ROUGH EDITED COPY

CONSUMER: CASEY JUDD

EHDI

NARITA A/B – ACCESSIBILITY OF HEARING AID SERVICES

MARCH 5, 2019

CART CAPTIONING PROVIDED BY: SHERRIN PATTI

ALTERNATIVE COMMUNICATION SERVICES, LLC

www.CaptionFamily.com

\* \* \* \* \*

This is being provided in a rough-draft format. Communication Access Realtime Translation (CART) is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings

\* \* \* \*

>> I'm going to go ahead and get started. My name is Caitlin and I'm here to talk to you about Iowa medicaid. I know it's a barnstormer topic that everyone is so excited to hear about but I'm really, really interested in medicaid policy and how the policy that's at work at the state and national level really impacts our ability to do the clinical work that we're trained to do that I know we're motivated to do. I am here kind of representing the Wendell Johnson hearing and speech clinic and this started as a QI project out of our training clinic. It's associated with the University of Iowa's AU training clinic. There are faculty supervisors and we see about 6‑10 new students every year. They get their experience in the student clinic. I have a few goals for this presentation, things I want you to take away. Recognize the union of medicaid and audiology. Someone tries to tell you that's a policy question, that's for the public health people. I disagree. This is our lane. We are the ones that know about the impact of audiology. Be familiar with some policy changes at work in your state. If you think you're imagining something does it seem it's harder than it used to be to get medicaid coverage you're not imagining it. And appreciate the way that demographic changes can influence the way you plan clinical services. I will start with background around medicaid and I have two QI geared research questions as well as future directions. So moving into some medicaid background I think people, most people know children with medicaid are covered for hearing aids and you have equal model if you have coverage you have access you don't have to worry about who is going to pay for those hearing aids, how they're going to get on your ears. I would argue this relationship is kind of mediated by this other factor provider participation. It doesn't matter how strong your coverage is for hearing aids if there is no one in your community who will take your coverage. There's going to be an impact that's differential depending on your socioeconomic status. If you have the means to travel to a community that has providers.

Nationwide state medicaid programs are extremely popular. One in five Americans kind of has medicaid as their primary insurance. Especially for adults and children with disabilities. I will have you jump to that second section, when we talk about children in the United States, more than a third of American children have insurance coverage through medicaid. If you think about the incidence and prevalence of hearing loss many of the children who are served in EI, many of the children who are served by pediatric audiology departments are bringing medicaid coverage with them. Medicaid will cover hearing aids and it's kind of based on this early periodic screening diagnostic and treatment kind of aspect of medicaid. The EPSDT guarantees that if there's a medical condition for which we regularly screen kind of in your pediatrician's office, things that are screened for at birth, if we're screening to detect them, medicaid is going to cover the treatment. That's a major principle of screening is gnat ‑‑ not only do we want to screen for conditions that are fundamentally important but for those that we have the tools to intervene on and hearing loss is well within that scope.

If you're curious of other things that are screened this is available from the American academy of pediatrics. You would be interested to see what they're supposed to get. They need to cover the price of the screening so that diagnostic ‑‑ that screening code in the newborn nursery. They need to cover the diagnostic hearing evaluation so that once kids move forward in the EHDI process they should be paying for the ABR. When a permanent childhood hearing loss is detected they need to be paying for hearing aids. They do want you to work within a medical home system so medicaid will require that audiologists have a referral on file. Medicaid programs will vary distinctly from state to state. In 2014 there was a model put forth for states who have privatized medicaid. That's like the state of Iowa and also Texas and they recommended that as private insurance companies moved into the medicaid space they needed to guarantee certain quality aspects of medicaid programs. Including provider density, distance and travel time so how far are patients traveling to get to sort of critical services covered by medicaid? And then what is the wait time for those appointments? Appointments for not only your specialist but getting in for specialty appointments when it's indicated my research today will look at provider density or how many audiologists are there per enrollee in the medicaid system in Iowa we cover one in seven adults.

And you can kind of look at the balance of people who are enrolled in medicaid versus where the cost of medicaid go. So, you know, young working adults and children make up the bulk of people who are enrolled in medicaid but they actually represent a small amount of the total expenditures from state medicaid programs. In Iowa, as we said we've moved into the MCO market. The managed care organizations. Traditionally Iowa was a fee for service state meaning it functioned essentially like private health insurance, you're a physician or specialist.

Insurance can adjust the rate and send you kind of the compensation that they they you're due. In 2016 we moved into the managed care system.

With three providers at that point, health, group, and UnitedHealth. That's a small amount of COs to cover the state. They're going to get the quality up, they're going to get the prices down. That didn't end up being the case in 2017 in October we had one of those three companies exit the market leaving us with just two. They keep telling us another one is going to enroll but I haven't gotten the paperwork to enroll as a provider yet. I will tell you about the quality we address with our work.

The first is to get the lay of the land. You know, if I'm a patient and I need audiology services, what are the tools that I'm using and how accurate are they? Where are my medicaid representatives sending me for information about who can see for my audiology needs and finally within our clinic, has the number and sort of distribution of the patients we see changed as those policy changes came into effect in our state? Looking first at kind of the accuracy piece. And here a little bit about our methods. We wanted to approach this from a naturalistic perspective. Thinking let's put ourselves in the shoes of parent. A parent who needs hearing services for the child. What are they look towards. Call the phone number on the medicaid website. They kind of directed us to the medicaid provider directories online. We went through those that remain we combed the directories looking for audiologists. You can't search the whole state at once so we picked cities about 100 miles away from each other. We did overlapping areas. Once we had every listed we took out duplicates of people who were in two of the same groups. And then we did a confirmatory contact with a member of our research team.

We were looking to see are you still a medicaid provider? Do you bill for only hearing tests? If you're not still taking it for hearing aids, when did you stop and if you're not taking them anymore who are you sending families to when they call on the phone? I worked with one undergrad so I always put her name in her because she did such a good job. She was nervous on the phone. If you get a phone call out of the blue saying are you taking medicaid, why, when did you stop? She had some interactions with people and she had forward some to me. We were both named Caitlin and they would get the right person no matter who they called back. Here's the state of Iowa. Here's our search area. And so I'm kind of just going to walk you through what we find. Big picture. Who are the audiologists working in Iowa? We have 286 audiologists with a current license. Or a publicly available information you can search through current license. We have 122 unique audiologists who are currently providing some sort of service within the medicaid system. They're listed on the website. They still return when you go to those web resource and ask who should I be going to. We found that only 81 of those audiologists are doing any participation in Iowa at all. There were actually some women health nurse‑practitioners who had been listed as audiologists. Some who retired. Some who actually died and were no longer provided any services in the state of Iowa ‑‑ who is providing the hearing aid services we see actually there are only 49 audiologists enrolled in the Iowa medicaid program who will actively schedule patients for hearing aid evaluations and fittings.

The funny thing is actually only 32 of those audiologists are even in the state of Iowa. We see 17 out of state picking up the slack. And we will look at the map to see who is outside of Iowa pulling their weight in the Iowa medicaid program. One of the limitations of the study is it's self‑report. We are calling people on the phone and how often do you come up with an answer that sounds like what you think the other person want to hear. What is an option we have for corroborating these findings. If we can go to a third party source and I tried reaching out to medicaid to say can you tell me how many unique people are actually participating. I got nothing. Just crickets. No one calling me back. And I understand, it's kind of a black eye for medicaid that they may not be pulling up their end and I think about the kinds of people who are most commonly getting medicaid hearing aids. Often children I said why don't I reach out to a hearing aid company who provides a lot of audiology products for the state of Iowa will they tell me how many unique audiologists are billing. It's 29. This is from Phonak and I asked Oticon the same question and it was similar.

Two audiologists reported they're currently fitting hearing aids under the system and Phonak said 29 people is what we see. Over the past year 29 unique audiologists submitted an order with the pricing. Here's the provider distribution. I don't know how many of you guys are in Iowa. You are looking at our state. The practice size is made to represent how many audiologists work in that so what you might see is our urban areas so primarily Des Moines Iowa City, they have lots of coverage, so if you're a child growing up in one of those communities, a more urban area, you likely have access and there's kind of a few more spread throughout the state but then you also see vast tracks where those families are going to be driving a long way. There's a single provider up in Algona. Her clinic is open two days a week.

So there may be some vast areas not well served currently from the medicaid hearing system. Here are the providers outside the state of Iowa. That big circle over in Nebraska represents Boys Town National Research Hospital where I know many Iowa children are served just over the border.

Additionally there's a large practice, I'm blanking even on what the name of the clinic is. Gunderson, thank you. And they are ‑‑ enroll seven audiologists who bill medicaid for hearing aids.

So as I mention the limitation this was a self‑report measure. We corroborated that. We stopped collecting. It's hard to say if there's been change since last summer.

Future directions, I would love it if we could corroborate this directly from state medicaid that would not only give you the corroboration number but gives you a contact number to say does that seem acceptable to you and finally we would like to present these findings to Iowa medicaid. Our second ‑‑ now we know there are fewer and fewer people who are providing medicaid services can we see that there's a detectable change in, for example, the pediatric patient who is ‑‑ patients who we see in our clinic.

This is the same gum shoe research, it really is the combing through the records one by one, nothing super, super sophisticated. We schedule our patients through electronic medical records. That started in 2016. There was an effort made to find the schedule before that time. It was in a paper book at the front of the desk. They were not available. They were we were look for scheduled encounters for those patients under age 18. Total number of encounters. There's kind of a cyclic nature of hearing aid fitting in kid so you'll be sign for an ‑‑ seen for an evaluation and then scheduled for a fitting and then the first evaluation after that.

We counted total numbers of encounters not unique patients. It's important to plan for those patients even though it's repeat patients. And then we manually tally them. How many kids are being seen in a given month? And here's the raw data. The blue bars represent all kids under age 18 and then the green bar is just under age three. We are looking for an increase in those kids. It's cyclical data. It goes up and down. We have, you know, as clinic planners we know, oh, in July we have a pediatric program so our number of kids goes way up. We know in December the AUD students will go home on holiday. We will always have this drop. It makes it hard to look across this span and get an intuitive feel for has anything increased.

One option to plot the different years, month by month. So this is kind of a lot going on but I'll have you look at an example month like July. So that lowest month would represent July of 2017. And then by 2018‑19 fiscal year you see this big jump. So even controlling for the month of the year, knowing this is July, this is when we'll see the most pediatric patients we still see this big difference in the amount of patients who are being seen in a given month in one of those two pediatric patient categories.

You know, it's hard to say statistically, is that a big difference? Can we say that's an important different. One option we thought is to look at timing. What was really happening in the Iowa health community at that time? We are in Iowa City, we're a student run clinic. Right next door there's a large university based medical center that also participated in the medicaid system and as the MCOs rolled out those community partners stopped taking medicaid so suddenly within the Iowa City area there were no other community partners accepting medicaid for hearing aid services so one option, what we ended up doing was saying, let's just cut the data off then and say at this point we were the last man standing for hearing aids. Can we say that just our monthly average prior compare to our monthly average after our community partners took that step? And we can say that, yes, for both the 0‑18 group narrowing the 0‑3 group we see our average number of appointments has increased significantly. The timescale, you know, were we already increasing in April 2016? Were we limited to our ability to not go back to the paper schedule and these are pretty broad categorizations so if I'm a student clinician and capable of serving an 18‑year‑old does that carry over to the very youngest patient. Should those be grouped together? So future directions with this project you know, I want you to think back to that model from 2014. This is health and human services from the ‑‑ under the Obama administration gave us these guidelines to say you're free to privatize your medicaid system but this is the bare minimum. This is the level of quality you need to be delivering to those in medicaid. Looking at those 32 Iowa audiologists we can see there's one participating for every 12,000 Iowans who are enrolled the recommendations from that position statement said for specialists they recommended no more than 1200 so today we can say, no, we are not meeting this quality benchmark. Not enough hearing aid services for those enrolled. In the state of Iowa adults are also covered for hearing aids in addition to children. This doesn't represent enough participation. Anecdotally our waitlist is incredibly long for adults to get in. We can also look at distance, travel time, this is a question that may be well answered by partnerships for state EHDI programs. This is captured in our EHDI information system and back for wait time. Now that we have that list of 32 participating audiologists we'll just hit the phones again. Call them back up. When is the appointment starting from today? How long will I wait for the fitting, for the evaluation and do those fall within recommendations. Different recommendations are at work within different states. Some are in five days to see your primary care provider and with some in about a month to get in with a specialist which we assume audiology will fall under although there are no specific delineations.

For our planning purposes there's major implications. If we see a more challenging population. Staffing and supervision is a question. Are the same supervisors with essentially all experience serving adults seeing a lot of adults in our student training clinic which had been for more adults who are ready to try hearing aids? Did their need to be some sort of additional training for supervisors to make sure students are following best practices? Some of these patients within the medicaid system can be complex. One qualification to get medicaid is additional developmental disabilities and, you know, are we considering hears login concert with other developmental challenges. Referrals and compliance. So it may not be a habit within the student training clinic to enter results in the EHDI database. Are we following up with reports back to pediatrician to early interventionist to your school team. Each and every time? And then we all know that we serve sometimes really vulnerable populations which can have its own considerations. Do their need to be more flexible scheduling. It's kind of measures taken and are we taking all the steps we can to provide ‑‑ really human care. With those challenges, I mean, you can turn a lot of them on their head and say these are additionally opportunities. This is going to be the water in which our students will go onto swim with professionals. Learning the right way helps you to practice the right way. There's opportunities for new collaboration. We're going ‑‑ I'm going to show you a slide we're adding ABR services. Nonsedated ABR services this provides an opportunity to collaborate with specialists who we were not meeting halfway. Things such as infectious diseases. Expanded clinic scheduling.

Do we need to have an ‑‑ previously our clinic has not seen patients for example on Friday. Do we need to add additional time. Refining protocols when we see babies with CMV, kids with cranial facial anomalies once we see more kids do we need to refine the practice that we do? Then being responsive within our clinic planning as medicaid changes in our state we may shoulder your burden of the medicaid population and we need to acknowledge the students that, yeah, this is different and this is new but this will also be part of your job. Letting your clinical practice rise to meet the changes that will always present themselves within health care policy in the U.S. One example of our policy responsive clinic planning has been adding diagnostic infant services to our student training clinic. This is something we just got off the ground. We've seen about four babies and I think it's a new challenging opportunity. The students are really excited. And it provides meaningful contact points to teach lessons about EHDI which may not be well communicated just in the classroom. I think there's nothing like scrubbing a tiny newborn baby to give you lessons which you may have taken in a classroom. In summary I hope you feel more convince ed that medicaid is important for services. Participation may be less than it appears. If you talk to a medicaid rep that says, no, audiologists, we have plenty.

You know, ask them how often they're collecting that metric. You know for today, knowing that six months from now things might be quite different but knowing about the changes gives you a power to have a voice and then responsiveness is a challenge but I think it's a pleasant one. Provides opportunities to collaborate with your state project, you know, talking to those within your service center so if you're in a hospital for example. They probably don't know as much about hearing aids as you do. So taking that opportunity to be a voice for kind of the most needed areas of change within our field. Does anyone have any questions about ‑‑ I know medicaid is like the ‑‑ it topic everyone wants to ask about but I appreciate you guys coming today.

I don't have my e‑mail up here but I am happy to give it to you if you have questions about your own medicaid or need anymore information.  
>> (Speaker far from mic).  
>> I ‑‑ she asked if I had a list of the medicaid providing audiologists. I do. As we sort of prepare this gathering these two other aspects we will probably publish something about this and we kind of haven't talked about what to do with that info in the meantime. You are not only the one who had asked about that. If you're looking for a specific area I am happy to share with you kind of a clinical approach, who you need in your community. Yeah. All right. Thank you so much. Enjoy the rest of the conference.  
>> (APPLAUSE).