COMMONWEALTH *of* VIRGINIA

Department of Medical Assistance Services

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November 1, 2009

MEMORANDUM

TO: The Honorable Charles J. Colgan
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

FROM: Patrick W. Finnerty

SUBJECT: Report on Durable Medical Equipment Reimbursement

Chapter 781 of the 2009 Virginia Acts of Assembly requires the Department of Medical Assistance Services to examine the methodology for reimbursing durable medical equipment (DME), make recommendations on cost savings, and report its findings by November 1. I have enclosed for your review the report for 2009.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

Enclosure

Cc: The Honorable Marilyn B. Tavenner, Secretary of Health and Human Resources

DURABLE MEDICAL EQUIPMENT REIMBURSEMENT

A Report to the
Senate Finance Committee and House Appropriations Committee

Virginia Department of Medical Assistance Services

November 1, 2009

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EXECUTIVE SUMMARY

Chapter 781 of the *2009 Virginia Acts of the Assembly* directed the Virginia Department of Medical Assistance Services (DMAS) to examine the methodology for reimbursing durable medical equipment (DME) and to make recommendations on cost savings. DMAS recommends reductions of 10 percent for DMAS rates that are based on Medicare rates and an average 5.5 percent reduction on DMAS fee schedule rates effective July 1, 2010. DMAS also recommends consideration of competitively bidding incontinence supplies. Using a hybrid approach, DMAS estimates total savings of $3.8 million in state fiscal year 2011 and $5.9 million in state fiscal year 2012 in its Fee for Service program.

INTRODUCTION

Item 306.OOO of the 2009 Appropriation Act directed DMAS to examine the methodology for reimbursing durable medical equipment and to report findings to the House Appropriations and Senate Finance Committees by November 1, 2009, including the specific strategies recommended to effectuate savings. The budget also indicated that DMAS may consider proposals from CGI Technologies Solutions, Inc (CGI). DMAS contracted with CGI and this report is based to a great extent on the work performed by CGI. A copy of Item 306.OOO is included as Appendix A to this report.

BACKGROUND

DMAS fee-for-service (FFS) annually reimburses DME providers over $50 million using multiple reimbursement methodologies. DMAS reimburses 30 percent of DME services via Durable Medical Equipment Regional Carriers (DMERC) rates published periodically by Medicare. Medicare has four DMERCs who are responsible for publishing fees in their region. DMAS uses its own fee schedule, last revised July 1996, for other DME products. When DMAS implemented national procedure codes in 2004, many of the non-DMERC based rates were converted to the appropriate national code. If there is no national code, providers bill a miscellaneous national code, E1399. DMAS uses two other reimbursement methodologies: usual, customary and reasonable charges for products with a national code but no DMERC or DMAS fee schedule rate and cost plus 30 percent for products without a national code or a DMAS fee schedule rate. See Table 1 for a summary of DMAS' current reimbursement policies for DME.

In April 2007, CMS announced the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Part of Virginia was included in Round 2 of the competitive bidding program. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 enacted on July 15, 2008, delayed the DMEPOS Competitive Bidding Program until 2010. MIPPA reduced 2009 DMERC rates by 9.5 percent if the codes were to be included in competitive bidding and increased other DMERC rates by 5 percent.

Table 1 – Current DME Reimbursement Methodology Categories	
DME ITEM	**RATE**
1. DME items that have a national code and a DMERC (Medicare) rate	Rate will be the DMERC (Medicare) rate.
2. If no DMERC rate for a national code	Rate will be the DMAS fee schedule (established July 1, 1996).
3. DME items that have a rate from the DMAS fee schedule, but do not have a national code	The rate will be the DMAS fee schedule (established July 1, 1996).
4. DME items that have a national code, but do not have a DMERC or a DMAS rate	Rate will be the usual and customary charge to the general public.
5. DME items that do not have a national code, and do not have a DMAS rate effective July 1, 1996	Rate will be the manufacturer's charge to the provider, less shipping and handling, plus 30 percent.

In addition to the actions of CMS, DMAS' internal review and audit of DME services provided by Medicaid enrolled providers to Medicaid recipients identified potential areas for improvement to the Department's reimbursement policies. Preliminary comparisons to other Medicaid states and other payers provided support for revision of the reimbursement methodology, as well as the basis for developing cost savings initiatives.

DISCUSSION

The PowerPoint report prepared by CGI is available in Appendix B. To develop the report, CGI collected DMAS claims data and interviewed subject matter experts (SMEs). CGI performed line-item data analysis and benchmarking of pricing from the following benchmark states: Connecticut, Delaware, Indiana, Maryland, Michigan, Missouri, Ohio, Pennsylvania, Washington, and Wisconsin. These states were chosen for similarity to Virginia, including regional proximity, total Medicaid expenditures, size of Managed Care Organization (MCO) program, and population mix between rural and urban. Rate comparisons were adjusted for cost of living differences.

As a result of the interviews and data analysis, CGI developed four approaches to savings: 1) DMERC Code Discount, 2) Non-DMERC Code Discount, 3) Benchmark Rate Match, 4) Competitive Bidding. CGI recommended a hybrid approach of standard rate reductions including DMERC and Non-DMERC reductions and competitive bidding for incontinence supplies that would save between $4.9 million and $6.3 million in FY10;

a percentage reduction between 8.1 percent and 11.6 percent. This hybrid approach recommendation is detailed on page 34 of the CGI analysis report. CGI does not recommend adopting the most competitive rates from other states, rather, reducing rates close to the average for other benchmark states

Hybrid Approach

DMAS recommends implementing the hybrid approach beginning in FY11, but phasing in the competitive bidding of incontinence supplies. The savings estimated by CGI using FFS claims data were trended to state fiscal years 2011 and 2012 in Table 2. These figures reflect the savings only for FFS claims utilization. These savings initiatives may impact MCOs that participate with the Virginia Medicaid Program. MCO reimbursement of DME services does not mirror the FFS reimbursement method and varies across the health plans. DMAS is in the process of evaluating the impact of potential changes on MCO reimbursement methods and capitation payments.

Table 2 – Summary of Savings by Hybrid Cost Savings Approach

CGI Recommended Approach	Estimated Savings* SFY 2011	Estimated Savings* SFY 2012
DMERC Code Discount	$1.8 million	$2.0 million
Non-DMERC Code Discount	$2.0 million	$2.2 million
Competitive Bidding		$1.7 million
Total	$3.8 million	$5.9 million

** Fee for Service program savings only*

DMERC Code Discount

DMAS recommends adopting the CGI proposed 10-percent reduction to DMERC rates effective July 1, 2010 (SFY 2011), resulting in a savings of approximately $1.8 million in SFY 2011; $2.0 million in SFY 2012. Since MIPPA recently reduced some DMERC rates and increased others, CGI considered different reductions; however, the analysis indicates that similar reductions are justified for all DMERC rates.

Non-DMERC Code Discount

DMAS recommends adopting the CGI reductions to the DMAS fee schedule for non-DMERC rates effective July 1, 2010 (SFY 2011). Based on the benchmarking, CGI recommended different reductions by product category, in some cases no reduction or up to a 20 percent reduction in others. See p. 29-30 of the CGI report for the recommended reductions by product category. The proposed savings includes a 10 percent reduction to incontinence supplies. The net savings would be 5.5 percent of current spending for a savings of approximately $2.0 million in SFY 2011; $2.2 million in SFY 2012.

Competitive Bidding

Incontinence supplies are the largest single DME product category, representing more than 30 percent of total DME expenditures. DMAS recommends further consideration of the CGI proposed competitive bidding of incontinence supplies, but does not believe it can be implemented as soon as the other rate reductions. While it may be possible to implement this earlier, this report assumes that, if approved, competitive bidding could be implemented as early as July 1, 2011 (SFY 2012). An estimated $1.7 million in savings from competitive bidding is anticipated in addition to the savings from the 10 percent rate reduction for incontinence supplies which would be effective July 1, 2010. This is the low end of the savings in the CGI report. It is possible the savings could be $1.4 million more. Savings assume there is no offsetting increase in utilization. DMAS also would need to devote resources to procurement and contract monitoring, which currently is not funded.

Competitive bidding of DME products has been used by other state Medicaid agencies. Indiana Medicaid has specifically bid incontinence, ostomy and urological supplies. DMAS has no experience doing so and therefore recommends using a contractor, as Indiana did, to assist DMAS in the competitive bidding of incontinence supplies. If DMAS does not receive funding for a contractor, it may not be possible to implement this. In lieu of competitive bidding of incontinence supplies, DMAS could consider reducing the rates for incontinence supplies by 15-20 percent instead of 10 percent. Five of the benchmark states have lower prices than DMAS for incontinence supplies, an average of 15 percent lower, and two of the states have prices 20 percent or more lower than DMAS prices. Reducing the price of incontinence supplies by 20 percent would achieve most of the potential savings from competitive bidding on the low end and avoid the resource issues related to competitive bidding.

Improvement Opportunities

The CGI report describes other improvement opportunities beginning on page 42. The other improvement opportunities include changes to the miscellaneous code E1399, changes to codes reimbursed at the "Usual and Customary Charge" (U.C.C.) or via "Individual Consideration" (I.C.), and implementation of capped rental periods. While there may be minor cost savings associated with these improvement opportunities, they are for the most part operational efficiencies. Implementing the proposed changes also may involve MMIS system or prior authorization (PA) contract changes. DMAS is in the process of converting to a new MMIS vendor, which impacts the ability to implement system changes. While PA changes may be desirable, DMAS must consider the cost-benefit and the timing of the implementation.

Tables 3-5 summarize DMAS' response to the improvement opportunities.

Table 3 – Summary of Miscellaneous Code E1399 Improvement Opportunities and DMAS Proposed Response (Improvement Opportunities summarized on p. 43 of the CGI report)	
CGI Proposed Improvement Opportunity	**DMAS Proposed Response**
Migrate spending to more appropriate category specific "miscellaneous/NOC" Level II procedure codes.	DMAS concurs with the improvement opportunity and will: 1. Research other Level II codes available; 2. Shift appropriate E1399 codes to these category specific miscellaneous codes. This shift will decrease but not eliminate the use of E1399 miscellaneous codes. As new codes are created, DMAS will notify providers and require use of the new code.
Address problem between KePRO and MMIS systems that cause recorded claim comment fields to not transmit.	DMAS concurs with the improvement opportunity. Implementing this change will require system changes for the PA contractor and may not be implemented immediately due to cost.
Request or require providers to identify local code as first piece of information in comment field. Consider updating PA forms to require this information.	DMAS concurs with the improvement opportunity. The DME provider manual Appendix B contains the list of local codes. DMAS will notify providers to implement this change when the PA contractor is able to transmit the comment field (see previous opportunity.
Proactively ensure KePRO receives Appendix B code updates. Include a "quick check" list of new Level II codes for easy reference by reviewers.	DMAS concurs with the improvement opportunity and will implement this recommendation immediately.

Table 4 – Summary of "Usual and Customary Charge" (U.C.C.) or "Individual Consideration" (I.C.) Improvement Opportunities and DMAS Proposed Response (Improvement Opportunities summarized on p. 46 of the CGI report)	
CGI Proposed Improvement Opportunity	**DMAS Proposed Response**
Establish fixed reimbursement rates for selected items	DMAS concurs with the improvement opportunity and will develop new rates in the DMAS fee schedule for codes with benchmark rates in other states. This would be effective with other rate changes, if approved.
Adopt a new definition of allowable price for U.C.C. claims to facilitate auditing.	DMAS concurs with the improvement opportunity. DMAS will use cost plus 30 percent for any unpriced DME rather than usual and customary charge. This would be effective with other rate changes, if approved.
Tighten Appendix D language regarding I.C. claim requirements.	DMAS concurs with the improvement opportunity. I.C. items are priced at cost plus 30 percent. DMAS will notify providers of any changes. Changes may need to be coordinated with the PA contractor.
Require providers to submit cost evidence for I.C. claims.	DMAS will review this opportunity to determine if there is a positive cost/benefit. Submitting cost evidence up front will require additional work on the part of the PA contractor as well as system changes. Alternatively, providers could be required to maintain adequate cost evidence for post payment audits.
Require providers to submit statements of estimated net costs for I.C. claims.	DMAS will review this opportunity to determine if there is a positive cost/benefit. Submitting cost evidence up front will require additional work on the part of the PA contractor as well as system changes. Alternatively, providers could be required to maintain adequate cost evidence for post payment audits.

Table 5 – Summary of Capped Rental Periods Improvement Opportunities and DMAS Proposed Response (Improvement Opportunities summarized on p. 50 of the CGI report)

CGI Proposed Improvement Opportunity	DMAS Proposed Response
Discount purchases by amount of previous rental payments.	DMAS will continue to review its rental policies. Implementing rental policy changes are contingent on system changes, which cannot be implemented in the near future.
Investigate potential system controls to limit extended rentals.	DMAS will continue to review its rental policies. Implementing rental policy changes are contingent on system changes, which cannot be implemented in the near future.
Adopt rental period caps established by CMS for the Medicare program; 36 months for Oxygen equipment; 13 months for other DME.	DMAS will continue to review its rental policies. Implementing rental policy changes are contingent on system changes, which cannot be implemented in the near future.

CONCLUSION

DMAS recommends adopting a modified version of the hybrid approach CGI proposes for rate reductions as part of the budget process for the 2010-2012 biennium. The DMERC and non-DMERC rate reduction recommendations would be authorized as part of the budget process effective July 1, 2010. If funded to utilize a contractor and for monitoring costs, DMAS recommends that it further explore competitively bidding incontinence supplies. This could be implemented as early as July 1, 2011. All of these changes will require promulgation of revised regulations governing DME services and reimbursement for DME services.

Other opportunities will be evaluated and implemented based on policy and resource decisions. Many of the other opportunities require system changes. DMAS is in the process of converting to a new MMIS vendor which impacts the ability to implement system changes. During the conversion process, system changes are limited and prioritized with mission critical system changes taking precedence. Changes to its PA contract and provider training may incur additional cost.

The Medicaid Program will monitor and track changes in the CMS reimbursement methodology for DME services. As CMS expands the competitive bidding process and/or modifies its reimbursement methods, DMAS will evaluate the impact of these changes on the current and proposed reimbursement policies and methodologies enacted.

APPENDIX A

OOO. The Department of Medical Assistance Services shall examine the methodology for reimbursing durable medical equipment. The Department may consider proposals from CGI Technologies Solutions, Inc. to effectuate savings as part of its review. The Department shall report its findings to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2009 including the specific strategies recommended to effectuate savings.

APPENDIX B

See attached adobe .pdf document of the CGI presentation.

Virginia DMAS DME Rate Analysis

Steering Committee Meeting Report
Updated August 2009

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_experience the commitment ™

Agenda

- Executive Summary
- Project Summary
- DME Expenditures
  - Historical Baseline
  - Projected Baseline
- Benchmarking
  - Process Summary
  - Target States
  - Transitioning Incontinent Undergarment Codes to Per Each Pricing
  - Benchmarking Results
- Rate Recommendations
  - Potential Approaches & Savings Opportunity
  - Decision Framework
  - Approach Recommendation
  - Approach Recommendation Details
- Other Opportunities
- Next Steps

Executive Summary

- Historical claims data, expenditures, and current DMAS fee schedules were used to project the forecasted Durable Medical Equipment and Supplies (DME) expenditures baseline.
- Rate benchmarking was conducted focusing on ten comparable states including Connecticut, Delaware, Indiana, Maryland, Michigan, Missouri, Ohio, Pennsylvania, Washington and Wisconsin.
- The Phase 1 Rate Analysis exercise reveals multiple opportunities for cost savings as well as a number of process improvements.
- CGI recommends the Commonwealth implement a **hybrid approach** to garner the **highest level of cost savings** within the shortest period of time, dollars which could then be used to fund additional cost savings activities.
- Hybrid approach combines elements of competitive bidding and application of standard reductions to current rates.
- The estimated savings potential of this approach is **$4.9-6.3M or 9-12% of the total projected DME baseline.**

Project Summary

The CGI team performed a detailed assessment of DMAS' DME rates and spending, with the goal of identifying potential savings from rate changes. During this assessment, the following activities were performed:

- **Data Analysis and Evaluation:** Profiled historical and forecasted DME purchases by conducting a line-item analysis of DMAS DME claims.
- **Benchmarking:** Findings from the data evaluation were benchmarked against DME pricing and acquisition processes used by other State Medicaid DME programs, Federal Centers for Medicare and Medicaid Services (CMS) DME purchasing, and CGI's public-sector procurement best practices.
- **Recommendation Development:** Coupled public sector experience with the benchmarking findings to develop customized approach and savings recommendations, focused primarily on identifying areas where the Commonwealth can generate savings from rate changes.

DME Expenditures

Historical Baseline
Process Summary

CGI has analyzed Virginia's DME expenditures and developed a spend baseline and usage profiles for identified categories.

Baseline and Usage Profile Development Process

1. Collect usage data (1 year of claims data)
2. Cleanse and analyze claims data
3. Identify categories and associated annual spend levels
4. Validate spend levels and cleanse data
5. Develop category Usage Profiles

Historical Baseline
Page 1 of 2

Total expenditures for a 52 week period ending in April 2009 were analyzed.

Net of Waiver expenditures and inclusive of both Commonwealth and third party payments, the historical baseline is slightly above $54 million.

Product Category Baselines

Dollars, Percent

Product Category	Current Tent_Pay ($)	Current Pri_Pay ($)	Current Total Paid ($)	Percent of Total
Bed Pans, Urinals, Incontinence, Catheters and Irrigation Equipment and Supplies	$16,190,427	$48,006	$16,238,433	30.0%
Apnea Monitors, Respiratory, Oxygen and Ventilators	9,401,482	307,452	9,708,934	18.0%
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	6,240,829	260,948	6,501,777	12.0%
Miscellaneous Durable and Expendable Supplies	5,727,180	320,228	6,047,408	11.2%
Wheelchairs and Accessories	5,055,370	486,969	5,542,338	10.3%

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Historical Baseline

Page 2 of 2

Product Category Baselines, Continued

Dollars, Percent

Product Category	Current Tent_Pay ($)	Current Pri_Pay ($)	Current Total Paid ($)	Percent of Total
Diabetic Products	$2,168,830	$44,177	$2,213,007	4.1%
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	2,049,058	24,930	2,073,988	3.8
Orthotics	1,336,183	250,634	1,586,817	2.9
Beds, Mattresses and Accessories	1,266,436	58,094	1,324,530	2.5
Bandages, Dressings, Gauze and Tape	1,178,805	13,261	1,192,066	2.2
Decubitus / Ulcer Products	534,514	$0	534,514	1.0
Communication Devices	377,811	75,849	453,659	0.8
Ostomy and Colostomy Pouches and Accessory Supplies	296,970	6,644	303,614	0.6
Dry Heat Application, TENS, NMES	145,746	$20	145,766	0.3
Canes, Crutches and Walkers	127,816	2,285	130,102	0.2
Elastic Support Items	47,648	55	47,703	0.1
Traction Equipment	9,536	60	9,596	0.0
EPSDT ONLY	5,138	0	5,138	0.0
Burn Garments	412	0	412	0.0
TOTAL	**$52,160,192**	**$1,899,612**	**$54,059,804**	**100.0%**

Projected Fiscal Year 2010 Baseline

Process Summary

Projected Fiscal Year 2010 (FY2010) Baseline Forecasting Process[1]

Cleanse Data

- Ensure standard units of measure per code
- Correct inaccurate modifiers
- Review outliers
- Calculate weighted average price per unit

Calculate Baseline

- Calculate historic weighted average price[2] for items with rate changes, apply rate change factor[3] and multiply by the total units
- Calculate weighted average price[2] per unit for items without rate changes and multiply by the total units
- Apply historical spending values for any remaining exceptions and outliers[4]

Finalize and Review Projected Baseline

- Review for accuracy
- Validate results against historical spending

[1] Additional details outlining forecasting logic to be provided within supplementary file
[2] Calculation excludes outliers
[3] Percent difference between 2008 and 2009 rates
[4] Outliers are claims where the CPU is greater than or 50% below the Appendix B rate. Three codes with unusually low average payments relative to Appendix B rates (A4595, E0240, E0443) were projected to be equivalent to historical levels for all claims at or below published rates. Historical spend levels were also applied to codes without Appendix B rates.

Projected FY2010 Baseline
Page 1 of 2

Changes in annual spending are based exclusively on Appendix B rate changes effective February 1, 2009. At that time, many Appendix B rates were reduced in accordance with DMERC changes.

Volume changes are not projected, as these are driven by policy, recipient demographics and macroeconomic factors.

Product Category Baselines
Dollars, Percent

Product Category	Projected Total Paid ($)	Percent of Total	Historical Total Paid ($)	Increase ($)	Increase (%)
Bed Pans, Urinals, Incontinence, Catheters and Irrigation Equipment and Supplies	$16,363,949	30.7%	$16,238,433	$125,516	0.8%
Apnea Monitors, Respiratory, Oxygen and Ventilators	9,345,157	17.5	9,708,934	(363,776)	(3.7)
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	6,184,329	11.6	6,501,777	(317,448)	(4.9)
Miscellaneous Durable and Expendable Supplies	6,060,066	11.4	6,047,408	12,658	0.2
Wheelchairs and Accessories	5,374,065	10.1	5,542,338	(168,274)	(3.0)

Projected FY2010 Baseline

Page 2 of 2

Product Category Baselines, Continued

Dollars, Percent

Product Category	Projected Total Paid ($)	Percent of Total	Historical Total Paid ($)	Increase ($)	Increase (%)
Diabetic Products	$2,091,921	3.9%	$2,213,007	($121,086)	(5.5%)
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	2,087,754	3.9	2,073,988	13,766	0.7
Orthotics	1,650,582	3.1	1,586,817	63,765	4.0
Beds, Mattresses and Accessories	1,323,428	2.5	1,324,530	(1,102)	(0.1)
Bandages, Dressings, Gauze and Tape	1,254,498	2.4	1,192,066	62,432	5.2
Decubitus / Ulcer Products	490,163	0.9	534,514	(44,351)	(8.3)
Communication Devices	471,961	0.9	453,659	18,301	4.0
Ostomy and Colostomy Pouches and Accessory Supplies	315,956	0.6	303,614	12,342	4.1
Dry Heat Application, TENS, NMES	150,525	0.3	145,766	4,759	3.3
Canes, Crutches and Walkers	123,695	0.2	130,102	(6,406)	(4.9)
Elastic Support Items	48,323	0.1	47,703	619	1.3
Traction Equipment	9,481	0.0	9,596	(115)	(1.2)
EPSDT ONLY	5,159	0.0	5,138	21	0.4
Burn Garments	412	0.0	412	0	0.0
TOTAL	**$53,351,425**	**100%**	**$54,059,804**	**($708,379)**	**(1.3%)**

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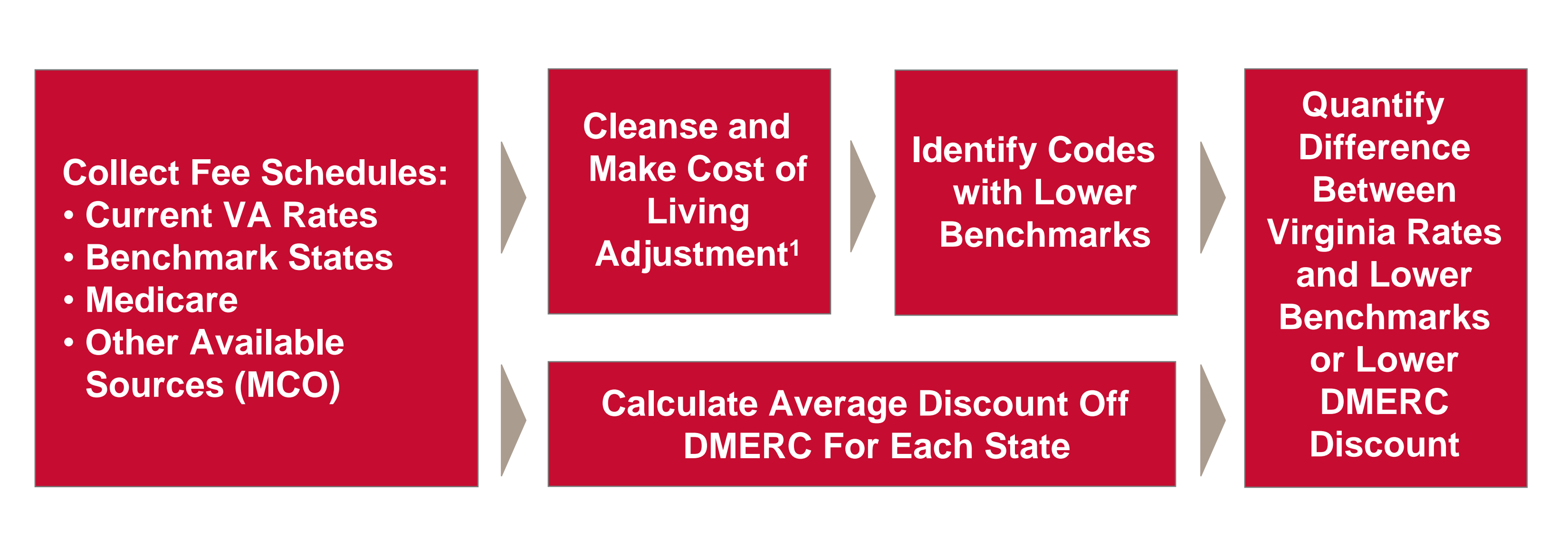
Benchmarking

Process Summary

CGI has analyzed Virginia DME reimbursement rates against identified benchmarks and state DMERC discounts, to identify areas where rates may be lowered.

Rate Benchmarking Process



[1] Rates varying more than 50% from VA are discarded due to likely unit-of-measure discrepancies
Cost of living adjustment conducted using Missouri Economic Research and Information Center (MERIC) national healthcare cost of living index.

Target Benchmark States

In consultation with DMAS, ten states have been selected as targets for DME rate benchmarking.

Target State Considerations

◔ → ● Best VA Match

State	CMS Region 3	Medicaid Expenditures Medicaid total net expenditures from most recent available data	MCO Proportion MCO expenditures relative to total net	Urban / Rural Mix Population distribution & geographic diversity	Overall
Connecticut		●	◕	◔	●
Delaware	✓	◑	◕	◔	◕
Indiana		◕	◑	●	●
Maryland	✓	◕	◑	◑	◕
Michigan		◑	●	●	●
Missouri		◑	◑	◕	◕
Ohio		◔	◑	◕	◕
Pennsylvania	✓	◔	◕	◕	◕
Washington		◕	◕	◑	●
Wisconsin		●	◑	◕	●

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Source: CMS - FY 2005 Medicaid Financial Management Report; U.S. Census Bureau - Census 2000 Statistics; CGI Analysis

Incontinence Undergarment Benchmarking

Case Counts and Budget-neutral Per-unit Pricing

Due to the fact that VA prices incontinence undergarments on a per-case basis, a per-unit price was derived for benchmarking purposes.

Incontinence Undergarments – Unit Price Conversion

Dollars

HCPCS Code	Code Description	VA Rate Per Case	Case Count[1]	Rate Per Unit
A4554	Disposable Underpads, All Sizes	$ 50.36	150	$ 0.34
T4521	Adult Small Diaper	42.37	96	0.44
T4521 - U1	Adult Small Diaper, Extra Absorb.	54.89	96	0.57
T4522	Adult Medium Diaper	53.37	96	0.56
T4522 - U1	Adult Medium Diaper, Extra Absorb.	69.10	96	0.72
T4523	Adult Large Diaper	70.63	72	0.98
T4523 - U1	Adult Large Diaper, Extra Absorb.	74.72	72	1.04
T4524	Adult Ext. Large Diaper, Ext. Absorb.	74.72	60	1.25
T4525	Adult Pull Up, Small	62.40	80	0.78
T4526	Adult Pull Up, Medium	62.40	80	0.78
T4527	Adult Pull Up, Large	62.40	72	0.87
T4528	Adult Pull Up, Extra Large	62.40	56	1.11
T4529	Pediatric Diaper Small/Med, Ext. Absorb.	59.72	105	0.57
T4530	Pediatric Diaper L/XL, Ext. Absorb.	59.72	90	0.66
T4535	Incontinence Pad	49.34	130	0.38

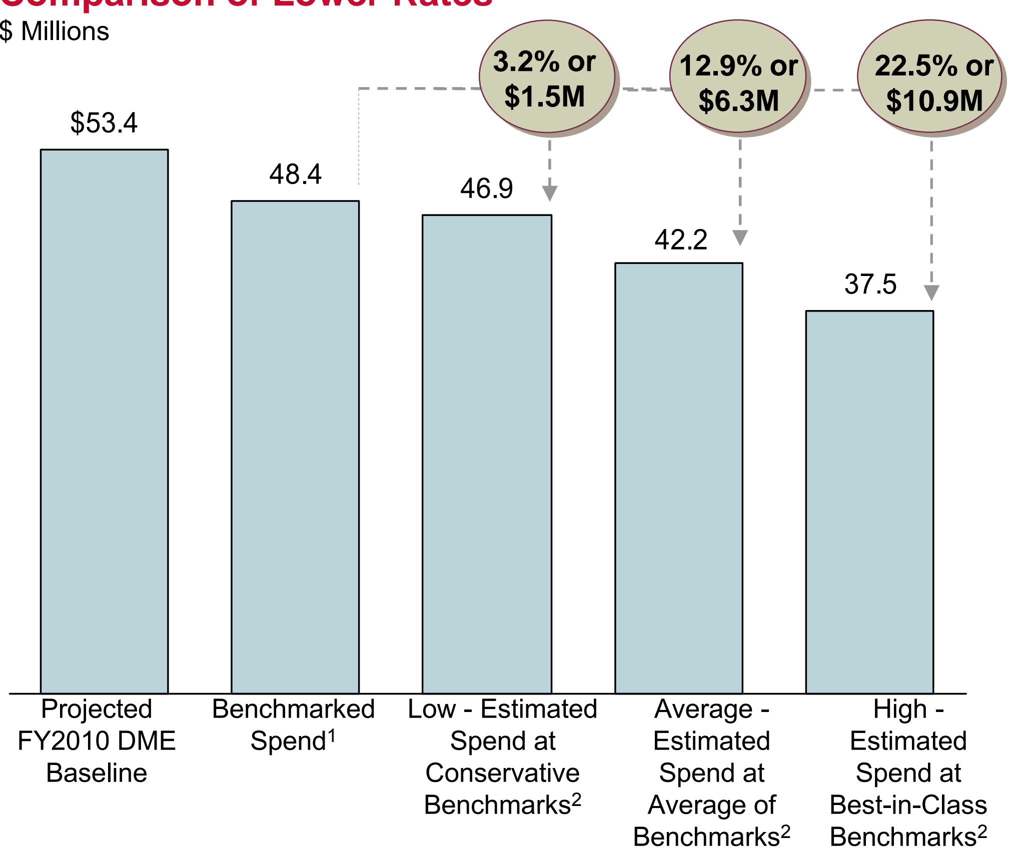
[1] DMAS research, except T4535 - CGI research (South Carolina DHHS Medicaid Bulletin)

Note: Quantity limit benchmarks for Incontinence Undergarments are provided in an appendix document

Benchmarking Results

Summary – Individual Rate Analysis

Benchmarking of Virginia DME reimbursement rates against comparable states reveals a significant number of codes with lower rates elsewhere.



The difference between Virginia DME rates and lower payment rates in other states is $1.5-10.9 million

Note: Analysis includes DME with modifiers NU and RR

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009; 2009 fee schedules from CT, DE, IN, MD, MI, MO, OH, PA, WA, WI, and Medicare; Cost of living adjustment conducted using Missouri Economic Research and Information Center (MERIC) national healthcare cost of living index; CGI analysis

[1] Includes only procedure code spending with available state benchmarks, based on estimated projected spend

[2] Benchmarks were adjusted for cost of living; all outliers varying more than 50% from Virginia Medicaid rates were excluded from analysis; best-in-class benchmarks represent the lowest price below VA rate; conservative benchmarks represent highest price below VA rate; average benchmarks represent average below VA rate

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Category Results – Individual Rate Analysis – NU Expenditures (1 of 2)

Benchmarking of DME purchase rates (NU modifier) indicates a wide range of difference, depending on product category.

Benchmarking Results

Dollars, Percent

Product Category	Benchmarked Spend[2] ($)	Benchmark Difference[1]			
		Low ($)	Average ($)	High ($)	Range (%)
Bed Pans, Urinals, Incontinence, Catheters and Irrigation Equipment and Supplies	$14,031,175	$618,985	$2,700,007	$4,786,739	4.4 – 34.1%
Apnea Monitors, Respiratory, Oxygen and Ventilators	5,367,030	226,363	657,808	1,160,686	4.2 – 21.6
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	5,299,633	135,822	636,933	1,251,395	2.6 – 23.6
Miscellaneous Durable and Expendable Supplies	5,758,678	27,000	106,712	181,691	0.5 – 3.2
Wheelchairs and Accessories	5,012,510	102,359	378,871	724,464	2.0 – 14.5
Diabetic Products	2,002,605	142,256	291,131	444,932	7.1 – 22.2%

[1] Benchmarks were adjusted for cost of living; all outliers varying more than 50% from Virginia Medicaid rates were excluded from analysis; best-in-class benchmarks represent the lowest price below VA rate; conservative benchmarks represent highest price below VA rate, average benchmarks represent average below VA rate

[2] Includes only procedure code spending with available state benchmarks, based on estimated projected spend

Note: Details are provided in an appendix and supplementary analysis files; Totals may not foot due to rounding

Source: Virginia Medicaid claims data from period 4/25/08 to 4/24/09; 2009 fee schedules from CT, DE, IN, MD, MI, MO, OH, PA, WA, WI, and Medicare; CGI analysis

Category Results – Individual Rate Analysis – NU Expenditures (2 of 2)

Benchmarking Results, Continued

Dollars, Percent

Product Category	Benchmarked Annual Spend[2] ($)	Benchmark Difference[1] Low ($)	Average ($)	High ($)	Range (%)
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	$1,816,070	$21,597	$330,191	$337,773	1.2 – 18.6%
Orthotics	901,062	37,287	163,736	302,396	4.1 – 33.6
Beds, Mattresses and Accessories	787,176	3,625	56,814	67,246	0.5 – 8.5
Bandages, Dressings, Gauze and Tape	1,167,502	24,726	197,118	330,070	2.1 – 28.3
Decubitus / Ulcer Products	96,341	4,345	12,714	17,642	4.5 – 18.3
Communication Devices	469,004	6,208	36,133	75,716	1.3 – 16.1
Ostomy and Colostomy Pouches and Accessory Supplies	308,443	4,369	49,137	98,087	1.4 – 31.8
Dry Heat Application, TENS, NMES	140,775	6,921	23,958	40,206	4.9 – 28.6
Canes, Crutches and Walkers	121,774	1,773	16,595	41,881	1.5 – 34.4
Elastic Support Items	34,512	562	2,919	4,474	1.6 – 13.0
Traction Equipment	7,118	161	866	1,943	2.3 – 27.3
EPSDT ONLY	3,070	53	425	790	1.7 – 25.7
TOTAL	**$43,324,479**	**$1,364,411**	**$5,662,069**	**$9,868,131**	**3.1 – 22.8%**

[1] Benchmarks were adjusted for cost of living; all outliers varying by more than 50% from Virginia Medicaid rates were excluded from analysis; best-in-class benchmarks represent the lowest price below VA rate; conservative benchmarks represent highest price below VA rate, average benchmarks represent average of prices below VA rate

[2] Includes only procedure code spending with available state benchmarks, based on estimated projected spend

Note: Details are provided in an appendix and supplementary analysis files; Totals may not foot due to rounding

Source: Virginia Medicaid claims data from period 4/25/08 to 4/24/09; 2009 fee schedules from CT, DE, IN, MD, MI, MO, OH, PA, WA, WI, and Medicare; CGI analysis

CGI

Category Results – Individual Rate Analysis – RR Expenditures

The majority of DME rental reimbursement (RR modifier) spend is with Oxygen/Respiratory equipment, and shows lower rates elsewhere.

Benchmarking Results

Dollars, Percent

Product Category	Benchmarked Annual Spend[2] ($)	Benchmark Difference[1] Low ($)	Average ($)	High ($)	Range (%)
Apnea Monitors, Respiratory, Oxygen and Ventilators	$3,930,114	$125,653	$450,422	$760,991	3.2 – 19.4%
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	65,949	2,505	13,936	22,510	3.8 – 34.1
Miscellaneous Durable and Expendable Supplies	74,454	2,963	12,671	24,194	4.0 – 32.5
Wheelchairs and Accessories	96,453	4,017	12,062	22,618	4.2 – 23.4
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	14,849	2,164	3,403	5,282	14.6 – 35.6
Beds, Mattresses and Accessories	518,346	16,070	64,489	129,290	3.1 – 24.9
Decubitus / Ulcer Products	393,614	17,754	41,335	71,510	4.5 – 18.2
Communication Devices	25	1	3	5	2.6 – 20.5
Dry Heat Application, TENS, NMES	9,537	43	1,283	1,452	0.4 – 15.2
Canes, Crutches and Walkers	8	0.3	1	2	3.5 – 29.4
Traction Equipment	$2,363	73	317	700	3.1 – 29.6
TOTAL	**$5,105,712**	**$171,243**	**$599,923**	**$1,038,554**	**3.4 – 20.3%**

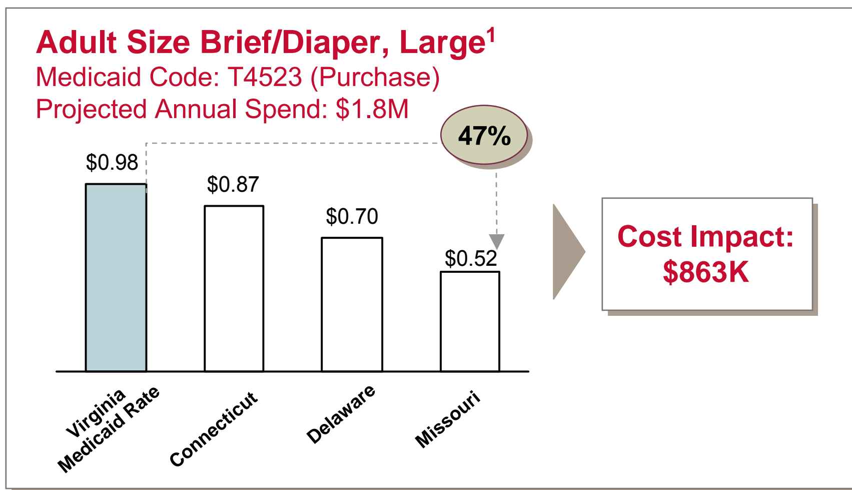
Note: Analysis includes DME with modifiers NU and RR; Details are provided in an appendix and supplementary analysis files; Totals may not foot due to rounding

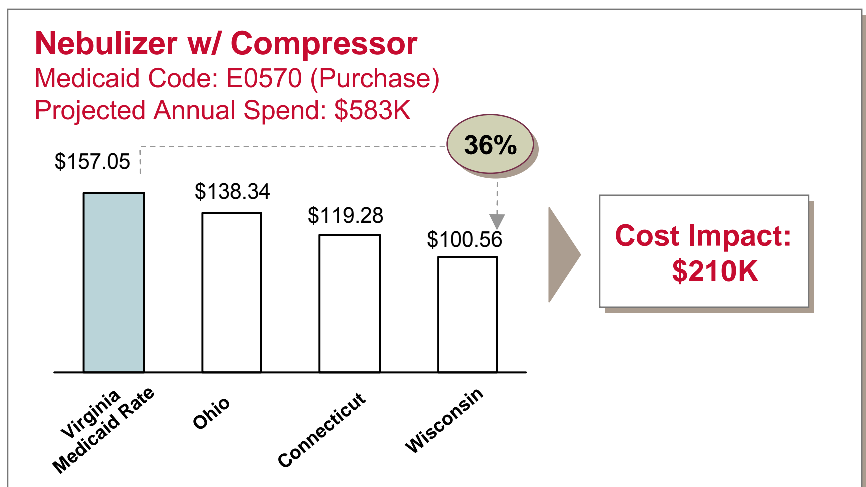
Source: Virginia Medicaid claims data from period 4/25/08 to 4/24/09; 2009 fee schedules from CT, DE, IN, MD, MI, MO, OH, PA, WA, WI, and Medicare; CGI analysis

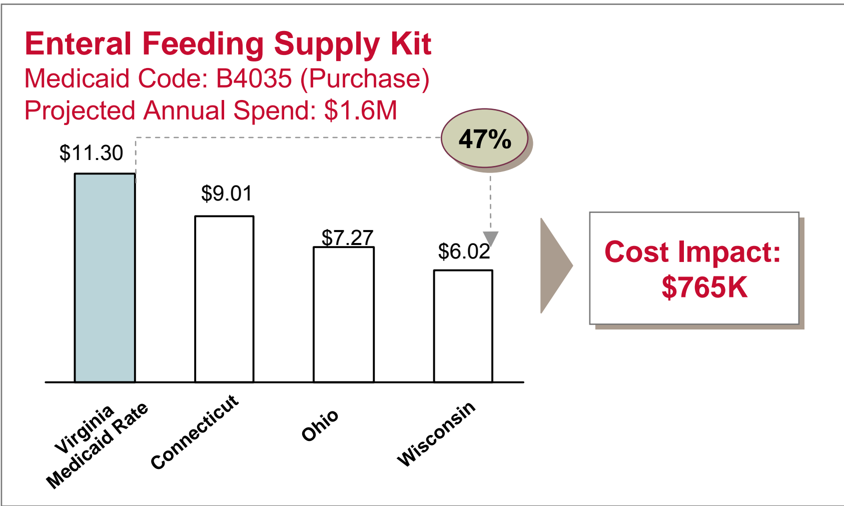
[1] Benchmarks were adjusted for cost of living using Missouri Economic Research and Information Center (MERIC) national healthcare cost of living index; All outliers varying by more than 50% from VA Medicaid rates were excluded from analysis; Best-in-class benchmarks represent the lowest price below VA Medicaid rate; Conservative benchmarks represent highest price still below VA rate

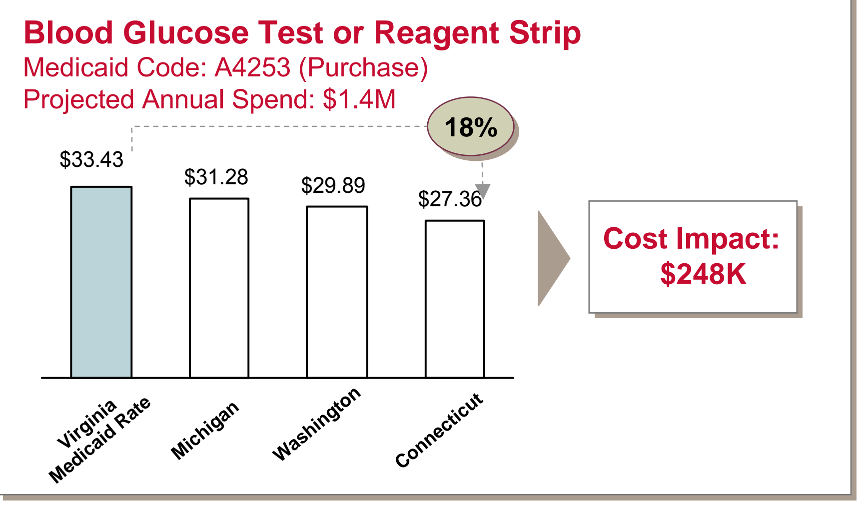
[2] Includes only procedure code spending with available state benchmarks, based on estimated projected spend

Sample Benchmarks









[1] Rate per case converted to rate per unit

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009; 2009 fee schedules from CT, DE, IN, MD, MI, MO, OH, PA, WA, WI, and Medicare; Cost of living adjustment conducted using Missouri Economic Research and Information Center (MERIC) national healthcare cost of living index; CGI analysis

Benchmarking Results

Summary – DMERC Discount Basis

The projected baseline for codes with published DMERC rates is $19.7M, 37% of total projected baseline.

Impact of DMERC Discount Approach[1]

$ Millions

	Projected FY2010 DME Spend	Projected DMERC Code Spend	5% DMERC Discount	10% DMERC Discount	15% DMERC Discount
$ Millions	$53.4	19.7	19.0	18.1	17.1
Savings			3.6% or $0.7M	8.4% or $1.7M	13.4% or $2.6M

Recommendation: 10% DMERC Discount (8.4% or $1.7M)

[1] Analysis takes conservative approach of assuming all future claims will be at 100% of the allowable rate. The Weighted Average Price Paid (WAPP) for current claims is below 100% of the allowable amount. Therefore projected savings are less than the DMERC discount might imply (e.g., 8.4% vs. 10%)

Note: Projected spend calculated by multiplying forecasted weighted average price paid by forecasted number of units allowed; projected "discounted DMERC" spend calculated using the lower of forecasted weighted average price paid or discounted DMERC rate, multiplied by forecasted number of units allowed.

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009; CGI analysis

DMERC Discount Research

Benchmark states do not typically price at a discount to DMERC. Analysis of states' DMERC-priced codes reveals an "effective discount" that suggests a 10% discount is viable in VA. Interview findings show that a large MCO reimburses at 85-90% of DMERC for most codes.

State Effective DMERC Discount

Percent

Product Category	Percent of Total VA Spend	State Effective DMERC Discount								
		CT	DE	MD	MO	PA	WA	Min	Avg.	Max
Bed Pans, Urinals, Incontinence, Catheters and Irrigation Equipment and Supplies	1.6%	18.7%	8.9%	2.4%	4.8%	10.9%	n/a	2.4%	9.1%	18.7
Apnea Monitors, Respiratory, Oxygen and Ventilators	10.9%	11.8	9.3	0.2	6.0	12.7	3.1	0.2	7.2	12.7
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	8.7%	15.7	10.1	-	n/a	21.8	4.8	0.0	10.5	21.8
Miscellaneous Durable and Expendable Supplies	0.4%	15.4	8.9	0.2	9.8	6.6	1.8	0.2	7.1	15.4
Wheelchairs and Accessories	5.5%	10.7	7.1	-	7.9	13.0	-	0.0	6.4	13.0
Diabetic Products	3.1%	19	4.9	-	n/a	14.2	4.8	0.0	7.5	19.0
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	0.1%	19	8.9	-	n/a	4.8	4.8	2.4	9.1	18.7
TOTAL	**30%**							**0.4%**	**8.1%**	**17.1%**

Source: 2009 fee schedules from CT, DE, MD, MO, PA, WA, and DMERC A, C, D; CGI analysis

DMERC Discount – Impact by Category (Page 1 of 2)

A DMERC Discount of 10% addresses one third of the expenditures, resulting in $1.7M in potential savings.

Impact by Category: DMERC (10% Discount)

Dollars, Percent

Product Category	FY2010 Projected Annual Spend ($)	Baseline Addressed by Approach ($)	Savings ($)	Savings[1] (%)
Bed Pans, Urinals, Incontinence, Catheters and Irrigation Equipment and Supplies	$16,363,949	$856,230	$74,530	8.7%
Apnea Monitors, Respiratory, Oxygen and Ventilators	9,345,157	5,823,002	540,995	9.3
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	6,184,329	4,647,954	317,653	6.8
Miscellaneous Durable and Expendable Supplies	6,060,066	205,079	18,230	8.9
Wheelchairs and Accessories	5,374,065	2,919,882	260,280	8.9
Diabetic Products	2,091,921	1,629,052	148,424	9.1
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	2,087,754	30,066	2,662	8.9
Orthotics	1,650,582	845,380	76,650	9.1

CGI

1 Savings based on Baseline Addressed by Approach

Note: Spend calculated by multiplying forecasted weighted average price paid by forecasted number of units allowed; projected “discounted DMERC” spend calculated using the lower of forecasted weighted average price paid or discounted DMERC rate, multiplied by forecasted number of units allowed.

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009; CGI analysis

DMERC Discount – Impact by Category (Page 2 of 2)

Impact by Category: DMERC - 10% Discount

Dollars, Percent

Product Category	FY2010 Projected Annual Spend ($)	Baseline Addressed by Approach ($)	Savings ($)	Savings[1] (%)
Beds, Mattresses and Accessories	$1,323,428	$562,920	$54,550	9.7%
Bandages, Dressings, Gauze and Tape	1,254,498	729,137	60,768	8.3
Decubitus / Ulcer Products	490,163	489,955	49,009	10.0
Communication Devices	471,961	434,511	14,580	3.4
Ostomy and Colostomy Pouches and Accessory Supplies	315,956	293,192	28,447	9.7
Dry Heat Application, TENS, NMES	150,525	141,854	5,340	3.8
Canes, Crutches and Walkers	123,695	121,782	11,206	9.2
Elastic Support Items	48,323	-	-	0.0
Traction Equipment	9,481	2,550	211	8.3
EPSDT ONLY	5,159	1,807	81	4.5
Burn Garments	412	-	-	0.0
TOTAL	**$53,351,425**	**$19,734,355**	**$1,663,618**	**8.4%**

[1] Savings based on Baseline Addressed by Approach

Note: Total Savings (%) is less than 10% because some providers charge less than the DMAS fee (DMAS pays the lower of charge or fee) and therefore a 10% reduction to the fee does not achieve 10% savings. Actual savings will vary by product category based on how much the weighted average price was lower than the weighted average fee in the product category before applying the reduction. In addition, a small number of claims were excluded from the reduction because of unique circumstances. Due to the unique circumstances, we could not evaluate whether it was possible to calculate savings on these claims.

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009; CGI analysis

DMERC Discount – MIPPA Considerations

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) instituted a 9.5% rate reduction in 2009 for certain codes. Other codes received a 5% rate increase. In implementing reduced rates through a discount to DMERC fee screens, the Commonwealth must consider the overall impact for those codes reduced through MIPPA.

Rate Change Analysis

Percent

Code Type	2009 Rate Change	Overall Impact of a 10% DMERC Rate Reduction[1]
DMERC Codes with Rates Reduced Under MIPPA	-9.5%	-18.6%
Other DMERC Codes	+5.0%	-5.5%

Savings Impact

Dollars

		Savings
Code Type	FY2010 Projected Annual Spend ($)	10% DMERC Discount For All Codes
DMERC Codes with Rates Reduced Under MIPPA	$12,413,456	$1,065,967
Other DMERC Codes	7,320,899	597,651
TOTAL	**$19,734,355**	**$1,663,618**

CGI

[1] Price change relative to 2008 rate

Source: CGI analysis

DMERC Discount Research (MIPPA Only Items)

Benchmark states do not typically price at a discount to DMERC though analysis of states' DMERC-priced codes reveals an "effective discount" that suggests a 10% discount is viable in VA, for all products and categories, including those impacted by recent MIPPA rate reductions.

State Effective DMERC Discount

Percent

Product Category	Percent of Total VA Spend	State Effective DMERC Discount								
		CT	DE	MD	MO	PA	WA	Min	Avg.	Max
Bed Pans, Urinals, Incontinence, Catheters and Irrigation Equipment and Supplies	1.6%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Apnea Monitors, Respiratory, Oxygen and Ventilators	10.9%	6.1%	n/a	-	n/a	11.6%	-	0.0%	4.4%	11.6%
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	8.7%	8.5	16.9	-	n/a	n/a	n/a	0.0	8.5	16.9
Miscellaneous Durable and Expendable Supplies	0.4%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Wheelchairs and Accessories	5.5%	6.0	1.5	-	18.2	9.8	n/a	0.0	7.1	18.2
Diabetic Products	3.1%	19.0	4.9	-	n/a	n/a	4.8	0.0	7.2	19.0
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	0.1%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
TOTAL	**30%**							**0.0%**	**7.1%**	**14.6%**

Note: Totals for Min, Max, Avg factor in smaller spend product categories not listed within the table above.
Source: 2009 fee schedules from CT, DE, MD, MO, PA, WA, and DMERC A, C, D; CGI analysis

DMERC Discount Research (Non MIPPA Items)

Non MIPPA items also demonstrate an opportunity for savings if VA were to enact a 10% overall reduction to all DMERC items.

State Effective DMERC Discount

Percent

		State Effective DMERC Discount								
Product Category	Percent of Total VA Spend	CT	DE	MD	MO	PA	WA	Min	Avg.	Max
Bed Pans, Urinals, Incontinence, Catheters and Irrigation Equipment and Supplies	1.6%	18.7%	8.9%	2.4%	4.8%	10.9%	n/a	2.4%	9.1%	18.7%
Apnea Monitors, Respiratory, Oxygen and Ventilators	10.9%	13.0	9.3	0.2	6.0	12.9	3.7	0.2	7.5	13.0
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	8.7%	17.5	7.8	-	n/a	21.8	4.8	-	10.4	21.8
Miscellaneous Durable and Expendable Supplies	0.4%	15.4	8.9	0.2	9.8	6.6	1.8	0.2	7.1	15.4
Wheelchairs and Accessories	5.5%	13.8	7.2	0.1	7.5	16.9	-	-	7.6	16.9
Diabetic Products	3.1%	19.0	n/a	-	n/a	14.2	n/a	-	11.1	19.0
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	0.1%	19.0	8.9	-	n/a	4.8	4.8	-	7.5	19.0
TOTAL	**30%**							**0.4%**	**7.6%**	**14.0%**

CGI

Note: Totals for Min, Max, Avg factor in smaller spend product categories not listed within the table above.
Source: 2009 fee schedules from CT, DE, MD, MO, PA, WA, and DMERC A, C, D; CGI analysis

Benchmarking Results

Summary – Non-DMERC Discount

The projected baseline for codes without DMERC rates is $33.6M (63% of total projected baseline). A number of these codes have published rates in Appendix B and at benchmarked states, and can be analyzed to identify a reasonable discount to current rates.

Impact of DMERC Discount Approach

$ Millions

	$ Millions
Projected FY2010 DME Spend	$53.4
Projected Non-DMERC Code Spend	33.6
5.5% Overall Discount (Varies by Category)	31.8

5.5% or $1.8M

Recommendation

Note: Discount applied to codes with modifiers NU and RR only; projected spend calculated by multiplying forecasted weighted average price paid by forecasted number of units allowed; projected "discounted" spend calculated using the lower of forecasted weighted average price paid or discounted VA Medicaid rate, multiplied by forecasted number of units allowed.

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009; CGI analysis

Non-DMERC Discount Research (Page 1 of 2)

Analysis of states' non-DMERC-priced codes suggests multiple opportunities for rate reductions across product categories.

Benchmarking Results and Recommended Reductions

Percent

Product Category	Percent of Total Spend (%)	State Benchmarks				
		Low (%)	High (%)	Average (%)	Average with Savings (%)[1]	Recommended Reduction (%)
Bed Pans, Urinals, Incontinence, Catheters and Irrigation Equipment and Supplies	29.1%	-11.5%	27.9%	5.1%	15.0%	10.0%
Apnea Monitors, Respiratory, Oxygen and Ventilators	6.6%	-8.2	15.0	6.9	8.6	5.0
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	2.9%	0.0	0.0	0.0	0.0	0.0
Miscellaneous Durable and Expendable Supplies	11.0%	-17.9	23.5	3.2	8.9	5.0
Wheelchairs and Accessories	4.6%	-16.2	26.8	4.4	14.6	10.0
Diabetic Products	3.9%	0.9	31.2	18.4	18.4	15.0
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	0.9%	16.9	42.3	27.7	27.7	20.0
Orthotics	1.5%	-43.2	41.3	-1.3	26.2	0.0
Beds, Mattresses and Accessories	1.4%	-18.0	15.3	-1.4	7.6	0.0

[1] Average of only benchmark states yielding positive savings benefits to VA

Source: 2009 fee schedules from VA, CT, DE, IN, MD, MI, MO, OH, PA, WA, and WI; CGI analysis

Non-DMERC Discount Research (Page 2 of 2)

Analysis of states' non-DMERC-priced codes suggests multiple opportunities for rate reductions across product categories.

Benchmarking Results and Recommended Reductions

Percent

Product Category	Percent of Total Spend (%)	State Benchmarks				
		Low (%)	High (%)	Average (%)	Average with Savings (%)[1]	Recommended Reduction (%)
Bandages, Dressings, Gauze and Tape	1.0%	5.2%	19.7%	13.2%	13.2%	10.0%
Decubitus / Ulcer Products	0.0%	0.0	0.0	0.0	0.0	0.0
Communication Devices	0.1%	0.0	0.0	0.0	0.0	0.0
Ostomy and Colostomy Pouches and Accessory Supplies	0.0%	-18.9	19.7	2.4	11.3	5.0
Dry Heat Application, TENS, NMES	0.0%	19.3	19.3	19.3	19.3	15.0
Canes, Crutches and Walkers	0.0%	0.0	0.0	0.0	0.0	0.0
Elastic Support Items	0.1%	-43.6	48.6	11.3	29.5	15.0
Traction Equipment	0.0%	-36.5	12.4	-5.2	5.5	0.0
EPSDT ONLY	0.0%	-38.9	-38.9	-38.9	0.0	0.0
Burn Garments	0.0%	0.0	0.0	0.0	0.0	0.0
TOTAL	**63%**					

CGI

[1] Average of only benchmark states yielding positive savings benefits to VA

Source: 2009 fee schedules from VA, CT, DE, IN, MD, MI, MO, OH, PA, WA, and WI; CGI analysis

Non-DMERC Discount – Savings Impact by Category (Page 1 of 2)

Non-DMERC Discount approach addresses one third of the spend, resulting in $1.8M in potential savings.

Impact by Category: Non-DMERC Discount

Dollars, Percent

Product Category	FY2010 Projected Annual Spend ($)	Baseline Addressed by Approach ($)	Recommended Reduction (%)	Savings ($)	Savings[1] (%)
Bed Pans, Urinals, Incontinence, Catheters and Irrigation Equipment and Supplies	$16,363,949	$15,507,719	10.0%	$1,279,368	8.2%
Apnea Monitors, Respiratory, Oxygen and Ventilators	9,345,157	3,522,155	5.0	62,965	1.8
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	6,184,329	1,536,375	0.0	-	0.0
Miscellaneous Durable and Expendable Supplies	6,060,066	5,854,987	5.0	9,312	0.2
Wheelchairs and Accessories	5,374,065	2,454,183	10.0	108,729	4.4
Diabetic Products	2,091,921	462,869	15.0	44,028	9.5
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	2,087,754	2,057,688	20.0	295,789	14.4
Orthotics	1,650,582	805,201	10.0	0	0.0

[1] Savings based on Baseline Addressed by Approach

Note: Discount applied to codes with modifiers NU and RR only; projected spend calculated by multiplying forecasted weighted average price paid by forecasted number of units allowed; projected “discounted” spend calculated using the lower of forecasted weighted average price paid or discounted VA Medicaid rate, multiplied by forecasted number of units allowed.

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009; CGI analysis

Non-DMERC Discount – Savings Impact by Category (Page 2 of 2)

Impact by Category: Non-DMERC Discount

Dollars, Percent

Product Category	FY2010 Projected Annual Spend ($)	Baseline Addressed by Approach ($)	Recommended Reduction	Savings ($)	Savings[1] (%)
Beds, Mattresses and Accessories	$1,323,428	$760,508	0.0%	-	0.0%
Bandages, Dressings, Gauze and Tape	1,254,498	525,361	10.0	40,188	7.6
Decubitus / Ulcer Products	490,163	209	0.0	-	0.0
Communication Devices	471,961	37,449	0.0	-	0.0
Ostomy and Colostomy Pouches and Accessory Supplies	315,956	22,764	5.0	-	0.0
Dry Heat Application, TENS, NMES	150,525	8,671	15.0	796	9.2
Canes, Crutches and Walkers	123,695	1,913	0.0	-	0.0
Elastic Support Items	48,323	48,323	15.0	1,172	2.4
Traction Equipment	9,481	6,931	0.0	-	0.0
EPSDT ONLY	5,159	3,351	0.0	-	0.0
Burn Garments	412	412	0.0	-	0.0
TOTAL	**$53,351,425**	**$33,617,070**		**1,842,347**	**5.5%**

[1] Savings based on Baseline Addressed by Approach

Note: Total Savings (%) is less than the "Recommended Reduction" percentage because some providers charge less than the DMAS fee (DMAS pays the lower of charge or fee) and therefore a specific reduction percentage for fees in a product category will not always achieve the same actual percentage savings. Actual savings will vary by product category from the recommended reduction percentage based on how much the weighted average price was lower than the weighted average fee in the product category before applying the reduction. In addition, a small number of claims were excluded from the reduction because of unique circumstances. Due to the unique circumstances, we could not evaluate whether it was possible to calculate savings on these claims.

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009; CGI analysis

CGI

Rate Recommendations

Rate Recommendations

Potential Approaches

DMERC Code Discount

Adopt a 10% discount off of DMERC for codes with DMERC rates

Non-DMERC Code Discount

Adopt category-specific discounts off current rates for codes that have a set rate, but no DMERC rate

Benchmark Rate Match

Adopt more competitive rates from other states based on benchmarking

Competitive Bidding

Conduct competitive bidding pilot for Incontinence Undergarments

Hybrid

Combination of DMERC Discount, Non-DMERC Discount (excluding Incontinence Undergarments), and Competitive Bidding

Potential Approach Savings Estimates

Millions $, Percent

Potential Approach	Savings Estimates ($M)	Savings Estimates (%)[1]
DMERC Code Discount	**$1.7**	**3.1%**
Non-DMERC Code Discount	**1.8**	**3.5%**
Benchmark Rate Match	**1.5 – 10.9**	**2.9 – 20.4%**
Competitive Bidding	**2.6 – 4.0[2]**	**4.9 – 7.4%**
Hybrid	**4.9 – 6.3**	**9.1% – 11.6%**
– DMERC Code Discount	1.7	3.1%
– Non-DMERC Code Discount[3]	0.6	1.1%
– Competitive Bidding	2.6 – 4.0	4.9 – 7.4%

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[1] Savings rate based on total DME expenditure baseline of $53,351,425
[2] Incontinence Undergarments only - conservative estimate of 20-30% savings based on CGI experience
[3] Excludes Incontinence Undergarments

Rate Recommendations

Decision Framework

	Considerations
Savings Potential	• Total amount of spend addressed • Expected savings rate on spend addressed
Provider Acceptance	• Provider push-back related to reduction in profits • Impact of any recent rate and/or policy changes on affected parties • Resistance related to reduction in the number of providers allowed or choosing to participate in Medicaid program
Ancillary Benefits	• Ease of provider management • Ease of audit • Access to additional services
Implementation Complexity	• Time to implement rate recommendations • Necessary training and education measures for providers and/or vendors • Necessity or complexity of periodic review

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Approach Recommendation

CGI recommends the Commonwealth adopt the Hybrid approach, pursuing multiple opportunities for savings.

Approach Recommendation

Approach Overview Opportunity Matrix

Approach Recommendation Details
DMERC Code Discount

Less Favorable ◄—► More Favorable

	Favorability	Rationale
Savings Potential	◔	• DMERC fee schedule addresses only 37% of total spend; high-spend medical supplies categories (i.e. incontinence supplies) are not addressed • Current rates are set at 100% of Medicare • Due to the small fraction of spend affected, savings potential is low
Provider Acceptance	◕	• Some Provider push back is expected due to reduction in profit • Average DMERC discount of 8.1% in benchmark states forms basis for a recommended 10% discount in Virginia • Reduction in Provider base is unlikely, given common use of DMERC discounts in the range of 10-15% by a large VA MCO
Ancillary Benefits	○	• N/A
Implementation Complexity	◕	• Straightforward implementation requiring few resources • Periodic review is required, when updated DMERC fee schedules are published • Dispensation for codes affected by MIPPA will complicate periodic rate updates
Overall	◑	

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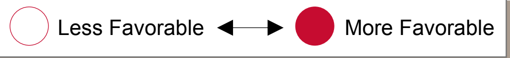
Approach Recommendation Details

Non-DMERC Code Discount



	Favorability	Rationale
Savings Potential	Quarter filled	• Non-DMERC codes address 63% of spend; however, a third of the spend falls under "UCC" and "I.C." codes to which a discount can not be applied • Additionally, discount has not been applied to codes with modifiers "Other" and "U1", as benchmarks for these codes were not available • Due to the limited addressable spend, savings potential is low
Provider Acceptance	Half filled	• Some Provider push back is expected due to reduction in profit and may be more pronounced in categories with larger rate reductions • Average savings estimates per benchmark states by category for the basis for the category specific recommended reductions
Ancillary Benefits	Empty	• N/A
Implementation Complexity	Half filled	• Additional resources may be required to conduct benchmarking research and analysis in the future if rate review is desired • Provider communications requirements may be more extensive for some categories
Overall	Quarter filled	

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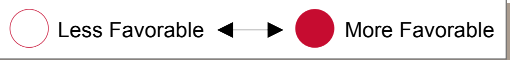
Approach Recommendation Details

Benchmark Rate Match



	Favorability	Rationale
Savings Potential		• Majority of expenditures is addressed • Favorable benchmarks have been identified for majority of codes • Potential savings may range from $1.5 – 10.9M, though lower level is most readily applicable
Provider Acceptance		• Provider push back is expected due to reduction in profit • Providers may raise concerns regarding the applicability of rates adapted from other states • Potential for voluntary reduction in Provider base due to lower rates
Ancillary Benefits		• N/A
Implementation Complexity		• Additional resources may be required to conduct benchmarking research and analysis in the future • Provider communications requirements may be more extensive than with a simpler discount approach
Overall		

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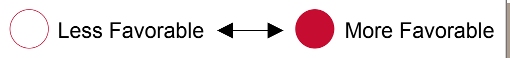
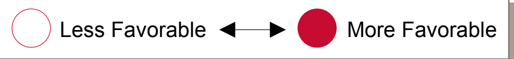
Approach Recommendation Details
Competitive Bidding



	Favorability	Rationale
Savings Potential	Half	• CGI experience indicates savings potential of 20-30% in the Incontinence Undergarments expenditure area • Potential to pursue other expenditure areas based on success with Incontinence Undergarments
Provider Acceptance	Half	• Reduction in approved provider base necessary, though potentially mitigated by the fact that one vendor already has approximately 50% of the expenditures
Ancillary Benefits	Full	• Unique ability to clearly define performance standards and required recipient services • Ease of auditing fixed price contracts with limited vendor set • Less incentive for providers to engage in suspect billing practices • Fixed rates for contract duration eases burden of periodic rate change procedures
Implementation Complexity	Quarter	• Competitive bidding using a comprehensive RFP is more time consuming than rate setting procedures, but somewhat mitigated by multi-year fixed rate agreements • Provider communications requirements are extensive at start of process
Overall	Half	

Approach Recommendation Details
Hybrid



	Favorability	Rationale
Savings Potential	● (full)	• Majority of expenditures is addressed • Favorable benchmarks have been identified for majority of codes • Competitive bidding for Incontinence Undergarments achieves significant savings
Provider Acceptance	◔ (quarter)	• Provider push back is expected due to reduction in profit • Providers may raise concerns regarding reduction in approved provider base with competitive bidding
Ancillary Benefits	● (full)	• Numerous benefits associated with competitive bidding • Customizable approach for each category and subcategory
Implementation Complexity	◔ (quarter)	• Additional resources may be required to pursue various rate setting approaches • Competitive bidding using a comprehensive RFP is more time consuming than rate setting procedures, but somewhat mitigated by multi-year fixed rate agreements • Provider communications requirements are significant
Overall	● (full)	

Other Opportunities

E1399 Opportunities

Overview

Observations

- Code E1399 – "Durable Medical equipment, miscellaneous" is used to capture spending for Individual Consideration (I.C.) items as well as retired local codes with published 1996 rates in Appendix B
- It is very difficult to determine which items are actually being purchased and at what amounts during the prior authorization and auditing processes
- Other available state examples show approximately one-fifth the E1399 spending proportion exhibited by the Commonwealth, suggesting current E1399 expenditures could be shifted to other Level II codes

Improvement Opportunities

- Migrate spending to more appropriate category specific "miscellaneous/NOC" procedure codes
- Address problem between KePRO and MMIS systems that cause recorded claim comment fields to not transmit
- Request or require providers to identify local code as first piece of information in comment field
  - Consider updating PA forms to require this information
- Proactively ensure KePRO receives Appendix B code updates
  - Include a "quick check" list of new Level II codes for easy reference by reviewers

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E1399 Opportunities
Issue Analysis

Issue	Current Situation	Improvement Opportunities
Expenditure Visibility	• E1399 account for 9.2% of total spending (10.3% of Tent_Pay) and is used to classify spending for: – Items with older local codes and set fees – Items priced for Individual consideration (I.C.) • It is difficult to determine what items are actually being purchased, in part because KePRO’s detailed comment field does not transmit to MMIS system • Those items with former local codes and 1996 pricing within Appendix B are grouped under E1399, but the local code is not recorded in claims information • Post Payment auditing is very difficult, in part due to information not passing from KePro to the MMIS	• Assign more narrowly defined "Miscellaneous" or "Not Otherwise Classified" Level II codes – For example use B9998 (NOC for Enteral Supplies) for Mic-Key buttons to help ID claims for this high expenditure item • Record former local code as first item within KePRO comment field whenever applicable – Requires cooperation from providers • Work through technology issues with KePRO to at a minimum transmit abbreviated comments to MMIS system to ease auditing and monitoring burden
Claim Approval	• E1399 items may already have an existing Level II HCPCS code (new code after periodic update, or an existing code) – Dependent on skill of PA reviewer to catch, but reviewers sometimes are not aware of Appendix B updates – Opportunity for providers to get a higher payment than the actual price limit – Opportunity for providers to skirt quantity limits – Provider "inertia" may cause them to not actively find and apply newly applied Level II codes	• Ensure KePRO receives Appendix B updates in advance of roll-out • Create summary of new HCPCS codes replacing E1399s in KePRO system for PA reviewer use

E1399 Opportunities

Sample NOC (Not Otherwise Classified) Codes

More narrowly defined “Miscellaneous” or “Not Otherwise Classified” Level II HCPCS Codes may be applied to better monitor and track the Commonwealth’s expenditures.

Sample Miscellaneous Level II HCPCS Codes[1]

HCPCS Code	Description	Product Category	Currently in Appendix B
A4913	Misc. Dialysis Supplies, Not Otherwise Specified	Dialysis Equipment & Supplies	√
A6512	Compression Burn Garment, NOC	Burn Garments	√
B9998	Enteral Supplies, NOC	Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	√
B9999	Parenteral Supplies, NOC	Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	NO
E0625	Patient Lift Bathroom Or Toilet, NOC	Miscellaneous Durable and Expendable Supplies	NO
E2399	Power Wheelchair Accessory, NOC Interface	Wheelchairs and Accessories	√
K0898	Power Wheelchair, NOC	Wheelchairs and Accessories	NO
S8189	Tracheostomy Supply, NOC	Apnea Monitors, Respiratory, Oxygen and Ventilators	NO

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[1] A full list of identified miscellaneous codes is provided in a supplementary file

U.C.C. and I.C. Opportunities

Overview

Observations

- Over 100 codes appearing in the dataset are reimbursed at the providers "Usual and Customary Charge" (U.C.C.) or via "Individual Consideration" (I.C.)
  - Over half of U.C.C. codes have set rates in benchmark states
  - Reimbursement rates found in benchmark states are often below the VA average price paid
- Excessive utilization of U.C.C. and I.C. codes places a burden on the Commonwealth and Providers in determining appropriate reimbursement rates and are difficult to audit
- Provider Manual language can be vague, and documentation requirements either do not exist (U.C.C. codes) or are not enforced (I.C. codes)

Improvement Opportunities

- Establish fixed reimbursement rates for selected items
- Adopt a new definition of allowable price for U.C.C. claims to facilitate auditing
- Tighten Appendix D language regarding I.C. claim requirements
- Require providers to submit cost evidence for I.C. claims
- Require providers to submit statements of estimated net costs for I.C. claims

U.C.C. and I.C. Opportunities
Issue Analysis

Issue	Current Situation	Improvement Opportunities

U.C.C. Expenditures and Auditing	• A significant number of DME codes with expenditures in the review period are priced as U.C.C. (99 codes), with no set dollar amount within Appendix B
	• Providers are allowed to claim their usual and customary charge to the general public, with no verification
	• Performing price audits on U.C.C. codes is impossible, since no verification is required
	  – Per ACS, prices on some U.C.C. claims seem high, but cannot be readily challenged
		• Benchmarking has shown that 52 of the U.C.C. codes have fixed fee schedule rates in other states
		  – The Commonwealth should consider establishing fixed rates for U.C.C. codes through benchmarking or by analyzing usual and customary rates offered by providers
		  – Publicly available commercial payment data[1] may be used as a “sanity check” for other codes
		• The Commonwealth should consider adopting a new definition of allowable price for U.C.C. claims
		  – MSRP or cost-plus are measures that can be more readily audited post-payment

I.C. Expenditures and Auditing	• A small number of DME codes with expenditures in the review period are priced as I.C. (6 codes), with no set dollar amount within Appendix B
	• Documentation of estimated cost is required per the provider manual, but is rarely submitted
	• Performing audits on I.C. codes can be complex, given the lack of a fixed dollar ceiling, and a lack of sufficient documentation from providers
	  – Per ACS, a large proportion of provider claims require adjustment post-audit, suggesting a many unaudited claims are currently over-paid
		• Tighten language in Appendix D to make it clear that obligation is on providers to submit a reasonably accurate price for claims, and to restate claims if eventual price (net of subsequent discounts) is lower
		• Require providers to submit cost evidence, together with a statement of estimated net cost
		  – In conjunction with tighter provider manual language, this will make it more difficult for providers to rationalize submitting overstated claims

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[1] Research compiled by CGI will be provided in a supplementary file

U.C.C. and I.C. Opportunities
U.C.C. Codes with Benchmarked Prices

Sample Virginia U.C.C. Codes With Established Prices Elsewhere[1]

Category	VA U.C.C. Codes Priced Elsewhere	Priced Elsewhere			
		CT	IN	MD	WI
Oxygen & Respiratory Equipment	E0445 – Oximeter Device For Measuring Blood	✓		✓	✓
	E0471 – RAD W/ Backup Non Inv. Intrfc.	✓		✓	✓
Wheelchairs & Accessories	K0884 – PWC PG4 Std. Mult. Power Opt. S/B		✓		
	K0868 – PWC PG4, Std., Seat/Back		✓		
	K0877 – PWC PG4 Std. Sing. Power Opt. S/B		✓		
	K0007 – Extra Heavy Duty W/C	✓		✓	✓
	K0001 – Standard W/C			✓	✓
I.V. Supplies	E0784 – External Ambulatory Infusion Pump	✓	✓	✓	✓

[1] A complete set of VA U.C.C. codes with fixed fee schedule pricing in other states is provided in a supplementary file

Source: VA claims data from period April 25, 2008 to April 24, 2009; fee schedules from IN, CT, MD and WI; CGI analysis

U.C.C. Codes with Benchmarked Pricing – Savings Potential

The Commonwealth may save a significant amount of money by assigning set rates to U.C.C. codes, using benchmarks found elsewhere.

Benchmarking Results

Dollars

Product Category[1]	Projected Annual Spend	Annual Financial Impact[2]		
		Low	Average	High
Wheelchairs and Accessories	$970,009	$11,324	$159,955	$166,076
Apnea Monitors, Respiratory, Oxygen and Ventilators	1,750,410	30,216	71,637	135,610
I.V. Service Day Rate, I.V. Stands, I.V. Needles and Supplies	308,884	22,539	78,889	118,662
Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes	526,809	8,477	9,779	10,761
Elastic Support Items	22,047	3,166	7,076	8,003
Communication Devices	34,516	-	6,317	6,317
Orthotics	11,817	1,319	3,255	4,627
Bandages, Dressings, Gauze and Tape	27,982	1,096	2,620	4,346
Miscellaneous Durable and Expendable Supplies	2,616	176	792	1,249
Miscellaneous Durable and Expendable Supplies (E1399 Only)	5,186,598	-	-	-
5 Other Categories (No Financial Impact)	274,749	-	-	-
TOTAL	**$9,116,435**	**$78,314**	**$340,320**	**$455,650**

1 Details for each category are provided in the appendix and a supplementary analysis file

2 Financial impact is assessed by comparing projected weighted average per unit price paid for codes in Virginia to benchmark rates

Note: Analysis focuses on NU codes only; all outliers varying by more than 50% from Medicaid rates were excluded from analysis; benchmarks were adjusted for cost of living; analysis filtered to exclude claims where purchase rate exceeded Medicaid rate or the percentage paid of purchase rate is =< 50%; totals may not foot due to rounding

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009; 2009 fee schedules from CT, DE, IN, MD, MI, MO, OH, PA, WA, WI, and Medicare; CGI analysis

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Capped Rental Periods
Overview

Observations

- Purchase is recommended for most equipment beyond three months of continuous use
  - Rental periods for oxygen equipment is unlimited
- Purchases are reimbursed at the full cost, and not discounted for previous rental payments
- Despite guidelines, compliance is not rigorously tracked or adhered to
  - As observed by ACS and validated by CGI analysis, rental periods well beyond 3 months occur
- CMS and many states have adopted a rent-to-own policy rendering the rental equipment fully owned and purchased after 10-13 months of rental payments

Recommendations

- Discount purchases by amount of previous rental payments
- Investigate potential system controls to limit extended rentals
- Adopt rental period caps established by CMS for the Medicare program[1]
  - 36 months for Oxygen equipment
  - 13 months for other DME

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[1] CMS website (http://www.cms.hhs.gov)

Capped Rental Periods

Observed Equipment Rental Periods

Rentals Periods for Items Available for Purchase (Based on 12 Months of Claims Data)

# of Recipients, Category

Product Category	3 months or less	4 to 6 months	7 to 11 months	12 months or more
Wheelchairs	442	93	38	9
Bed/Mattress Related	304	66	43	12
Nutrition Related	150	29	23	16
I.V.	92	28	24	4
Miscellaneous	75	12	6	0
Dry Heat, TENS/NMES	34	9	4	0
Traction Equipment	40	5	1	0

Y-axis: Number of Recipients (0, 50, 100, 150, 200, 250, 300, 350, 400, 450, 500)

X-axis: Product Category

Note: Oxygen-related category excluded from this analysis due to common use of 36 month rental periods by CMS and other states

Source: Virginia Medicaid claims data from period April 25, 2008 to April 24, 2009