, partial hospitalization, and day treatment. The discharge plan at a minimum includes the following first three items: 1) the next appointment(s) and/or place of care, 2) medications (if applicable), 3) emergency contact numbers, and 4) as applicable; restrictions (if any) on activities and when they can return to work/school including the school setting.
- 95% of enrollees who received services in an emergency room and for whom inpatient care was requested but not authorized shall have a follow-up contact within 3 business days of the date the Contractor is notified of the ER service.
- At least 60% of enrollees discharged from 24-hour substance abuse services including PMIC (excluding Level III.1 – Halfway House) receive a follow-up substance abuse service within 30 days of discharge.
- A discharge plan shall be documented on the day of discharge for 90% of enrollees being discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting. The discharge plan at a minimum includes the following first two items: 1) the next appointment(s) and/or place of care, 2) emergency contact numbers, and 3) as applicable; medications, restrictions (if any) on activities and when they can return to work/school including the school setting.
- The percentage of enrollees under the age of 18 discharged from a mental health inpatient setting to a homeless or emergency shelter shall not exceed 3% of all mental health inpatient discharges of children under the age of 18.
- Medicaid claims shall be paid or denied within the following time periods: 85% within 12 calendar days; 90% within 30 calendar days; 100% within 90 calendar days
- 95% of appeals will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received the appeal, other than in instances which the enrollee has requested, or DHS has approved, an extension. 100% must be resolved within 45 calendar days from the date the Contractor received the appeal, even in the event of an extension.
- In the event of an extension, 95% of the time the Contractor will resolve the appeal within the additional 14 calendar day period, and, in the case of a DHS-approved extension, give the enrollee written notice of the reason for the decision to extend the timeframe.

- 95% of expedited appeals will be resolved as expeditiously as the enrollee's health condition requires and within 3 working days from the date the Contractor received the appeal, other than in instances which the enrollee has requested, or DHS has approved, an extension. 100% must be resolved within 45 calendar days from the date the Contractor received the appeal, even in the event of an extension.
In the event of an extension, 95% of the time the Contractor will resolve the appeal within 14 calendar days from the end of the 3 working day period, and, in the case of a DHS-approved extension, give the enrollee written notice of the reason for the decision to extend the timeframe.
- 95% of grievance will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received all information necessary to resolve the grievance, and 100% must be resolved within 90 calendar days of the receipt of all required documentation.
- Credentialing of all Iowa Plan providers applying for network provider status shall be completed as follows: 60% within 30 days; 100% within 90 days.
- Revisions to the Provider Manual shall be distributed to all network providers at least 30 days prior to the effective date of the revisions.
Mailing dates of provider manual material shall be sent at least 30 calendar days prior to the effective date of material contained in the mailing. This measure applies to all information sent for all network providers.
- New enrollee information, including a list of network providers, will be mailed to each new enrollee in the Iowa Plan within 10 working days after the first time their name was provided to the Contractor. The standard shall be met for 95% of all enrollees, and in no case shall more than 15 working days elapse.

The Physical Health Quality Strategy does not contain comparable quantified objectives.

Feedback: CMS would like each state to convert the objectives of its Quality Strategy to quantified, measurable performance targets (e.g., as target percentage changes in quantitative measures) as part of its continuous quality improvement program. Iowa, should, when it integrates the two Quality Strategies, develop quantified objectives for its Physical Health plan as it has already done for its Behavioral Health Plan.

3) "Terms and Conditions" concerning compliance with regulation

Feedback: Iowa's "Terms and Conditions" have no provisions which would waive or limit application of the Quality Assessment or EQRO provisions of the managed care regulations. Therefore, this review was performed in consideration of all components of these regulations.

4) Code of Federal Regulations

As noted in Appendix A, the State is required to have a Quality Strategy that addresses all mandatory elements outlined in 42 CFR 438.202 and 42 CFR 438.204. Appendix B describes these regulatory requirements for state quality strategies by area.

Feedback: CMS believes that Iowa's Quality Strategy adequately meets all regulatory requirements for state quality strategies in Appendix B. This is true of both the Physical Health and the Behavioral Health documents.

5) Specific Comments on the Quality Strategy

Appendix C of this review includes a tool developed by CMS that provides a listing of topics that CMS would like to see addressed in a state's Quality Strategy.

Feedback: CMS believes that Iowa's Quality Strategy adequately addresses the following topics (Appendix C):

- Overview
- MCO / PIHP Requirements
- Strategy Effectiveness.
- Quality and Appropriateness of Care
- MCO / PIHP Contractual Compliance
- Evolution of Health Information Technology
- Improvement / Intervention

However, CMS believes that Iowa's Quality Strategy does not adequately address the following topics (Appendix C):

- Strategy Objectives
- Conclusions.

Feedback: As stated above, Iowa has quantified objectives only for its Behavioral Health Plan. It needs to develop quantified objectives for its Physical Health Plan as part of a unified Quality Strategy. As to the Conclusions section, CMS would appreciate more information from Iowa in the Quality Strategy on its participation in pay for performance, health information technology, and other value-based purchasing initiatives. Neither the Physical Health nor the Behavioral Health documents contain much information on these topics.

Some other minor issues require revision. The Behavioral Health Document contains many references to "MCOs," but that carve-out is structured as a PIHP. This confusion could be eliminated by using the phrase MCO/PIHP in any new combined Quality Strategy. Also, both documents contain references to a CMS document entitled, "A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States." This document was superseded by the new Managed Care Regulations and references to it in the Quality Strategy should be deleted. One other minor issue is that JCAHO no longer accredits MCOs and consequently the references in the documents to "JCAHO and NCQA" as acceptable accrediting agencies should drop the JCAHO language.

Taken as a whole, the Iowa Quality Strategy is a thoughtful and well-drafted document. The State has clearly set forth its overall quality agenda. The above recommended changes are not of immediate concern and should be considered when the next overall revision is done.

6) CMSO Quality Initiative (Appendix D)

See attachment.

Appendix A

Regulatory Requirements

CFR 438.204 Elements of State Quality Strategies

At a minimum, State strategies must include the following:

- (a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart.
- (b) Procedures that—
 - (1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.
 - (2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.
 - (3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.
- (c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.
- (d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.
- (e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.
- (f) An information system that supports initial and ongoing operation and review of the State's quality strategy.
- (g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

- Continues next page -

Regulatory Requirements: continued

CFR 438.202 State Responsibilities

Each State contracting with an MCO or PIHP must do the following:

- (a) Have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
- (b) Obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.
- (c) Ensure that MCOs, PIHPs, and PAHPs comply with standards established by the State, consistent with this subpart.
- (d) Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically, as needed.
- (e) Submit to CMS the following:
 - (1) A copy of the initial strategy and a copy of the revised strategy, whenever significant changes are made.
 - (2) Regular reports on the implementation and effectiveness of the strategy.

Appendix B

CMS Review List for State Quality Assessment & Improvement Strategies

Each state must submit to CMS:

- a copy of the initial strategy;
- a copy of the revised strategy whenever significant changes are made; and
- regular reports on the implementation and effectiveness of the strategy.

The quality strategy must include:

I. Process for quality strategy development, review, and revision

- A. A description of the process the state will use for the development of the quality strategy.
- B. A description of the formal process the state will use to obtain beneficiary and stakeholder input and public comment before final adoption in final.
- C. A description of how and how often the State will conduct periodic reviews of the effectiveness of the strategy.
- D. The state's definition of "significant changes" to strategy that will trigger shareholder input.
- E. The state's timeframes for updating the quality strategy.

II. Managed care program goals and objectives

A description of the goals and objectives of the state's managed care program, including priorities, strategic partnerships, etc.

III. Medicaid contract provisions

Either:

- 1) the provisions in the State's Medicaid MCO and PIHP contracts that incorporate the established standards for access to care, structure and operations, and quality measurement and improvement, or
- 2) a summary description of the contract provisions in its Medicaid MCO and PIHP contracts that incorporate the established standards for access to care, structure and operations, and quality measurement and improvement. If the State chooses the latter

option, the description must be sufficiently detailed to offer a clear picture of the specific contract provisions.

IV. State standards for access to care

A. A summary description of the state standards for access to care with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in §§438.206-438.210 including—

1. Availability of Services

- a) Maintains and monitors a network of appropriate providers.
- b) Provides female enrollees with direct access to a women's health specialist.
- c) Provides for a second opinion from a qualified health care professional.
- d) Must provide necessary services that are not available in the network.
- e) Requires out of network providers to coordinate with the MCO or PIHP with respect to payment.
- f) Demonstrates that providers are credentialed.
- g) Timely access.
- h) Cultural considerations.

2. Assurances of adequate capacity and services

- a) Offers an appropriate range of preventative, primary care, and specialty services.
- b) Maintains a network of providers that is sufficient in number, mix, and geographic distribution.

3. Coordination and continuity of care

- a) Ensure that each enrollee has an ongoing source of primary care,
- b) Coordinate all services that the enrollee receives,
- c) Share identification and assessment information to prevent duplication of services for individuals with special health care needs.
- d) Protect the enrollees privacy in the process of coordinating care
- e) Additional services for persons with special health care needs, including:
 - i. Identification;
 - ii. Assessment;
 - iii. Treatment plans; and
 - iv. Direct assess to specialists.

4. Coverage and authorization of services

- a) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, and PAHP is required to offer.
- b) Specify what constitutes "medically necessary services".
- c) That the MCO, PIHP, or PAHP have in place and follow written policies and procedures for authorization of services.
- d) That any decision to deny a service be made by an appropriate health care professional.

B. Detailed information related to the access to care standards, including—

Identification of mechanisms the State uses to identify persons with special health care needs to MCOs, PIHPs, and PAHPs.

Identification of standards the State uses to determine the extent to which treatment plans are required to be produced by MCOs, PIHPs, and PAHPs for individuals with special health care needs.

V. State standards for structure and operations

A. A summary description of the state standards for structure and operations with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in §§438.214-438.230 including—

1. Provider selection
 - a) Each State must establish a uniform credentialing and recredentialing policy
2. Enrollee information
3. Confidentiality
4. Enrollment and disenrollment
5. Grievance system
6. Subcontractual relationship and delegation
 - a) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor

B. Detailed information related to the structure and operation standards, including—

1. State procedures for the review of the records of MCO and PIHP grievances and appeals, and for identifying and resolving systemic problems.

VI. State standards for quality measurement and improvement

A. A summary description of the state standards for quality measurement and improvement with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in §§438.236-438.242 including—

1. Practice guidelines
 - a) Based on valid and reliable clinical evidence.
 - b) Consider the needs of MCO's, PIHP's, and PAHP's enrollees.
 - c) Adopted in consultation with contracting health care professionals.
 - d) Reviewed and updated as appropriate.
2. Quality assessment and performance improvement program
 - a) Conduct performance improvement projects.
 - b) Submit performance measurement data.

- c) Have in effect mechanisms to detect both overutilization and underutilization of services.
- d) Have in effect mechanisms to assess quality and appropriateness of care to enrollees.
- e) Measure performance and/or report performance data to the State.
- f) Report the status and results of each project to the State as requested.
- g) State must review at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program.

3. Health Information Systems

- a) Collect data on enrollee and provider characteristics as specified by the State.
- b) Ensure the data received from providers is accurate and complete.
- c) Make all collected data available to the State and upon request to CMS.

B. Detailed information related to the quality measurement and improvement standards, including—

1. A description of the methods and timeframes to assess the quality and appropriateness of care and services to all Medicaid beneficiaries.
2. An identification of the populations the State will consider when determining individuals with special health care needs.
3. The state standards for the identification and assessment of individuals with special health care needs.
4. Procedures the state will use to separately assess the quality and appropriateness of care and services furnished under the State's MCO and PIHP contracts to all Medicaid enrollees and to individuals with special health care needs.
5. A description of the state's information system(s) and how these systems support the initial and ongoing operation and review of the State's quality strategy; for example, a description of how the state intends to use its MMIS and any other system to monitor quality, produce reports on performance indicators, collect data on different quality measures, etc..

VII. State monitoring and evaluation

A description of how the state will regularly monitor and evaluate MCO and PIHP compliance with the State-established standards for access to care, structure and operations, and quality measurement and improvement; this may include for example, a description of the types of reviews the state will perform, how often it will monitor these standards, and how the results of the State's efforts will be reported.

A. Arrangements for external quality reviews

A description of the state's arrangements for an annual, independent external quality review of the timeliness, outcomes, and accessibility of the services covered under each MCO and PIHP contract. This section should include a broad description of the scope of the contract (e.g., calculating HEDIS measures or designing performance improvement projects), including the term of the contract.

B. Nonduplication of mandatory external quality review activity

A description of the standards and activities that will be monitored through the use of Medicare or private accreditation review information and an explanation of the rationale for why the State review would be duplicative of review activity already performed.

VIII. Procedures for race, ethnicity, and primary language

- A. A description of how the state identifies the race, ethnicity, and primary spoken language of each Medicaid MCO and PIHP enrollee and how it will provide this information on each Medicaid enrollee to the MCO and/ or PIHP at the time of enrollment.
- B. A description of the state's efforts to collect information on ethnicity and primary language spoken for any beneficiaries receiving Supplemental Security Income, as this information is not available from the Social Security Administration.
- C. An identification of the State's race, ethnicity, and primary language categories, including a description of how it defines and categorizes "ethnicity".

IX. National performance measures and levels

For MCOs and PIHPs, the performance measures and levels developed by CMS in consultation with States and other relevant stakeholders. (Note: at this time no performance measures and levels have been developed. At the point CMS undertakes their development, the States will be consulted in each phase of the development process, including the specification of the level of information to be included in the State's quality strategy.)

X. Intermediate sanctions

For MCOs only, a description of how the state uses intermediate sanctions in support of its quality strategy. These sanctions must, at a minimum, meet the requirements specified in 42 CFR 438 Subpart I. The State's description should specify its methodology for using sanctions as a vehicle for addressing identified quality of care problems.

Appendix C

Table B of the “State Quality Strategy Toolkit for State Medicaid Agencies, October 2006”

COMPONENTS TO ADDRESS IN A QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

| Quality Strategy Elements and Key Questions | Correlates to Structure Section | Potential Sources Of Information | Additional Information |
|--|---------------------------------|--|--|
| Overview | I.A | <ul style="list-style-type: none"> • BBA • MCO / PIHP contracting and turnover experience • Population description / changes • Driver for implementation of Managed Care | <ul style="list-style-type: none"> • Include history of managed care program • Process to get public input on strategy • How often will strategy be evaluated and revised? |
| Strategy Objectives | I.B | <ul style="list-style-type: none"> • Results from Prior program experience • Results from Performance Measurement / EQRO or other Quality Related Reporting | <ul style="list-style-type: none"> • Include measurable target (e.g. % increase or decrease) • May directly reference an intervention / initiative driving the objective |
| <p>Quality and Appropriateness of Care</p> <p>How are the race, ethnicity, and primary language spoken of each enrollee identified and transmitted to MCOs?</p> <p>How is EQRO Technical Report used to evaluate quality and appropriateness of care?</p> <p>Does the State require specific performance measures or performance improvement projects based on Strategy Objectives, and if so – what are the performance standards?</p> | II.A | <ul style="list-style-type: none"> • MMIS data • EQR Technical Report and recommendations • MCO required data reporting • Report Card efforts • Pay for Performance • Value Based Purchasing | <ul style="list-style-type: none"> • Include state standards for quality measurement and improvement • Include any standards that will be reviewed using private or Medicare accrediting information |

| | | | |
|---|--|--|--|
| Are any clinical guidelines provided to managed care plans? | | | |
|---|--|--|--|

| Quality Strategy Elements and Key Questions | Correlates to Structure Section | Potential Sources Of Information | Additional Information |
|--|--|---|--|
| <p>MCO / PIHP Requirements</p> <p>What requirements has the State established for its MCOs / PIHPs / HIOs in the following domains:</p> <ul style="list-style-type: none"> • Access to Care • Structure and Operations • Quality measurement and improvement | II.B. | <ul style="list-style-type: none"> • Performance incentive program • Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQR activities • Special studies • Contract compliance review • Provider network reporting | <ul style="list-style-type: none"> • Include availability of services, coordination and continuity of care and any utilization review requirements managed care plans must meet • Include required enrollee information; disenrollment; grievance / appeals, and confidentiality requirements that managed care plans must meet • Include encounter data requirements • Include specific performance measures and / or performance improvement projects • Include practice guidelines if required |
| <p>MCO / PIHP Contractual Compliance</p> <p>What contract provisions hold the MCO / PIHP / HIO accountable for meeting the standards outlined in preceding sections?</p> <p>What monitoring mechanisms does the State have in place to provide oversight to MCO / PIHP / HIO?</p> | II.B | <ul style="list-style-type: none"> • MCO / PIHP Contract • State-specific Statutes if applicable • MCO / PIHP Performance incentive program • Provider incentive program • NCQA information • Complaint, grievance and appeals reporting • EQR studies • Special studies • CFR Part 438 – Subpart D | <ul style="list-style-type: none"> • Include incentives and disincentives (sanctions) offered to MCOs as tool for quality • Include data reporting / analysis activities |
| Evolution of Health Information Technology | II.C | <ul style="list-style-type: none"> • MMIS Review | <ul style="list-style-type: none"> • Include any health information technology |

| | | | |
|--|--|---|--|
| <p>Is there an information system that supports initial and ongoing operation and review of the State's quality strategy objectives and progress toward performance targets?</p> | | <ul style="list-style-type: none"> • Encounter Data System • NCQA information • Regional or multi-state IT collaborative • New IT contracts • Implementation / revision of registries • Needs assessments for implementation of electronic health records • Telemedicine initiatives • Provider / MCO-PIHP Profiling • EQR Technical report recommendations • CMS Quality Roadmap | <p>initiatives that will support the objectives of the strategy.</p> |
|--|--|---|--|

| Quality Strategy Elements and Key Questions | Correlates to Structure Section | Potential Sources Of Information | Additional Information |
|--|--|---|--|
| <p>Improvement / Interventions</p> <p>How will the State implement interventions specific to each Strategic Objective?</p> <p>What interventions are under consideration pending baseline reporting of targeted information?</p> <p>What interventions are under development?</p> | <p>III</p> | <ul style="list-style-type: none"> • Cross-State Agency Collaborative • Performance Improvement Project activities • Pay-for-Performance Incentives • Value-Based Purchasing incentives and or disincentives • Telemedicine • Health Information Technology Changes | |
| <p>Strategy Effectiveness</p> <p>What are the planned evaluations (frequency, estimated target dates)?</p> <p>What are the reporting requirements for MCOs / PIHPS to State and from State to CMS?</p> | <p>IV</p> | | <ul style="list-style-type: none"> • Consider aligning routine reporting mechanisms from MCOs / PIHPS / EQR with planned evaluation periods |
| <p>Conclusions</p> | <p>V</p> | <ul style="list-style-type: none"> • Performance | |

| | | | |
|--|--|---|--|
| <p>What particular successes could be considered best practices?</p> <p>What ongoing challenges does the State face in improving the quality of care for Medicaid beneficiaries?</p> <p>What recommendations does the State make for ongoing Medicaid quality improvement activities in the State?</p> | | <p>Improvement Project activities</p> <ul style="list-style-type: none"> • Pay-for-Performance Incentives • Value-Based Purchasing incentives and or disincentives • Telemedicine • Health Information Technology Changes | |
|--|--|---|--|

Appendix D

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

Value-Based...Results-Driven...Healthcare:

The Medicaid / SCHIP Quality Initiative

August 2006

The Center for Medicaid and State Operations (CMSO) is committed to supporting State Medicaid and State Children's Health Insurance Programs (SCHIP) in their efforts to achieve safe, effective, efficient, patient-centered, timely, and equitable care. The CMSO will work in partnership to achieve these goals, recommended by the Institute of Medicine, by engaging states, providers, consumers, and others in implementing evidence-based care, rewarding quality performance, controlling costs, and promoting the use of information technology. The vision, as noted in the *CMS Quality Improvement Roadmap*, is the right care for every person every time.

States administering Medicaid and SCHIP are challenged to provide quality services to an expanding population within budget constraints. Increasingly, federal and state governments, health care professionals, and insurers are exploring reforms in the current payment systems which typically focus reimbursement on the number of services and procedures provided, rather than the quality and value delivered. Demand continues to grow for Federal leadership in these critical and complex areas of health care reform.

As one of the largest payers of healthcare in the United States, CMS has an important role to play in supporting states in their efforts to implement quality improvement strategies including pay-for-performance (P4P) programs, care coordination, patient safety initiatives, e-prescribing, electronic medical records, public reporting, evidence-based guidelines and performance measurement. States are eager to explore these innovative programs and have in fact led the way in many instances.

For example:

Indiana recently submitted an amendment to its State Plan to enhance the delivery of child health through the *Indiana Health Information Exchange*, a collaboration of Indiana health care institutions. The collaborative was formed for the purpose of using information technology and shared clinical information to improve the quality, safety, and efficiency of health care to children in Medicaid and SCHIP.

California, Michigan, and New York have implemented *Performance Based Auto-Assignment Programs* that rewards health plans with superior performance. The programs create an incentive to improve Medicaid quality and preserve the safety net by increasing enrollee volume and payment to those plans that provide a consistent level of quality improvement.

Louisiana is currently planning to expand a *Disease Management Outcomes Measurement System* that utilizes nationally recognized performance measures to improve outcomes in diabetes, asthma, and cancer screening. The expansion will promote improvement in the delivery system design, clinical information systems, patient self-management, and electronic decision support tools for practitioners.

Arizona recently developed a position paper that clearly articulates a need for the federal government to provide incentives to state Medicaid programs to develop methods of reducing medical error and improving quality measurement by exploring the development of models for P4P programs and electronic health networks.

CMSO will utilize a number of available avenues to assist states in their efforts to improve quality of care and reduce cost. The newly created Division of Quality, Evaluation, and Health Outcomes will provide technical assistance to states as they seek to advance quality improvement activities. CMSO also will strengthen the quality focus in its guidance for waiver applications, state quality strategies, external quality review activities, and state plan amendments.

Quality Strategy

CMSO is an integral part of CMS and as such, participated in the development of the agency-wide *CMS Quality Improvement Roadmap*. The five strategic components of the plan served as the foundation for the CMSO quality strategy. The CMSO quality strategy was modified to acknowledge the unique relationship between the federal government and states. Consistent with the philosophy of continuous improvement, CMSO attempts to avoid punitive and costly mandates but instead strives to encourage states participation in activities proven to improve the lives of beneficiaries.

CMSO recognizes the purchasing power held by federal and state governments and will join the national efforts to promote innovative approaches to transforming the delivery of health care. This transformation strategy requires CMSO to serve as a convener, change agent, and knowledge transfer organization. The basic elements of the plan include:

- Evidenced-Based Care and Quality Measurement
- Pay-for-Performance
- Health Information Technology
- Partnerships
- Information Dissemination and Technical Assistance
- Health Care Disparities

Evidenced-Based Care and Quality Measurement

CMSO will work with states to improve performance measurement and ultimately the quality of care. The need for consistency in performance measurement is becoming more evident as the demand for data continues to increase. Payers and providers are finding it

nearly impossible to fulfill the multiple requests for data, all of which have different data requirements unique to the individual payer. Federal and state governments, accreditation bodies, insurers, and health care professionals have now joined together to come to consensus on common evidence-based measure sets that have wide acceptability in the healthcare industry.

A voluntary consensus approach to measures development ensures that states will be able to maintain flexibility in measure selection while benefiting from having a menu of nationally recognized validated and tested measures from which to choose. Additionally, by using common measures, states can minimize the need to overhaul their information technology systems because they may be able to take advantage of existing databases such as those available through QualityNet Exchange, a secured communications site for data exchange.

Many states have already adopted the use of nationally recognized performance measures and utilize them in a number of areas including incentive programs, public reporting of quality, and in the development of policy reports. Maryland, Massachusetts, Minnesota, Ohio, Iowa, and Wisconsin are a few of the states that collect standardized measures. All of these states conduct internal quality improvement activities and report quality results publicly on their Web sites.

Many other opportunities are available for states to conduct data mining of existing systems. CMSO will help states explore opportunities to develop genetic-algorithm-driven data mining programs for such system as the MMIS databases or the MSIS database. Multiple opportunities may also exist to help states develop initiatives to influence pharmacy benefits through data mining of pharmaceutical databases. The data will be useful when making decisions on formularies, adoption of formularies from private health plans, and development of joint formularies.

National databases such as those used to generate the National Nursing Home Compare data also provide states with a readily available source of information upon which to make decisions related to quality of care. Additionally, CMS has built improved infrastructure for the survey and certification system, such as a new complaint tracking and management information system, to identify and track needed improvement in quality. Significant investments also have been made in reporting and tracking such quality measures as the prevalence of pressure ulcers, incontinence, and physical restraints.

CMSO can play an important role in promoting measures of quality for which there is broad clinical acceptance. For example, CMSO, working with the Office of Clinical Standards and Quality (OCSQ), will advance a project to improve quality of care for neonates. By sharing information about successful health outcomes and cost savings, other states will be encouraged to undertake similar programs customized to their unique needs and resources.

Examples of measurable project goals include:

- Increasing the use of antenatal corticosteroids in pregnant women who are at risk for preterm delivery (reduces the risk of death, respiratory distress syndrome, and intraventricular hemorrhage); and

- Increasing the use of prophylactic surfactant administration in eligible neonates (reduces the risk of pneumothorax, pulmonary emphysema, and mortality).

The above guidelines are well accepted and the potential for improved quality and cost reduction is great. The March of Dimes estimates that \$13.6 billion is spent on care for premature infants with nearly half of this cost or \$6.8 billion paid by Medicaid programs. NIH estimates savings of \$3000.00 per neonate treated with corticosteroids alone. Further, NIH notes that only 15% of eligible neonates receive the recommended therapy. If the percentage were increased to 60%, a conservative estimate of the annual savings in health care cost would be \$157 million from the initial hospitalization alone.

Based on prevalence, health care expenditure, and ability to make a positive impact through evidence-based approaches, CMSO, in partnership with states, will develop additional quality improvement program options.

Pay-for-Performance / Quality (P4P)

P4P is a quality improvement and reimbursement methodology aimed at changing the current payment structure which primarily reimburses based on the number of services provided regardless of outcome. P4P attempts to introduce market forces and competition to promote payment for quality, access, efficiency, and successful outcomes.

P4P is in its early stages of development and a great deal of work still must be done to determine the best method of approaching a comprehensive program. Several different models exist for P4P including extensive disease management programs. One demonstration currently in progress includes the *Disease Management Demonstration for Chronically Ill Dual Eligible Beneficiaries*. Under this demonstration, disease management services are being provided to dually eligible beneficiaries in Florida. LifeMasters, the demonstration organization, is being paid a fixed monthly amount per beneficiary and is at risk for 100% of its fees if performance targets are not met. Savings above the targeted amount will be shared equally between CMS and LifeMasters.

CMSO will provide technical assistance to those states that voluntarily elect to implement P4P programs. Additionally, CMSO will convene states for a conference designed to explore methods of propelling P4P programs. Efforts will be geared toward promoting the following important concepts in P4P:

Overarching Principles: P4P programs must be:

- Data driven
- Beneficiary-centered
- Transparent
- Developed through partnerships
- Administratively flexible

Quality Components: P4P programs should be built on:

- Evidence-based guidelines

- Consistent measures of access, quality, costs, and satisfaction
- Coordinated care programs
- Health information technology

Incentive Structure: P4P incentives must be:

- Equitable and fair to program participants including the beneficiary
- Timely
- Sufficient to motivate improvement
- Flexible enough to provide payment for innovative care processes
- Structured to avoid unintended consequences

Health Information Technology (HIT)

HHS currently has a 10-year plan to transform the delivery of health care by building a new health information infrastructure, including electronic health records and a new network to link health records nationwide. The plan lays out the broad steps needed to achieve always-current, always-available electronic health records (EHR) for all Americans. National HIT activities are currently coordinated through the Office of the National Coordinator for Health Information Technology (ONCHIT). EHR systems will enable physicians and other health professionals to electronically tap into a wealth of treatment information as they care for patients and improve quality and patient safety.

Many states have embraced advancements in HIT. For example New York recently announced its Federal-State Health Reform Partnership (F-SHRP) with a plan to reinvest \$1.5 billion of federal fund savings that were achieved under New York's section 1115 waiver. One component of the plan includes investing in health IT, including e-prescribing, electronic medical records, and regional health information organizations.

CMSO will join the CMS Quality Council Health Information Technology Workgroup in developing plans that will serve as models for states. The newly created Division of Quality, Evaluations and Health Outcomes has been charged with compiling information for states and providing technical assistance as they move forward with HIT activities.

Partnerships

Partnerships are essential to accomplishing the work ahead. The collective efforts of partners interested in true reform will have a great yield. Following are only a few examples of required partnerships:

- **National Association of State Medicaid Directors (NASMD)** – CMSO is working with NASMD to further refine a quality strategy and determine areas of collaboration. Formal communications channels for quality activities will also be established to facilitate the dissemination of information.

- **Agency for Healthcare Research and Quality (AHRQ)** – The Medicaid / SCHIP Quality Workgroup is currently collaborating with AHRQ on the next publication of the *National Healthcare Quality Report*. This report has been in existence for two years and, for the first time, CMSO will explore the publication of a section specific to Medicaid quality. Additionally, the workgroup is collaborating with AHRQ on a *Care Management Knowledge Transfer Project*.
- **Center for Health Care Strategies (CHCS)** – CMSO will work with CHCS in their efforts to provide training and technical assistance to help states, health plans, and consumer organizations effectively use managed care to improve the quality of services for beneficiaries, reduce racial and ethnic health disparities, and increase community options for people with disabilities.
- **National Quality Forum (NQF)** – The National Quality Forum currently has an informal workgroup established to explore pediatric quality of care measures. CMSO will begin a dialogue with NQF on potential measures of interest to Medicaid.
- **American Health Quality Association (AHQA)** – AHQA, the trade association for Quality Improvement Organizations (QIOs), has expressed an interest in working with states, CMSO and OCSQ to convert the current QIO / QIO-like review of quality and access in Medicaid fee-for-service and managed care into more meaningful quality improvement work for mothers, children, and the dually enrolled population.
- **National Committee on Quality Assurance (NCQA)** – NCQA continually addresses strategies and specifications for performance measures. Many of the measures that will be discussed over the next several months include attention deficit hyperactivity disorder (ADHD), diabetes, dental care, and asthma.
- **American Academy of Pediatrics (AAP)** – AAP has expressed strong support for improving the quality of care in the Medicaid / SCHIP population by exploring valid measures of quality and appropriate incentives for quality care. CMSO will continue to foster a collaborative relationship with AAP.
- **National Association of Children's Hospitals and Related Institutions (NACHRI)** – NACHRI has begun a dialogue with the CMSO to encourage improved pediatric performance measurement, national demonstrations, value based purchasing and other areas of importance in quality. CMSO will work with NACHRI to further develop these ideas.
- **Internal Partners** – The Medicaid / SCHIP Quality Workgroup and its subgroups will provide a formal structure for advancing quality efforts related to these programs. CMS regional offices will play a special role in information collection, analysis, information dissemination, and technical assistance. CMSO has also begun dialogue with internal CMS partners on such projects as HCAHPS (hospital experience of care), the Surgical Complication Interventions Project (SCIP), the Ambulatory Care project, and others.

Information Dissemination and Technical Assistance

Information dissemination, knowledge transfer, and technical assistance is extremely important in the Medicaid and SCHIP programs given that states enjoy wide flexibility in program implementation. CMSO will facilitate the sharing of model practices, lessons learned and innovative approaches to emerging issues through issues briefs, analysis of demonstration evaluations, development of a quality Web site, participating in conferences and Web casts and other methods. The Medicaid / SCHIP Quality Workgroup will develop and implement a formal communications strategy to ensure successful dissemination of information.

Health Care Disparities

As part of the Centers for Medicare & Medicaid Services' (CMS) overarching initiative to support health care quality improvement to underserved Medicare and Medicaid beneficiaries, the Center for Medicaid and State Operations (CMSO) has engaged in an intra-agency, private, and public sector collaboration with States, various community-based organizations, stakeholders, and underserved communities interested in addressing health disparities, incorporating a health disparities component into the Agency's quality initiatives, and providing beneficiaries with information about CMS' programs.

According to the *National Healthcare Disparities Report*, developed by the Agency for Healthcare Research and Quality (AHRQ), though there are differences in care seeking behavior, which are attributable to factors that include cultural beliefs, linguistics, and lifestyle choices, health disparities often represent an 'inequality in quality' and usually lacks the necessary framework for quality as defined by the Institute of Medicine (IOM): patient safety, patient-centeredness, timeliness, efficiency and equity.

As part of CMS's broader disparity strategy, the CMSO charge to address racial and ethnic health disparities in Medicaid and SCHIP will focus on the following objectives:

1. Disseminate information about promising / best practices in health disparities in Medicaid and SCHIP to the forum and external organizations.
2. Identify vulnerabilities and areas of opportunity in Medicaid and SCHIP for quality improvement and the reduction of health disparities in Medicaid beneficiaries.
3. Identify and collaborate with States and external organizations / resources to develop partnerships to reduce health disparities in Medicaid and SCHIP.

Moving Forward with All Deliberate Speed

The Medicaid and SCHIP programs are experiencing an unprecedented number of demonstration requests and state plan amendments that are focused on value based, results-driven approaches to providing health care to an expanded number of citizens. Professional organizations, providers, and consumers have growing expectations for Federal leadership in ensuring quality services within the limitation of resources. No one approach will satisfy the needs of all. CMSO looks forward to participating in the debate, driving improvement, and ultimately ensuring a system that works for America's most vulnerable populations.

Tab E

**Iowa External Quality Review Organization (EQRO)
2005 Annual Technical Report (ATR)**

Assessment of Iowa's 2006 - 2007 External Quality Review Annual Technical Report
(08/20/2008)

Thank you for your submission of the 2006 - 2007 External Quality Review Annual Technical Report for the managed care organization (MCO) participating in Iowa's managed care program and the Prepaid Inpatient Health Plan (PIHP). The Centers for Medicare & Medicaid Services (CMS) has reviewed these reports in an effort to support States in activities designed to improve quality and access to care that is safe, effective, efficient, timely, person-centered, and equitable. This assessment is based upon the criteria stated in the EQRO Technical Report Review Tool for CMS Regional Offices.

The External Quality Review must include the following deliverables:

1. A detailed technical report describing the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to care;
2. an assessment of each plan's strengths and weaknesses with respect to quality, timeliness, and access to care;
3. as the State determines, methodologically appropriate, comparative information about all plans;
4. recommendations for improving the quality of health care services furnished by the plans, and
5. an assessment of the degree to which each plan has addressed effectively the quality improvement recommendations made by an EQRO during the prior year's review.

The EQRO has submitted these deliverables in separate reports for the MCO (Coventry) and the PIHP (Magellan) providing managed care services to Medicaid beneficiaries in the State.

Background

Medicaid Managed Care was introduced to Iowa in 1986 when the State contracted for the delivery of medical/surgical services in Scott County on a risk-based, capitated basis. The State contracted with John Deere Health Plan as the first Medicaid MCO. In 1990 the State received approval of a 1915(b) Freedom of Choice waiver from CMS. The waiver allowed the State to implement the Medicaid Patient Access to Service Systems or MediPASS program in seven counties. Today, out of the 99 counties in the State of Iowa, the MediPASS program is offered in 95 counties, with two counties offering an MCO option. There are approximately 138,000 members in the PCCM (MediPASS) program and 4,800 in the MCO program. This enrollment represents approximately 43% of the total Medicaid population.

In counties with Medicaid managed care, the program is mandatory for recipients receiving assistance through the Family Investment Program (FIP) and FIP-related programs (TANF). Medicaid enrollees may choose between the managed care options available in their county, MCOs or PCCM. If the beneficiary fails to make a choice, they are assigned to a plan and provider.

Iowa currently contracts on a capitation basis with one MCO, Coventry Health Care of Iowa, Inc. Coventry Health Care of Iowa is a risk-based entity which accepts a capitation rate set by the State. The MediPASS program is a primary care case management program that enrolls the

recipient with a primary care physician (PCP) or patient manager who is responsible for providing primary care and for coordinating or authorizing other necessary care. Participating physicians are paid a monthly fee for providing case management services to assigned beneficiaries. All other services provided through the MediPASS program are reimbursed on a fee-for-service basis.

The Iowa Plan

In 1995 the State began separate managed mental health and substance abuse programs which served most beneficiaries not enrolled with an HMO who were under age 65. In July of 1997, mental health and substance abuse services were carved out of the MCO responsibility and moved to the mental health and substance abuse PIHP, which is a statewide contract, called the Iowa Plan. This program operates under a 1915(b) waiver granted by CMS.

The Iowa Plan for Behavioral Health (the Iowa Plan) integrates mental health care and substance abuse treatment and builds on the two previous separate managed care programs. The Iowa Plan is administered under a contract between IME and Magellan Health Services. Most Medicaid eligible members under the age of 65 are enrolled in the Iowa Plan. Current enrollment is approximately 285,000.

Through the use of savings in its waiver, Iowa is able to provide more services to Medicaid beneficiaries through the Iowa Plan than under traditional Medicaid fee-for-service. These "additional" services are provided under Section 1915(b)(3) authority and allow for the use of a number of community-based strategies that offer a cost-efficient, less restrictive, and more effective alternative to hospitalization.

In accordance with the Centers for Medicare and Medicaid Services (CMS) rule, section 438.350, the EQRO, Iowa Foundation for Medical Care (IFMC), conducts onsite evaluations of Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs) under contract with the Iowa Department of Human Services (DHS). The purpose of the evaluation is to assure that each contracted MCO/PIHP is providing quality services for its Medicaid members in accordance with the CMS Protocols. Plan compliance with these new protocols was effective August 2003 with much more stringent requirements per Federal regulations at 42 Code of Federal Regulations, section 438.350

Expectations

For the review of each MCO/PIHP, the State or its agent is required to conduct the following mandatory EQR activities:

- Validation of performance improvement projects required by the State
- Validation of reported MCO performance measures
- Assess standards for access to care, structure and operations, and quality measurement and improvement

Federal regulations at 42 CFR 438.364 requires that each ATR include objectives, data collection and analysis methods, description of data obtained, conclusions drawn from the data, an

assessment of each MCO's strengths and weaknesses, recommendations for quality improvement, and (as appropriate) comparative information about the various health plans.

The CMS also seeks confirmation through the Annual Technical Reports that each MCO addresses disparities in health care outcomes and uses health information technology to implement the State's quality strategy, as cited at 42 CFR 438.204(b)(2) and (f) respectively.

Validation of Performance Improvement Projects (PIP)

Federal regulations at 42 CFR 438.240(d) require MCOs to have an ongoing program of PIPs that focus on clinical and non-clinical areas. Regulations at 42 CFR 428.240(e) indicate that the annual EQR must assess the impact and effectiveness of the MCO performance improvement program. The EQRO reviewed three PIPs proposed by the MCO for 2006 implementation in various clinical areas that include:

- Childhood immunizations
- Cervical cancer screenings
- EPSDT

The PIHP, as a part of the EQRO on-site evaluation, under the direction of the Iowa DHS, has compiled six Performance Improvement Projects. They are:

- Intensive Care Management Program
- Outcomes Project
- Cultural Differences in Utilization
- Co-Occurring Disorders Services
- Reward for Quality
- Self-Directed Care

The IFMC sought to determine if the proposed PIP would result in sustained and meaningful improvement in outcomes of care. The MCO demonstrated significant improvement in their Performance Improvement Project processes, particularly their data collection and validation processes. There continue to be several areas requiring additional focus leading the IFMC to rate this PIP as Developing.

Some of the strengths of this PIP include documentation of the positive impact of preventive health screening, an effective group process strategy in analyzing results, and response to addressing data collection and validation issues. Processes were very clearly defined and easily validated.

Some of the recommendations include:

- Continued attention is recommended to ensure this level of accurate detail continues.
- Continue to focus attention on detailed descriptive documentation in all sections of the PIP report to ensure the greatest level of understanding and compliance.
- The MCO incorporate a member health outcomes perspective on all studies as opposed to a regulatory perspective on all Performance Improvement Projects.
- The MCO should review all study findings and develop a singular report format so that required information is consistently incorporated. This will address the inconsistencies that continue to be found in the documentation of required studies.

- MCO is encouraged to utilize IDHS and the EQRO team for technical assistance as necessary.

The PIHP population targeted for improvement in outcomes in this study is Plan members with high levels of symptom severity and service utilization. The IFMC found the PIHP Plan continues to demonstrate marginal performance in measuring PIP's. IFMC states "...EQR reports have provided direction to guide improvement efforts but deficiencies and inconsistencies continue in relatively random order. Where previous studies were firmly rated as "developing," this year's review revealed more inconsistencies and inconsistencies of greater magnitude requiring that three studies or half of the plan's efforts be rated as "not valid." This is a disappointing finding which reveals that PIPs have very definitely become a significant weakness for MHS. The IFMC rated the PIP as "developing" again this year.

Some of the recommendations include:

- Continue to request and receive technical assistance from the EQR.
- Work to improve the caliber of documentation of the PIP's incorporating all components of the study definitions
- Utilize a documented data analysis plan
- Develop intervention strategies
- Maintain a clear study design that differentiates between PIP's and PM's
- Train new staff to adequately report on PIP's to achieve and maintain a high level of data analysis

We look forward to seeing future reports that show an improvement in documentation and data analysis.

Validation of Reported MCO Performance Measures

Federal regulations at 42 CFR 438.240(c) provide that the annual EQR must address the MCOs' performance for the standard measures on which they are required to report. The State calculates its own performance measures using MCO-submitted encounter data. The MCO reports on two measures: Lead Screening and Monitoring of PCP Change Due to Dissatisfaction. The PIHP reports on the following two measures: Inpatient Facility Safety Survey and Schizophrenia Readmission.

The reports for both plans specify all performance measures specified by the State. However, the report does not document the State specifications for MCOS/PIHPS for collecting data, calculating rates, or reporting to the State. We would appreciate the state sharing with CMS the documented specifications for MCOS/PIHPS for collecting data, calculating rates, or reporting to the State.

The IFMC recommends that the MCO/PIHP apply the principles of Quality Improvement to the PM process to clearly define areas needing the greatest attention and the interventions that will most effectively address the identified needs. Until such time as improvement strategies are initiated, Performance Measures will continue to be a significant weakness for these Plans.

Assessment of Standards for Access to Care, Structure and Operations, and Quality Measurement and Improvement

The two health plans assessed in this review, Coventry (MCO) and Magellan (PIHP) are both NCQA accredited. The EQRO has audited the portions of the operational review which are not deemed by virtue of the NCQA Accreditation.

Information Systems - The report does not document efforts for MCOs/PIHPs efforts to enhance system technology, use of electronic health records, or e-technology. We would appreciate the State sharing with CMS any efforts to enhance system technology, use of electronic health records, or e-technology or the absence of these technologies.

The State does not mention utilizing any form of health information technology organizations. We would appreciate information being shared with CMS on the status of utilization of health information technology organizations.

Health Disparities - CMS was also assessing for attention to disparities in health care but no documentation was noted within the MCO although the PIHP has an intervention on cultural competency training for staff, not plan members. We would appreciate the State providing an update on efforts to assure that individuals for whom English is not the primary language have adequate access to care and necessary translation services.

We encourage Iowa to submit descriptions of any innovative initiatives undertaken through your Medicaid managed care plans that advance quality for Medicaid beneficiaries using the guidelines and format found on the CMS Medicaid/SCHIP Quality website (http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/10_Promising%20PracticesConceptNominationProcess.asp#TopOfPage).. See examples of promising practices for other States already posted to this site (<http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPDDL/list.asp#TopOfPage>).

Tab F

**Medicaid Information Technology Architecture (MITA):
An Opportunity to Improve Medicaid Quality**

Medicaid Information Technology Architecture (MITA): An Opportunity to Improve Medicaid Quality

Abstract

The Medicaid Information Technology Architecture (MITA) initiative seeks to re-orient Medicaid information systems toward a more beneficiary-centered approach that can help achieve the quality goals of the Department of Health and Human Services, the Centers for Medicare & Medicaid Services (CMS), and individual States. The focus of traditional Medicaid Management Information Systems (MMIS) has been on assuring accurate claim adjudication and standardized Federal reporting. The MITA framework seeks to move the MMIS toward a greater focus on the beneficiary, integration of clinical and administrative data, support of program analysis and decision making, and an enhanced capacity for Medicaid to communicate with other programs and payers.

The higher levels of maturity described within the MITA initiative describe scenarios that can support quality improvement by providing a more comprehensive base of information on individual beneficiaries and real-time data on changes in the delivery of services in real time. This can enhance the ability of providers to reduce unnecessary testing and procedures, avoid medical errors and adverse drug events, and assure that appropriate care is delivered. When the higher levels of maturity described in MITA have been achieved, Medicaid program managers will have the ability to identify and target at-risk populations, expedite prior authorization decisions, develop quality statistics for specific providers, and benchmark provider performance to measures calculated by other payers or States.

A July 2007 report issued by the DHHS Office of Inspector General cited numerous examples of State Medicaid HIT and HIE initiatives intended to serve these aims. CMS intends to take a series of concrete actions to explore opportunities for using MITA principles to advance quality goals for Medicaid beneficiaries

Introduction

The purpose of this paper is to provide background on the goals of CMS Medicaid quality efforts and on Medicaid information systems, particularly recent efforts to reorient these systems toward a beneficiary-centered focus guided by Medicaid Information Technology Architecture principles. The paper also considers how the MITA initiative can support quality improvement.

CMS Quality Goals

The quality vision of the Centers for Medicare & Medicaid Services is to provide the right care for every person every time. It seeks to assure that this care is safe, effective, efficient, person-centered, timely; and equitable.¹ The Center for Medicaid and State Operations (CMSO) works to realize this vision for Medicaid and the State Children's Health Insurance Program (SCHIP) through activities in six core areas:

¹ CMS website, Quality of Care Center (<http://www.cms.hhs.gov/center/quality.asp>)

- *Evidenced-Based Care and Quality Measurement* - CMS supports States in their efforts to improve performance measurement and ultimately the quality of care through the use of evidence-based measure sets that have wide acceptability in the health care industry.
- *Value-Based Payment Methodologies* - CMS supports States in their efforts to implement programs that promote reimbursement for quality, access efficiency, and successful outcomes.
- *Health Information Technology (HIT)* - CMSO encourages States to explore creative uses of HIT that contribute toward the building of new regional and national health information infrastructures.
- *Partnerships* – CMS works with other committed partners to help blend different perspectives and resources in the collective pursuit of common quality goals.
- *Information Dissemination and Technical Assistance* - CMS facilitates the sharing of promising practices, lessons learned, and innovative approaches to emerging issues through its website (<http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/>), conferences, publications, and participation in conferences.
- *Reduction of Healthcare Disparities* – CMS works to reduce racial and ethnic health disparities in Medicaid and SCHIP through identifying contributing factors and areas of opportunity, dissemination of promising practices, and forming partnerships with various agencies, private and public sector organizations, States, and other interested groups.²

Several of these core areas are reflected in Secretary Leavitt’s initiative that challenges State Medicaid programs to partner in value-driven healthcare activities centering around four cornerstones:

- *Interoperable Health Information Technology* – States are encouraged to engage in efforts such as monitoring the activities of national standard setting bodies, working with providers toward greater utilization of electronic health records (EHR) that have been certified by national certification bodies, and participating in health information exchange (HIE).
- *Measuring and Publishing Quality Information* – States are encouraged to request that health plans use and publicly report measures adopted by recognized national bodies and to request that plans and External Quality Review Organizations (EQRO) participate in national quality transparency collaboratives. States are also encouraged to participate in national public-private collaborative committees or workgroups to establish and support standards in measuring or reporting quality and to become a member of the National Quality Forum.
- *Measuring and Publishing Price Information* – States are encouraged to make price information available to beneficiaries so that they can make more confident decisions about their health care providers and treatment options.
- *Creating Positive Incentives for High Quality Health Care Purchasers* – These could include provider incentives such as rewards for delivering high-value care, direct financial incentives and/or public recognition to providers who demonstrate superior performance, and incentives to encourage provider adoption on electronic health records and health information exchange. They could also target beneficiaries through consumer-directed health plans with a health savings account or high reimbursement account,

² CMS website, *Medicaid and SCHIP Quality homepage*, (<http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/>)

beneficiary incentives for prevention and wellness, and provide beneficiaries with incentives for self-management of chronic illness.³

Medicaid and Health Information Technology

The Centers for Medicare & Medicaid Services recognizes the strategic importance of promoting the use of health information technology to advance quality of care and life. Released in August 2005, the CMS Quality Improvement Roadmap stresses the need for Medicare and Medicaid to use electronic health systems to support more effective quality improvement efforts.⁴ A key element of the Medicaid/State Children's Health Insurance Program (SCHIP) Quality Strategy, issued in July 2006, is to help States enhance their health information infrastructure and improve the effectiveness and efficiency of health care delivery.⁵

On August 22, 2006, President George W. Bush signed an Executive Order to "...ensure that health care programs administered or sponsored by the Federal government promote quality and efficient delivery of health care through the use of health IT, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers".⁶ Similarly, the Value-Driven Health Care initiative developed by Secretary Mike Leavitt commits the Department of Health and Human Services (DHHS) to partnerships intended to achieve the interoperability of health care information, the development of standards and a certification process to ensure that those standards are met, and the sharing of data to facilitate clinical and consumer decisions, as well as performance measurement.⁷

The Deficit Reduction Act of 2005 made \$150 million available for CMS to award in support of State Medicaid transformation initiatives. One of the permissible uses of transformation grant funds enumerated in section 1903(z) of the Social Security Act is to foster the development of "methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs". The April 27, 2007 State Medicaid Directors letter soliciting State applications for a second round of transformation grants indicated that the Secretary of DHHS also encouraged States "to apply for grant funds to develop value-driven health care initiatives including systems that provide transparency in health care that allow consumers to compare the quality and price of services so they can make informed choices among doctors and hospitals".⁸

³ HHS website, Value-Driven Health Care/Health Information Technology, <http://www.hhs.gov/valuedriven/fourcornerstones/healthit/index.html>

⁴ CMS website, Quality of Care Center (<http://www.cms.hhs.gov/center/quality.asp>)

⁵ CMS website, Medicaid and SCHIP Quality homepage, (<http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/>)

⁶ Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, "Clinical Health Information Technologies and the Role of Medicaid", p.16

⁷ HHS website, Value-Driven Health Care/Health Information Technology, <http://www.hhs.gov/valuedriven/fourcornerstones/healthit/index.html>

⁸ CMS website, Medicaid Transformation Grants Overview, <http://www.cms.hhs.gov/MedicaidTransGrants/>

Evolution of Medicaid Information Systems

In response to rapid growth in Medicaid spending during the early years of the program, Public Law 92-603 was enacted in 1972, requiring each State Medicaid Program to have an automated claims processing and information retrieval system that would facilitate accurate claim adjudication and standardized Federal reporting. While Federal prior approval of these Medicaid Management Information Systems (MMIS) and subsequent modifications was required for a State to claim enhanced Federal matching funds, Federal review tended to focus more on system outputs than on architecture, to permit States flexibility in developing customized solutions to their unique operational needs.^{9 10}

This has resulted in considerable variation among States in MMIS design and specifications, which has inhibited data sharing among State Medicaid programs and between the Medicaid agency in a given State and sister agencies.¹¹ Moreover, as each State automated additional program functions, the new components were often not fully integrated into the MMIS and could not easily communicate with one another because of their unique architecture, data standards, and maintenance and support elements.^{12 13} Because this claims-based system lacked clinical information and had a program rather than beneficiary-centered orientation, State Medicaid personnel were also unable to obtain meaningful information on health outcomes.¹⁴ For these various reasons, the traditional MMIS has not been well-suited for supporting quality assessment and improvement activities.

Genesis of the Medicaid Information Technology Architecture (MITA) Initiative

In its 2001 report entitled, “Crossing the Quality Chasm: A New Health System for the 21st Century”, the Institute of Medicine underscored the need for clinical information systems to be redesigned in support of evidence-based practice and improved outcomes. By sharing the data generated by such systems through health information exchanges, various stakeholders and the

⁹ Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, “Clinical Health Information Technologies and the Role of Medicaid”, p. 12

¹⁰ Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, “Medicaid Information Technology Architecture: An Overview”, p. 7

¹¹ Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, “Medicaid Information Technology Architecture: An Overview”, p. 1

¹² Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, “Medicaid Information Technology Architecture: An Overview”, p. 4

¹³ CMS website, MITA Information Series, “What Is MITA? An Overview”, http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWhitePapers.asp#TopOfPage, p. 5

¹⁴ Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, “Medicaid Information Technology Architecture: An Overview”, p. 9

health care system in general can become more efficient in their operations and providers are more able to deliver patient-centered care that is coordinated and coherent.¹⁵

Recognizing the need to modernize State Medicaid information systems, CMS, working with States and other stakeholders, launched the Medicaid Information Technology Architecture (MITA) initiative in 2002.¹⁶ MITA is a framework of national standards for use in developing the information systems that support a State's Medicaid Enterprise. The MITA framework is separated into three architecture components: Business Architecture, Technical Architecture, and Information Architecture.

The "Business Architecture" is generated by identifying and defining everything that a State Medicaid "enterprise" does as "Business Processes" within eight "Business Areas":

- Business Relationship Management,
- Care Management,
- Contractor Management,
- Member Management,
- Operations Management,
- Program Integrity,
- Program Management, and
- Provider Management.

Within each of these eight "Business Areas" are "Sub-Business Areas" or "Clusters". The individual "Business Processes" are defined within these "Sub-Business Areas / Clusters".

The mission of MITA is to establish a national framework of enabling technologies and processes that supports improved administration of the Medicaid program and health care outcomes for Medicaid beneficiaries. By establishing this framework, MITA seeks to move Medicaid information systems toward a greater focus on the beneficiary, integration of clinical and administrative data, support of program analysis and decision making, and an enhanced capacity for Medicaid to communicate with other programs and payers.¹⁷

MITA is based on the premise that interoperability works most efficiently when planned for, and built into, system designs at a very early stage. This prevents the need for more burdensome and expensive back-end fixes that are otherwise necessary to facilitate interoperability of systems for collaborative purposes, such as data exchange.

The MITA initiative is expected to lead to the development of a universal data dictionary and standard definitions of common data elements that will facilitate communications between a

¹⁵ Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 4

¹⁶ Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, "Clinical Health Information Technologies and the Role of Medicaid", p. 13

¹⁷ CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWHITEPAPERS.asp#TopOfPage, p. 3

State's core MMIS and any stand-alone systems that have been created for special operational purposes (i.e., interoperability).¹⁸ Adoption of MITA principles is also expected to enable State Medicaid programs to participate in regional and, ultimately, national data exchange efforts.¹⁹

In April 2007 CMS began asking States to conduct a self-assessment, in which they document current business areas and processes and set goals to improve these processes within the MITA framework.²⁰ CMS plans to work with individual States to test products that further MITA principles as they become available and disseminate model approaches taken by early adopter States.²¹ CMS will also revise the MMIS advance planning document (APD) review process and criteria, which States must meet before they can receive an enhanced MMIS Federal match, to assure that State information technology (IT) changes are consistent with MITA goals and objectives. These review criteria will be developed based on input from the first States to adopt MITA principles.²²

CMSO is in the process of adding "Quality Improvement" and "Quality Measurement" to the MITA Business Architecture in the "Program Quality Management" Sub-Business Area / Cluster in the "Program Management" Business Area. When that process has been completed, State Medicaid programs can begin to include these components in their implementation of the MITA.

Nexus Between MITA and Quality

The integration of system components and interoperability of Medicaid with non-Medicaid systems can support quality improvement in several ways. By facilitating communications among systems, MITA can provide analysts with a comprehensive base of information on beneficiaries who may rely at various times on sources of coverage other than Medicaid.²³ The greater systems efficiency made possible by interoperability also enables State Medicaid programs to become aware of changes in the delivery of services in real time.²⁴

¹⁸ CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWHITEPAPERS.asp#TopOfPage, pp. 5-6

¹⁹ CMS website, MITA Information Series, "The MITA Maturity Model", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWHITEPAPERS.asp#TopOfPage, p. 9

²⁰ Department of Health and Human Services Office of Inspector General Report, "State Medicaid Agencies' Initiatives on Health Information Technology and Health Information Exchange", issued August 21, 2007, p. 3.

²¹ CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWHITEPAPERS.asp#TopOfPage, p. 16

²² CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWHITEPAPERS.asp#TopOfPage, p. 6

²³ Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", pp. 4-5

²⁴ Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 6

With easier access to a broader picture of a beneficiary's health status and health care experience, providers are better able to reduce unnecessary testing and procedures, avoid medical errors and adverse drug events, and assure that appropriate care is delivered. This is particularly relevant for Medicaid populations with chronic conditions, physical and behavioral comorbidities, and long term care needs.²⁵ MITA can help Medicaid program managers identify and target at-risk populations, develop quality statistics for specific providers, and benchmark provider performance to measures calculated by other payers or States.²⁶

Health Information technology and health information exchange (HIE) can also enhance the efficiency of health insurance operations. The ability to obtain clinical information quickly can enable State Medicaid agencies to expedite prior authorization decisions and thereby assure that beneficiaries receive needed services sooner. The real-time capture of provider data through HIE can also streamline the collection of Medicaid data needed for quality monitoring and improvement purposes. Linking data from Medicaid and other public programs and private payers can facilitate more accurate and efficient population-based health surveillance activity²⁷ and provide Medicaid managers and providers with a more complete picture of each beneficiary's medical record (e.g., immunizations).

Consistent with the DHHS Secretary's Value-Driven Health Care initiative, MITA can help State Medicaid programs develop the tools needed to increase health care transparency, such as EHRs, electronic prescribing, and personal health records (PHRs).²⁸ This focus can aid State Medicaid programs in developing quality standards for comparative purposes, making quality and cost information more easily available to beneficiaries, and assessing return on investment.²⁹

Examples of Current State Medicaid Initiatives

In July 2007, the DHHS Office of Inspector General issued a report entitled, "State Medicaid Agencies' Initiatives on Health Information Technology and Health Information Exchange". The OIG found that 12 State Medicaid agencies had implemented HIT initiatives such as claims-based electronic health records, electronic prescribing, remote disease monitoring, and personal health records. Twenty-five State Medicaid agencies were involved in planning and developing Statewide HIE networks. In the context of these efforts, the OIG found that 13 State Medicaid

²⁵ Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, "Clinical Health Information Technologies and the Role of Medicaid", p. 15

²⁶ CMS website, MITA Information Series, "What Is MITA? An Overview", http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAWHITEPAPERS.asp#TopOfPage, p. 7

²⁷ Alfreds, Shaun T; Tutty, Michael; Savageau, Judith A; Young, Scott; Himmelstein, Jay Health Care Financing Review, Winter 2006/2007, "Clinical Health Information Technologies and the Role of Medicaid", p.16

²⁸ Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 1

²⁹ Friedman, Richard H, Health Care Financing Review, Winter 2006/2007, "Medicaid Information Technology Architecture: An Overview", p. 9

agencies include MITA in their HIT and HIE planning.³⁰ The Medicaid Directors in these 13 States indicated that implementing MITA will enhance the interoperability of their MMISs, facilitate Medicaid participation in HIT and HIE initiatives, and promote quality assessment through integration of clinical information with claims-based data.³¹

In January 2007, CMS awarded 33 first-round Medicaid Transformation Grants, totaling \$103 million. Eighteen of these grants, totaling \$64 million, addressed HIT and HIE initiatives.³² In September 2007, CMS awarded 17 second-round Medicaid Transformation Grants, totaling almost \$52 million. Twelve of these grants, totaling nearly \$37 million, addressed HIT and HIE initiatives. Summary information and grant applications for each initiative can be found on the CMS website at http://www.cms.hhs.gov/MedicaidTransGrants/02_2007awards.asp#TopOfPage.

Various State HIT, HIE, and MITA related initiatives are also referenced in the individual State quality packets disseminated in response to the CMS goal of increasing “the number of States that have the ability to assess improvements in access and quality of health care”.

Future Opportunities and Next Steps

CMS encourages State Medicaid programs to work toward incorporating MITA principles that will enable them to implement initiatives that can enhance the quality of care and life for their beneficiaries. As CMS indicates in responding to MITA Frequently Asked Question FC-003, “the true litmus test for making the business case for MITA will depend upon the extent to which it contributes to improving overall health outcomes and reduces overall health expenditures on behalf of Medicaid beneficiaries.”³³

CMS intends to take a series of concrete actions to explore opportunities for using MITA principles to advance quality goals for Medicaid beneficiaries. Initial steps will include the following:

- Develop a task force composed of State Medicaid Directors, Medicaid Medical Directors, and information technology and quality professionals
- Conduct an assessment of how States are currently using the MMIS or other data systems to support Medicaid quality and disseminate promising practices
- Determine gaps in transparency of quality and cost data to support ends, such as provider assessment, consumer choice, and reporting

³⁰ OIG News press release, “OIG Issues Report on State Medicaid Agencies’ Initiatives on Health Information Technology and Health Information Exchange”, August 21, 2007.

³¹ OIG Report, “State Medicaid Agencies’ Initiatives on Health Information Technology and Health Information Exchange”, issued August 21, 2007, p. 14-15.

³² OIG Report, “State Medicaid Agencies’ Initiatives on Health Information Technology and Health Information Exchange”, issued August 21, 2007, p. 4.

³³ CMS website, [Medicaid Information Technology Architecture \(MITA\)](http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAQuestions.asp#TopOfPage), “MITA Questions”, http://www.cms.hhs.gov/MedicaidInfoTechArch/02_MITAQuestions.asp#TopOfPage
p. 12

- Decide actions that can be taken to improve transparency
- Provide States with technical assistance through the joint efforts of CMS systems and quality staff
- Convene joint conference calls of standing systems, quality, and managed care Technical Advisory Groups to address issues impacting the re-engineering of Medicaid systems for quality purposes

Tab G

**Quality-Related Initiatives Recognized by
CMS and Other Health-Related Organizations - Iowa**

Quality-Related Initiatives Recognized by CMS and Other Health-Related Organizations - Iowa

Transformation Grants

Iowa does not have a Transformation Grant award at this time.

CMS-Posted Promising Practices

Iowa has no promising practices on the CMS Medicaid/SCHIP Quality website or the Survey and Certification website. We encourage Iowa to submit descriptions of any innovative initiatives that advance quality for Medicaid beneficiaries or SCHIP enrollees using the guidelines and format found at

http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/10_Promising%20PracticesConceptNomination%20Process.asp#TopOfPage. See

<http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp#TopOfPage>

for examples of promising practices for other States already posted to this site.

Iowa has the following promising practice profiled on the CMS Home and Community Based Services promising practices website

(<http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp#TopOfPage>):

Iowa – Retaining and Recruiting Direct Support Professionals

Issue: Training, Mentoring and Increasing Awareness of Direct Support Professionals

Like many states, Iowa is experiencing high turnover rates for direct support professionals in both institutions and in the community. The average turnover rate of direct care workers in nursing facilities in Iowa is 60-80% and has been reported as high as 200% in some facilities. The turnover rate for Home Health Aides is 40-60%. High turnover rates cost money, cause people's support to be inconsistent, and decrease the quality of life of persons with disabilities. Meanwhile, the need for direct support professionals in the community is steadily increasing as more people seek home and community-based services.

The Iowa CareGivers Association (ICA) implemented a Certified Nursing Assistant (CNA) Recruitment and Retention Project to decrease turnover among CNAs who provide direct support in three Northwest Iowa nursing facilities. ICA is a member-driven association that provides education, information, support, and advocacy for CNAs, Home Health Aides, and other specialized direct support professionals. The project targeted nursing facility staff, but a similar approach may work with direct support professionals in the community.

The National Resource Center for Family Centered Practice at the University of Iowa's School of Social Work evaluated the project in December 2002. The evaluation found that facilities that provided CNA in-service trainings, support groups, and CNA mentorship opportunities had an average length of CNA employment of 18.96 months, which was significantly higher than the control group average of 10.01 months. The CNAs in the treatment group also reported greater job satisfaction.

Recognition by Other Health-Related Organizations

Self-Directed, Self-Controlled Budget for Personal Assistance Services Reduces Unmet Needs, Improves Quality of Life for Medicaid Beneficiaries

Medicaid consumers sometimes face obstacles when seeking home care from State-contracted agencies, and as a result they might receive few or none of the personal assistance services they need or are authorized to receive. Cash & Counseling provides frail elderly and disabled individuals of all ages with Medicaid coverage with an annual budget, letting the individuals decide and pay for the combination of goods and services that best meets their personal care needs. Cash & Counseling participants may use their budgets to hire their own personal care aides, including friends or relatives, and to purchase items and services that will help them to live independently.

The original Cash & Counseling demonstration, supported by the Robert Wood Johnson Foundation and implemented as section 1115 Medicaid demonstrations, was conducted in Arkansas, New Jersey, and Florida beginning in 1998. When these states applied for and received grants to implement Cash & Counseling, there was little evidence that consumers could or would successfully direct their own personal care services. Advocates were passionate and policymakers were intrigued, but the idea had not been rigorously tested. Cash & Counseling tested its results, which were so positive that program funders provided grants for replication in 11 more states in 2004. In that same year the Retirement Research Foundation provided additional funding to replicate the Cash & Counseling model in Illinois.

A randomized controlled trial comparing Cash & Counseling with traditional agency-directed care in Arkansas, Florida, and New Jersey found that the program resulted in increased use of personal care services, significantly fewer unmet personal care needs, and improved the quality of life for participants and caregivers; in addition, the program did not increase (and sometimes reduced) the risk of adverse health outcomes, and did not result in the misuse of Medicaid funds or the abuse of consumers.

Source: AHRQ Health Care Innovations Exchange
(<http://www.innovations.ahrq.gov/content.aspx?id=1800>)

Tab H

CMS Regional Office Reviews of Iowa Home and Community Based Services Waiver Programs

(Note: This tab includes the Executive Summaries of, or excerpts of the recommendations from, the CMS Regional Office Review Reports. The complete final reports are available upon request.)



U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region VII

FINAL REPORT

Home and Community-Based Services Waiver Review

Iowa Elderly Waiver Program

IA 4155.90.R3

Conducted July 10, 2007

Home and Community-Based Services Waiver Review Report

Executive Summary:

- The Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME), is the single state agency that retains administrative authority of Iowa's Home and Community-Based Services Waiver (HCBS) for the Elderly (IA 4155). This waiver allows for the provision of services to individuals aged 65 and older meeting the nursing facility level of care (LOC). It was initially approved in 1990 and currently serves 8,703 individuals. The approximate average cost per person is \$4,536.
- As requested per the CMS Interim Procedural Guidance, Iowa submitted evidence to demonstrate that the State is meeting the program assurances as required per 42 CFR 441. In its submission of April 2, 2007, the State provided an introduction to its overall monitoring framework and various examples and summary reports specific to each assurance. After review of the information, an onsite visit was scheduled for July 10, 2007, to provide an opportunity for further clarification and demonstration of system processes, and actual participation in quality activities.

Iowa is in the midst of reviewing and revising its quality assurance activities after evaluating the system in 2006. A new quality improvement plan, "Inclusion through Quality" is in various stages of implementation. The plan includes the development of a Quality Management Oversight Structure. The CMS review team observed both the Quality Management Committee and the Incident Reporting/Complaint Workgroup meetings while onsite. Both meetings are part of this oversight structure.

The State has contracted quality oversight for all of its waiver programs to Iowa State University (ISU). The State is divided into ten regions, with an HCBS Specialist assigned to each. The HCBS Specialists provide monitoring, training, and technical assistance for the waiver programs. An HCBS Supervisor and QA Specialist are also part of the overall structure. A conference call was held with these individuals during the onsite to discuss their roles and responsibilities, training provided, and their perspective of both provider and consumer issues they are finding in day to day activities in the field.

Iowa utilizes a web-based program called the "Individualized Services Information System", or "ISIS" to support its waiver programs. This tool functions as a remediation of sorts in that the system creates a workflow, identifying milestones that must be completed before further action can take place. ISIS provides documentation (i.e., LOC determinations, service plans), provider information (i.e., certifications, provider lists), and management reports (i.e., tracking workflow, program statistics), to name a few of the functions. ISIS

continues to be modified and enhanced to incorporate improvements as necessary for oversight of the program. CMS was provided a demonstration of ISIS during the onsite visit.

▪ Summary of Findings:

1. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization - State substantially meets the assurance.
 - CMS has no recommendations at this time.
2. Service Plans are Responsive to Waiver Participant Needs - The State demonstrates the assurance but CMS recommends improvements or requests additional information.
 - CMS encourages the development of a formal process to document that consumers are afforded choice between institutional care and home and community-based waiver services. This process should also be included in the State's monitoring activities to assure that consumer choice is being provided.
3. Qualified Providers Serve Waiver Participants - The State substantially meets the assurance.
 - CMS has no recommendations at this time.
4. Health and Welfare of Waiver Participants – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.
 - CMS recommends Iowa move forward in its efforts to develop a consistent incident reporting management process that includes the Elderly Waiver program.
5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program – The State demonstrates the assurance but CMS recommends improvements or requests additional information.
 - CMS recommends a formal written document be created that can be used as an action plan to guide and consolidate the various activities of “Inclusion through Quality” into one central source. A plan that sets forth timeframes for defined actions, prioritizes activities, and establishes next steps when necessary, would enhance the State's oversight of its waiver programs.

6. State Provides Financial Accountability for the Waiver – The State substantially meets the assurance.
 - CMS has no recommendations at this time.



**U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Region VII**

FINAL REPORT

**Home and Community-Based Services Waiver Review
Iowa Physical Disability Review
Iowa – 0345.90
November 29, 2006**

Home and Community-Based Services

Waiver Review Report

Summary of Findings and Recommendations:

I. State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with care provided in a hospital, NF, or ICF/MR.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

The State substantially meets this assurance

Recommendations:

None

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of plans of care for waiver participants.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13

The State substantially meets this assurance

Recommendations:

It is recommended that the State continue with its efforts in the development and implementation of its QA process by documenting the issues and trends identified through analysis of data collection and what follow-up occurs as a result.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Authority: 42 CFR 441.302; SMM 4442.4

The State substantially meets this assurance

(The State has an adequate and effective system for qualifying and monitoring providers, and demonstrates ongoing, systemic oversight of providers.)

Recommendations:

As the oversight entity, the State of Iowa reviews and maintains authority of the waiver program. The State is responsible for monitoring training and taking action when providers do not meet requirements. The State meets this assurance; however, we recommend a few improvements. Documentation provided shows that while the State is tracking overall waiver systems, much of the data in Quarterly Summaries and Reviews are not broken down by specific waiver type. It is recommended that the State continue to pursue ways to focus reviews and monitoring to the PD waiver population. This will better allow the State to trend and analyze performance for the waiver in order to continually improve the program.

CMS recommends that Iowa continue their efforts to improve oversight of CDAC providers. Iowa has made improvements in this area over the past years. It is encouraged that the State continue to focus on improvements in oversight of non-licensed providers to ensure sufficient protections of waiver participants.

Evidence provided indicates that trainings held for HCBS providers focus primarily on processes. It is recommended that the State consider providing training specific to the PD Waiver. Separation of waiver data will assist the State in recognizing needed areas for training.

Such processes will better allow the state to practice oversight of providers and to provide training appropriate to individual provider needs, thus ensuring the highest quality of service to participants.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The State substantially meets this assurance X
(While the State may not have a full and comprehensive system to assure health and welfare, the systems in place are adequate and effective and the State demonstrates ongoing, systemic oversight of health and welfare; improvements may still be necessary)

Recommendations:

It is recommended that the State continue with its efforts in the development of the new incident reporting process, which includes reports documenting the issues and trends identified through analysis of data collection and what follow-up occurs as a result.

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The State must demonstrate that it retains administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application. Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM4442.7

The State substantially meets this assurance X
(The State Medicaid agency has an adequate and effective system for administrative oversight of the waiver, and the administration of the waiver program is consistent with the approved waiver.)

Recommendations:

Iowa indicated that informal meetings for monitoring purposes occur between the State and IFMC. CMS recommends the State formalize these meetings and document the discussions through meeting minutes to help identify issues and follow-up actions.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

The State substantially meets this assurance X
(While the State may not have a full and comprehensive approach to assuring financial accountability, the system in place is adequate and the State demonstrates ongoing, systemic oversight; improvements may still be necessary)

Recommendations:

None



U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region VII

Final Report

Home and Community-Based Services Waiver

Assessment

Iowa HIV/AIDS

Control 0213.90.R1.03

Date Report Issued:

June 17, 2005



Home and Community-Based Waiver Services
(Iowa HIV/AIDS Waiver) Assessment Report
Control # 0213.90.R1.03

Summary of Findings and Recommendations:

I. State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with care provided in a hospital, nursing facility or ICF/MR. Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5; SMM 4442.6

The State does not substantially meet this assurance
(The State demonstrates a pervasive failure to meet this assurance and has no internal plan of correction.)

Recommendations:

(Required – when the State does not substantially meet this assurance.)

Based on previous reviews, CMS staff is familiar with the ISIS system and reports. Because this is an evidentiary review, it is necessary for the State to provide the evidence to support the process. At this point, CMS do not have the evidence needed therefore we cannot validate that the State is meeting this assurance and are requesting a corrective action plan.

The CORRECTIVE ACTION PLAN should include that the State develop a formal process to monitor and provide oversight to IFMC. This will help the State in assessing any LOC changes or determinations made, which also directly correlates to the client's POC. This process should include the production of ISIS reports to document LOC determinations are being done timely and correctly. CMS requests the State provide this process within 6 months. Some examples of evidence that CMS is requesting along with the process include:

- a) Quarterly Report that IFMC provides to the State showing number of determinations and reassessments. The purpose of this report is to demonstrate the State is monitoring contract compliance.
- b) ISIS generated report that demonstrates the timeliness of assessments and reassessments.
- c) Documentation that a supervisory review is done at IFMC to demonstrate that they are checking for accuracy.

Also, CMS recommends that the State and IFMC work more closely together on devising a more inclusive summary regarding their actual LOC evaluation and determination process that also reflects their findings, recommendations, and actions taken at their quarterly meetings. CMS requests the State and IFMC prepare formal minutes on a quarterly basis of their meetings. CMS also suggests using the QA committee meetings as an avenue to analyze findings, recommendations, actions taken, and follow-up. CMS requests the State send on a quarterly basis the QI committee meeting minutes.

CMS also recommends the State update the quarterly summaries reporting procedures for HCBS specialists to collect data by each specific waiver.

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented a system to assure that plans of care for waiver participants are adequate and services are delivered and are meeting their needs.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13

- 1 The State does not substantially meet this assurance
(The State demonstrates a pervasive failure to meet this assurance and has no internal plan of correction.)

Recommendations:

(Required – when the State does not substantially meet this assurance.)

For the State to meet this assurance, CMS is requesting a CORRECTIVE ACTION PLAN for the State to implement a process to monitor and document that the POCs are updated, revised when needs and/or services change, and that problems have been resolved. CMS requests the State develop a process which includes reporting documentation on how they will begin to monitor and document the changes that need to occur to consumer's POCs. CMS requests the State provide this process within 6 months. The process should include the following:

- a) Segregated data for AIDS consumers;
- b) Reports with analysis of data ;
- c) Summaries of data analysis;
- d) Documentation of discussion and recommended actions on the part of the State to address findings that do not meet the threshold or that are unacceptable
- e) Follow-up actions taken and documented
- f) Report, including analysis, concerning the satisfaction survey of all consumers interviewed
- g) QI monitoring results from monitoring for abuse, neglect, and exploitation; and complaints of and by AIDS waiver consumers.
- h) Summaries of incident reports that are reported to the QA committee
- i) Reports and analysis, actions, and follow-up of Iowa IFMC monitoring findings.

It is also recommended that the State continue the QA Committee meetings. CMS suggests the State use their QA Committee meetings to report monitoring findings and data and analyze and trend this information. As stated in the previous section, CMS requests the State send on a quarterly basis the QA committee meeting minutes.

It is recommended that the State develop a system whereby consumers are given a comprehensive list of providers they may choose from. This could be a current provider listing on the State website, or information that could be provided during annual consumer assessments. CMS requests a timeline and will follow-up with the State within 6 months to document progress.

The regional office would also like to offer technical assistance to the State in developing a more comprehensive quality assurance plan. This may include topics such as reporting mechanisms, analyzing data, and general State oversight. Additionally, please consider utilizing CMS' contractor, Medstat, to assist you in this process.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Authority: 42 CFR 441.302; SMM 4442.4

The State substantially meets this assurance X
(The State has an adequate and effective for qualifying and monitoring providers, and demonstrates ongoing, systemic oversight of providers.)

Recommendations:

CMS recommends the State formally document the process for monitoring providers on a periodic basis, to ensure they meet required licensing and/or certification standards and adhere to other State standards. In addition, the State should track the number of AIDS/HIV providers selected annually for certification review and maintain written documentation of the provider certification reviews. This documentation would demonstrate the State is monitoring oversight and provide data that could be aggregated and trended for QA purposes. This data could then be taken to the QA committee to improve the overall quality of the waiver as it relates to waiver providers. CMS requests the State provide a timeframe for the completion of these recommendations.

It is also recommended the State QA Committee develop a QA process to monitor complaints as a whole from all sources including the local level. CMS requests to see a timeline for this process as well evidence of the process such as written rules and data collected and will follow-up with the State within 6 months to document progress.

The State should also modify the complaint log to include columns to identify the specific waiver, type of complaint, follow-up action taken, and a designation that the

complaint committee has reviewed the complaint. The complaint committee should meet on a regular basis and generate a report quarterly of the summary of findings and actions taken to resolve the complaints and the report should be taken to the QA committee to review for QA/QI purposes. CMS request a timeframe for the completion of these tasks.

As stated in the LOC section, it is recommended the State update the quarterly summaries reporting procedures for HCBS specialists to collect data by each specific waiver. The data can then be aggregated and trended for by specific waiver for QA/QI purposes to make recommendations to improve the overall quality of the waiver provider oversight.

The State should also document and implement a formal oversight plan of licensed and non-licensed providers into their QA/QI plan. This oversight will provide documentation that providers are monitored on periodic basis to provide sufficient protections to waiver participants. In addition, the State will be able to assess and identify specific training needs specific with regard to CDAC services.

CMS recommends the State develop a system for tracking provider training for monitoring purposes. CMS also recommend the State provide AIDS/HIV disease specific training to providers and provide documentation to CMS of the completion of this training such as training materials, and agenda.

VI. Health and Welfare of Waiver Participants

The State must demonstrate that it assures the health and welfare of waiver participants including identification, remediation and prevention of abuse, neglect and exploitation.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 447.200; SMM 4442.4; SMM 4442.9

The State substantially meets this assurance X
(The State's system to assure health and welfare is adequate and effective, and the State demonstrates ongoing, systemic oversight of health and welfare.)

Recommendations:

(Not all States that substantially meet this assurance will have full and comprehensive systems to assure health and welfare; improvements may be warranted.)

As stated in the qualified provider section, it is recommended that a mechanism be established at the local level for DHS to formally track all complaints. There should be a process in place that reports to the Department what complaints are received, what actions are taken, what follow-up occurred, and what referrals were made to the complaint committee. The State should also be able to separate complaints and documentation for each waiver to ensure that there is monitoring and evidence of assurance of health and welfare for waiver participants in each specific waiver. CMS requests a written plan and timeline for this process and will follow-up with the State within 6 months to document progress.

Also, the State should implement a formal process to track deaths for AIDS/HIV waiver consumers and document and report the results to the QA committee to analyze and act upon. CMS requests the State provide a timeline for the completion of this task.

It is also recommended that the State implement the plans for a future rule to include all incident reporting for all waivers. CMS requests the State to provide a timeframe for this action and follow-up based on the timeframe provided.

The State should continue to design a process to track and trend HCBS complaints received through the new hotline for follow-up. CMS requests the State provide a timeline for completion of this task.

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The State must demonstrate that it retains administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application.

Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

The State substantially meets this assurance X
(The State Medicaid agency has an adequate and effective system for administrative oversight of the waiver, and the administration of the waiver program is consistent with the approved waiver.)

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 42 CFR 447.200; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

The State substantially meets this assurance X
(The State's system for assuring financial accountability is adequate and the State demonstrates ongoing, systemic oversight of waiver finances.)

Tab I

DATA FROM CMS HOSPITAL COMPARE AND
NURSING HOME COMPARE DATABASES

| HOSPITAL MEASURES | | | |
|------------------------------|---|------|-----|
| | | IOWA | USA |
| Surgery Measures | | | |
| 1 | Percent of Surgery Patients Who Received Preventative Antibiotic(s) One Hour Before Incision | 85% | 83% |
| 2 | Percent of Surgery Patients Who Received the Appropriate Preventative Antibiotic for Their Surgery | 91% | 90% |
| 3 | Percent of Surgery Patients Whose Preventative Antibiotics are Stopped Within 24 Hours after Surgery | 80% | 80% |
| 4 | Percent of Surgery Patients Whose Doctors Ordered Treatments to Prevent Blood Clots From Certain Types of Surgeries | 81% | 80% |
| 5 | Percent of Surgery Patients Who Received Treatment to Prevent Blood Clots Within 24 Hours Before or After Selected Surgeries to Prevent Blood Clots | 78% | 76% |
| Myocardial Infarction | | | |
| 1 | Percent of MI Patients Given Aspirin at Arrival | 91% | 93% |
| 2 | Percent of MI Patients Given Aspirin at Discharge | 87% | 91% |
| 3 | Percent of MI Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction | 91% | 87% |
| 4 | Percent of MI Patients Given Smoking Cessation Advice/Counseling | 95% | 92% |
| 5 | Percent of MI Patients Given Beta Blocker at Discharge | 92% | 91% |
| 6 | Percent of MI Patients Given Beta Blocker at Arrival | 89% | 89% |
| 7 | Percent of MI Patients Given Fibrinolytic Medication Within 30 Minutes of Arrival | 51 | 39% |
| 8 | Percent of MI Patients Given Percutaneous Coronary Interventions Within 90 Minutes of Arrival | 76% | 63% |
| Pneumonia Measures | | | |
| 1 | Percent of Pneumonia Patients Given Oxygenation Assessment | 100% | 99% |
| 2 | Percent of Pneumonia Patients Assessed and Given Pneumococcal Vaccination | 84% | 77% |
| 3 | Percent of Pneumonia Patients Whose Initial ER Blood Culture was Performed Prior to the Administration of the First Hospital Dose of Antibiotics | 92% | 90% |
| 4 | Percent of Pneumonia Patients Given Smoking Cessation Advice / Counseling | 75% | 85% |
| 5 | Percent of Pneumonia Patients Given Initial Antibiotic within Six Hours After Arrival | 96% | 93% |
| 6 | Percent of Pneumonia Patients Given the Most Appropriate Initial Antibiotic | 87% | 87% |

| | | | |
|---|--|-----|-----|
| 7 | Percent of Pneumonia Patients Assessed and Given Influenza Vaccination | 84% | 75% |
| | Heart Failure Measures | | |
| 1 | Percent of Heart Failure Patients Given Discharge Instructions | 63% | 68% |
| 2 | Percent of Heart Failure Patients Given an Evaluation of Left Ventricular Systolic Function | 78% | 86% |
| 3 | Percent of Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction | 84% | 85% |
| 4 | Percent of Heart Failure Patients Given Smoking Cessation Advice / Counseling | 83% | 88% |

NURSING HOME MEASURES

| Measures | Average in Iowa | National Average |
|---|--------------------|---------------------|
| <u>Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season</u> | 90% | 88% |
| <u>Percent of Long-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination</u> | 95% | 87% |
| <u>Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased</u> | 15% | 16% |
| <u>Percent of Long-Stay Residents Who Have Moderate to Severe Pain</u> | 4% | 4% |
| <u>Percent of High-Risk Long-Stay Residents Who Have Pressure Sores</u> | 8% | 12% |
| <u>Percent of Low-Risk Long-Stay Residents Who Have Pressure Sores</u> | 2% | 2% |
| <u>Percent of Long-Stay Residents Who Were Physically Restrained</u> | 2% | 5% |
| <u>Percent of Long-Stay Residents Who are More Depressed or Anxious</u> | 17% | 14% |
| <u>Percent of Low-Risk Long-Stay Residents Who Lose Control of Their Bowels or Bladder</u> | 43% | 50% |
| <u>Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder</u> | 7% | 6% |
| <u>Percent of Long-Stay Residents Who Spend Most of Their Time in Bed or in a Chair</u> | 1% | 4% |
| <u>Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse</u> | 12% | 13% |
| <u>Percent of Long-Stay Residents With a Urinary Tract Infection</u> | 9% | 9% |
| <u>Percent of Long-Stay Residents Who Lose Too Much Weight</u> | 8% | 9% |
| <u>Percent of Short-Stay Residents Given Influenza Vaccination During the Flu Season</u> | 86% | 77% |
| <u>Percent of Short-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination</u> | 89% | 79% |
| <u>Percent of Short-Stay Residents With Delirium</u> | 3% | 2% |
| <u>Percent of Short-Stay Residents Who Had Moderate to Severe Pain</u> | 25% | 20% |

Percent of Short-Stay Residents With Pressure Sores

11%

16%

Tab J

2007 State Children's Health Insurance Program (SCHIP) Data: Iowa

2007 State Children's Health Insurance Program (SCHIP) Data: Iowa

In order to measure improvement in the delivery of, access to and quality in the State Children's Health Insurance Program (SCHIP), in 2003, States began collecting data on four core clinical performance measures: (1) well child visits in the first 15 months of life; (2) well-child visits in the third, fourth, fifth, and sixth years of life, (3) use of appropriate medications for children with asthma; and, (4) Children's access to primary care practitioners.

Iowa reported data for all four core measures. Rather than report the percent of children who received a specific number of well child visits in the first 15 months, the State reported the percent who received at least one such visit. The rate for this measure increased by 8.5 percentage points between 2006 and 2007.

The rates of Well Child Visits for Children in the 3rd, 4th, 5th, and 6th Years of Life declined between 2005 and 2007 for 4- and 5-year olds. The percent of 6-year olds receiving well child visits was quite low for each of the 3 years reported.

The percent of children in each age group measured who used appropriate asthma medications rose consistently and considerably over the three-year period, 2005-2007. Children's Access to a PCP declined noticeably between 2005 and 2007 for 12-24 month-old children. Rates for the other three age groups reported changed little over the three years reported. The lowest rates over the 3-year period were reported for the age group, 25 months to 6 years.

We would appreciate the State's efforts to provide the percent of children in the first 15 months who receive specific numbers of visits. We would also appreciate additional information to explain the low rates and downward trends in certain measures, discussed above. We will be glad to provide technical assistance to enhance the State's reporting of each of these measures.

Well Child Visits in First 15 Months (W15)

| Visits | 2005 | 2006 | 2007 ** |
|--------|-------|-------|---------|
| 0 | * | * | * |
| 1 | 55.2% | 53.2% | 61.7% |
| 2 | * | * | * |
| 3 | * | * | * |
| 4 | * | * | * |
| 5 | * | * | * |
| 6 | * | * | * |

* State reported only the number of children who had one or more well-child visits

** Claims were expanded to include in this measure from a five to seven month timeframe surrounding the date the child turned 15 months of age.

Well Child Visits for Children in the 3rd, 4th, 5th, and 6th Years of Life

| Age | 2005 | 2006 | 2007 ** |
|------------|-------------|-------------|----------------|
| 3 | 47.3% | 46.6% | 49.9% |
| 4 | 58.7% | 59.3% | 55.9% |
| 5 | 62.2% | 61.2% | 58.2% |
| 6 | 22.5% | 19.8% | 21.6% |

Use of Appropriate Asthma Medications (ASM)

| Age (yrs) | 2005 | 2006 | 2007 |
|------------------|-------------|-------------|-------------|
| 5-9 | 66% | 75% | 85% |
| 10-17 | 56% | 63% | 86% |
| 5-17 | 60% | 68% | 86% |

Children's Access to PCP (CAP)

| Age (mo/yrs) | 2005 | 2006 | 2007 |
|---------------------|-------------|-------------|-------------|
| 12-24 mo | 95% | 90% | 88% |
| 25 mo-6 yrs | 87% | 88% | 86% |
| 7-11 | 92% | 92% | 93% |
| 12-19 | 94% | 94% | 94% |