FINAL REPORT OF THE

DEPARTMENT OF HEALTH'S STUDY OF THE POSSIBILITY OF A PROGRAM BEING ESTABLISHED FOR THE SALE OR RENTAL OF HEARING AIDS TO THE HEARING-IMPAIRED POOR TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 16

COMMONWEALTH OF VIRGINIA
Richmond
1981

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Final Report of the

Department of Health's Study of the Possibility of a Program Being Established for the Sale or Rental of Hearing Aids to the Hearing-Impaired Poor

To

The Governor and the General Assembly of Virginia

Richmond, Virginia

January 1981

To: Honorable John N. Dalton, Governor of Virginia

and

The General Assembly of Virginia

I. INTRODUCTION

During its 1979 session, the General Assembly passed Senate Joint Resolution No. 172 creating this study. That resolution is as follows:

SENATE JOINT RESOLUTION No. 172

WHEREAS, the Commonwealth presently has no comprehensive program to provide hearing aids to its hearing-impaired citizens who cannot afford them; and

WHEREAS, hearing rehabilitation programs for the poor, presently conducted through the Bureau of Crippled Children and the Department of Vocational Rehabilitation, provide no assistance to the vast majority of Virginia's poor who are hearing-impaired; and

WHEREAS, the federal Medicare program does not presently cover the cost of hearing aids for the elderly, and only veterans are assisted by hearing rehabilitation programs of the U. S. Veterans' Administration; and

WHEREAS, a 1978 study conducted by a joint subcommittee of the Committees on General Laws of the Senate and House of Delegates found there to be a great need for hearing aids among Virginia's poor, particularly the elderly; and

WHEREAS, many of these latter Virginians cannot afford hearing aids presently available commercially; now, therefore, be it

RESOLVED by the Senate of Virginia, the House of Delegates concurring, That the State Department of Health is hereby requested to study the possibility of establishing a program for the sale or rental of hearing aids to the hearing-impaired poor of the Commonwealth. The Department is requested to consider both the costs occasioned by such a program and the mechanism by which it could be put into operations; and, be it

RESOLVED FURTHER, That the Department is requested to submit a report of its findings and recommendations to the General Assembly upon the completion of its study.

II. DISCUSSION

To carry out the study, the State Health Commissioner appointed the following Committee members: Willard R. Ferguson, M.D., Director, Bureau of Crippled Children; Frank M. Butts, M.Ed., Director of Audiology and Speech Pathology, Medical College of Virginia; S. James Cutler, representing the Virginia Council for the Deaf; Thomas M. Deadmore, Purchase Manager, Department of Purchase and Supply; Pat T. Dewey, M.Ed., Speech and Hearing Services Administrator, Bureau of Crippled Children; William Gates, representing the Association of Hearing Aid Dealers; K. Michael Kines, Administrator of Facilities Services, Virginia Medical Assistance Program; Jose A. Lafitte, Ed.D., State Coordinator, Hearing Impaired Program, Department of Rehabilitativ Services; Pam R. Lathrop, State Planner, Office on Aging; Stephen R. Thomas representing the Lions Club.

This is the Department of Health's final report to study the possibility of establishing a program to sell or rent hearing aids to the poor. The Committee's first order of business was to gather statistics to determine the extent of the problem and volume which would be involved and the criteria to use in defining the term poor.

According to estimation, the total population of Virginia is 5,211,518[1] and 344,117[2] are hearing impaired to the degree requiring amplification for communication, a prevalence rate of 6%. Approximately 440,000 Virginia citizens are 65 years, or older. If one applies the estimation rate stated by the Office of Aging that 5% of the citizens 65 or older require hearing aids, as many as 22,000 Virginians could require amplification. Of the 54,790 Medicaid enrolls 65 or older, this 5% rate indicates that as many as 2,739 could require hearing amplification.

The Department of Health, Bureau of Crippled Children and Department of Rehabilitative Services provide hearing aid services for children and young adults who are defined as poor. This Committee reached the same conclusion as the Committee on General Laws of the Senate and House of Delegate did in 1978, when they found a great need for hearing aids among the Virginia poor, particularly the elderly, who were not covered under state or federal programs.

[1]Tayloe - Murphy Institute

[2]Schein and Delk

Based on analysis of the data gathered, the Department of Health Committee feels the numbers requiring amplification is so great, creating too large a commitment on a short supply of state tax dollars. Therefore, the pragmatic course is to recommend a plan covering only the poor as defined by the Medical Assistance Program and limiting consideration to the Medical Assistance Program eligible population. After limiting the program a comprehensive plan for the purchase and fitting of hearing aids (attachment 1) was designed. Attachment 2 gives a review of equitable fees and estimated costs of such a plan assuming 2,500 clients. The following approaches were reviewed and discussed.

The Committee studied four state plans for procurement of hearing aids including South Carolina, Michigan, Alabama, and Arizona, relative to their strengths and weaknesses and their applicability to Virginia.

The Committee next evaluated proposed rules promulgated by the Health Care Financing Administration governing the reimbursement for hearing aids through Medicaid programs as published in the Federal Register.

There are three systems for purchasing hearing aids: (1) volume purchase plan, (2) acquisition cost plan, and (3) some combination of the two.

A review of the proposed rules promulgated by the Health Care Financing Administration governing the reimbursement for hearing aids through Medicaid programs reveals that both a Volume Purchase Plan (VPP) and an Acquisition Cost Plan (AC) have both good and bad points.

Under VPP the State would purchase aids directly from a supplier by bid establishing a contract price and provide a reasonable dispensing fee to the provider based on cost of hearing aid dispensing operations, including costs of rvices, overhead and reasonable profit. The dispensing fee would be based on t price, bid or usual and customary charge to the general public. The State uld buy in quantity from the supplier, who would agree to supply participating providers with the items at the agreed-upon prices or the State might take more control with volume purchasing and warehousing with centralized dispensing by salaried employees through out-patient clinics.

Under an AC program payments to providers would be limited to the lower of actual acquisition cost plus a reasonable dispensing fee, or the provider's usual and customary charge to the public. The dispensing fee would be by a set State price or by bid. The State would determine the conditions of purchase, specifications, and requirements for prescription, fitting, and follow-up.

Legally VPP is a viable option. The State is free to require that Medicaid providers obtain their products at contract prices. The State is also free to retain title to the supplies and either store them in a centralized warehouse or arrange with the manufacturer to ship them to Medicaid providers.

It was the consensus of all Committee members that the greatest potential for cost control involves direct purchase of hearing aids from the manufacturer, by bid, and under contract (Volume Purchase Plan). The State provides volume purchase incentives and can take advantage of the manufacturer's price controls as well as the elaborate communication network with local dealer. The most realistic approach is for the State to deal with the manufacturers for the cost of the aid only and then approve the dispensing fee the State will accept participating hearing aid dealers. If the bid is prepared with care, if

the firm selected is held accountable to the terms of the contract (with penalty clauses for breaking the terms) and if dispensers are paid a fair fee for their services, then Volume Purchase Plan can work, and it can save money.

The next problem involved the determination of a fair and reasonable dispensing fee to the hearing aid dealers who must fit the purchased aid.

The Committee considered the time and costs coincident with a hearing aid fitting step by step. They evaluated the average time required for the fitting of a hearing aid and equated all this to a dispensing fee on a per-required-visit basis applying the dealer's time and costs. This approach enabled the group to develop a suggested dispensing fee which is considered resonable and appropriate.

The final ingredient required for a comprehensive and controlled plan involves follow-up after purchase and fitting of a hearing aid. Follow-up is essential.

If the State purchases and fits a complicated instrument and there is no formal plan for follow-up, it is wasteful, expensive, and not in the best interest of the State and the patient. Training, education in use, instrument adjustment and testing for continuing benefit are required to protect an investment. There is a paramount obligation that the system demands clear and quantifiable evidence that not only the hearing aid is needed and properly fitted, but that it continues to function properly, that the patient demonstrates knowledge of required care and ability to use the aid, and that the aid continues to serve the patient. A follow-up format was therefore incorporated into the formal plan.

The committee could not agree to the designation of a single state agency to manage the program as recommended (Attachment I) even though they recognized the necessity of tying together the otological and audiological report and recommendations; followed by the hearing aid evaluation recommended (specific type of aid); plus ordering the aid; and the report of hearing and fitting and follow-up recommendation.

As the committee could not agree upon a single state agency, it is felt by the Department of Health that as the recipients of the service will be Medicaid eligibles, any funds approved should be awarded to the Medicaid Program. The Department of Health, Bureau of Cripple Children Program has the necessary mechanism in place to manage the plan for children and adults. The Medicaid Program can contract with and reimburse the forementioned program to provide the required services through their ten (10) statewide hearing clinics. The federal participation would be 56.54% and Commonwealth of Virginia 43.46%. It is anticipated that administrative overhead cost will be approximately fifteen (15) % of the total cost of the recommended program.

CONCLUSIONS OF THE COMMITTEE

1. The most practical and realistic target population to be served is medicaid-eligible older persons who need hearing aids during a one-year period.

2. The fear that the bid system will invite inferior and low quality services is not valid. The contract must indicate that if the provider is not

cooperative and/or does not provide satisfactory services, the contract is broken.

3. It was the consensus that the Committee cannot categorically recommend what it considers a fair and equitable fee. Any recommendation must be based on quantifiable and measurable factors supported by data. This should then be reduced to a cost-per-visit figure.

4. It was the consensus of all Committee members that the greatest potential for cost control involves direct purchase of hearing aids from the manufacturer, by bid, and under contract (Volume Purchase Plan).

III. RECOMMENDATIONS

1. The Department of Health should be the central agency for the management of the system.

2. The Medicaid-eligible older persons who need hearing aids were recommended as the population to be covered and the cost analysis is addressed to this group.

3. The hearing aids to be purchased directly from one manufacturer by the bid system and under contract.

4. An approved purchasing list with specifications and characteristics to be determined by a hearing aid selection committee.

5. The following requirements of the manufacturer in addition to any other contract specifications be established:

   a) Warranty of the aids for two years.

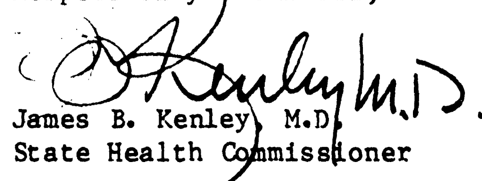
   b) Agreement to mail the hearing aid ordered to any dealer specified by the State.

   c) Review of selected aids allowed after one year with substitutes permitted that do not change overall costs.

6. Follow-up procedures be recommended after purchase and fitting of hearing aids.

7. The findings of the Advisory Committee indicated a sizable portion of the population with hearing impairment. Even when projections are limited to the Medicaid-eligible population, projected cost are high. Because of current budget restrictions the Department of Health does not recommend at this time the implementation of this program but, rather that it be held for priority consideration at a later date.

Respectfully submitted,



James B. Kenley, M.D.
State Health Commissioner

ATTACHMENT I

PLAN FOR THE PROCUREMENT OF HEARING AIDS

OBJECTIVE:

To provide an efficient, quality controlled, and cost effective program for the evaluation and determination of need for hearing aids, and the purchase, fitting, and follow-up for such hearing aid instruments for low income persons in Virginia suffering from defective hearing.

I. Introduction:

Primary and essential inter-related factors required:

A. Examination by an otolaryngologist to determine the nature, cause, and extent of hearing loss; to rule out conductive hearing losses amenable to correction by medical treatment and surgery; and to certify that a hearing aid is proper and required.

B. A full audiological examination by an audiologist including air and bone conduction, speech reception threshold, speech discrimination score in quiet and noise, and impedance.

C. The two steps above insure the need for a hearing aid and is naturally followed by:

1. A hearing aid evaluation by an audiologist to determine the proper and appropriate type of hearing aid required for the individual client.

2. The purchase of the hearing aid.

3. The fitting of hearing aid with instructions on use, care and maintenance of instrument.

4. Follow-up of the person fitted.

These factors must be correctly and efficiently coordinated to maintain a balance between cost containment and quality care.

II. Costs

A. Otolaryngologist
This involves the charge of an office visit. An E.N.T. specialist visit will be required if such specialist is available in a community, otherwise a visit to a licensed physician will be permitted.

B. Audiological
An audiological evaluation (air and bone conduction pure tone testing, speech and impedance autiometry) is reimbursed by the State presently at from $25 to $45 dollars.

C. Hearing Aid Evaluation

Speech reception and discrimination testing as well as discrimination in noise and comfortable loudness levels is presently reimbursed by the State at from $25 to $40 dollars. Aid evaluation also consists of a history taken to determine sociological, educational, psychological and health factors that would affect the habilitation of the patient.

D. Purchase of Hearing Aid

There is a dichotomy in the purchase of hearing aids: approved aid selection list and actual purchase.

1. Hearing Aid Selection System: Approved purchasing list with specifications and characteristics to be determined by a six-member committee representing physician, audiologist and hearing aid dealer; three-member Virginia group (and similar out-of-state group) to determine the general characteristics of a group of hearing aids for purchase.

2. Purchase of Hearing Aid From Manufacturer: With the prepared list, the State Purchasing Office, by competitive bid, to award one contract to a single manufacturer. Requirements of the manufacturer are:

   a.) Warranty of the aids for two years

   b.) Agreement to mail the hearing aid ordered to any dealer specified by the State

   c.) Review of selected aids allowed after one year with substitutes permitted that do not change overall costs

   The greatest potential for cost control lies with the hearing aid manufacturer. The State provides volume purchase incentives and can take advantage of the manufacturer's price controls, as well as the elaborate communication network with local dealers.

   Experience in other States has shown that the success and cost effectiveness of the bid system for volume purchase is dependent on how well the bid is written, how careful the State is in awarding the contract, how well the State monitors the contract, and how well the State deals with its provider.

   If the bid is prepared with care, if the selected firm is held accountable to the terms of the contract (with penalty clauses for breaching the terms), then the Volume Purchase Plan can work and it can save money.

E. Hearing Aid Fitting

To this point the procedures accomplished are:

1. The need for a hearing aid has been determined and confirmed by preferably an otolaryngologist with the support of an examination and an audiological report.

2. The hearing aid evaluation has determined the type and specifications of hearing aid required for that individual client.

3. The device is ordered from the manufacturer with instruction for delivery of the hearing aid to the specific participating hearing aid dealer in the appropriate area of residence.

At this point fitting and dispensing occurs and requires two visits:

1. The first visit involves the making and ordering of an ear mold and preliminary instructions to the client.

2. The second visit involves the fitting and adjustment of the instrument and orientation of the client in the function and care of the hearing aid. Batteries are supplied and a report made.

   Fitting has been completed.

F. Follow-up

A hearing aid is a delicate and sensitive instrument and cannot be fitted and forgotten. It must be monitored, cared for and occasionally repaired and the client must learn to adjust to apparatus, use it properly and benefit from it. Follow-up therefore is essential. Training, education in use, instrument adjustments, and testing for continuing benefit are required to protect an investment.

Procedures include:

1. After fitting, hearing aid dealer and audiologist share pertinent information and recommendations for future follow-up.

2. Within two weeks of the fitting, the audiologist and hearing aid dealer submit a combined report of the fitting and both agree and indicate the proper plan for follow-up and who (hearing aid dealer and/or audiologist) will be involved and how:

   a.) Only this combined report permits payment for follow-up

   b.) Should the hearing aid dealer and audiologist disagree concerning follow-up, the original physician involved will make the final decision.

3. Follow-up recommendations fall within two categories:

   1. Routine. This represents the over-whelming majority of patients. If the client demonstrates knowledge of and ability to use aid properly and care for its use, two visits are permitted in the first thirty days as most difficulties would occur early. Two more visits are permitted after the thirty days any time during the two year warranty. For routine patients, therefore, the State permits four visits following fitting during the two year warranty.

The visit at thirty days from fitting is mandatory. This is the end of the return privilege to the manufacturer and at this time if the hearing aid is not functioning properly or is not benefitting the client, the aid is returned to the manufacturer and the device is not purchased by the State.

2. Extended Follow-up. In the complicated case in which the client is unable to demonstrate proper care and use or there are sociological, psychological or health factors that jeopardize the fitting and use, four visits over a six-week period are permitted for training and counseling followed by one visit per month for three months. This is the maximum number of visits.

   The State will pay only for those visits actually conducted and reported. If extended and concentrated follow-up still fails to provide benefit and client fails to use or improperly uses instrument, it should be returned to the State.

G. Hearing Aid Lifetime

The average life expectancy of a hearing aid is four to five years. It is recommended that if the hearing aid is satisfactory at the end of the two year warranty period, the client is not eligible for another hearing aid for a two year period (making four years from fitting). At that time the client will start over the whole process of evaluation, fitting, etc. if a new aid is required.

During the two year warranty period the aid is considered to be the property of the State. At the end of this warranty period ownership is transferred to the client.

ATTACHMENT II

ESTIMATED COSTS OF A PROPOSED PLAN
FOR A TWELVE MONTH PERIOD
Based on an Estimated 2500 Hearing Aids
at 1980 Dollars

		Cost Per Aid	Total Cost
Manufacturers cost per aid		$100.00	$ 250,000
Dispensing fee		60.00	150,000
Otological Evaluation		50.00	125,000
Audiological Evaluation		35.00	87.00
Hearing Aid Evaluation		33.00	82,500
Routine Follow-up	(70% of clients) (1750)		
Total of Four visits ($15/visit)		$ 60.00	$ 105,000
Extended Follow-up 30% of client	(750)		
Total of Seven visits ($15/visit)		$105.00	$ 78,750
Total direct cost of program			$ 878,750
Total administration overhead cost, 15%			131,813
Total cost			$1,010,563
General Funds	43.46%		439,191
Special Funds (Federal)	56.54%		571,372