



# TEXAS HEALTH CARE POLICY COUNCIL

-POLICY PAPER-

CONTAINING COSTS FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES  
IN THE TEXAS MEDICAID PROGRAM

**RICK PERRY**  
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The Texas Health Care Policy Council believes that opportunities exist to improve the efficiency and cost-effectiveness of durable medical equipment (DME) and medical supplies purchase in Texas.

In state fiscal year 2005, there were 3,753 DME and medical supply providers in Texas. These providers served Medicaid beneficiaries in Medicaid's fee-for-service (FFS) and Primary Care Case Management (PCCM) programs. Currently, the Texas Medicaid program enrolls every qualified provider of DME services and supplies. This open provider enrollment system, in conjunction with current pricing methods, may not provide the most effective approach to controlling DME and medical supply costs.

DME and medical supplies are provided to Medicaid beneficiaries for both acute care and long-term care needs. DME costs for FFS and PCCM in state fiscal year 2005 totaled over \$217 million. FFS and PCCM beneficiaries comprised about 70 percent of all Medicaid enrollees in 2005. For those clients enrolled in a health maintenance organization (HMO), management and payment for DME is a responsibility of the HMO. DME costs for the roughly 30 percent of clients enrolled in the state's full risk Medicaid managed care program administered by HMOs are paid by the HMOs. These costs are not included in the above figure.

## COMPETITIVE ACQUISITION OF DME AND MEDICAL SUPPLIES

The Centers for Medicare and Medicaid Services (CMS) conducted a pilot program to purchase DME and medical supplies through a competitive bidding process under the authority of the 1997 Balanced Budget Act. CMS planned and implemented the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Demonstration in San Antonio from 2000-2002 to test the use of competitive bidding to set prices for DMEPOS for Medicare beneficiaries.

Overall, the demonstration reduced charges in San Antonio for a select group of DME items by \$4.6 million during its 23 months of operation, or 20.5 percent for each year of the demonstration project.

Texas could consider following the direction of the CMS pilot to reduce costs for DME and supplies for Medicaid beneficiaries not included in an HMO-based managed model. Using a competitive bidding system, the state could establish prices that may be more favorable than those that are obtained under the traditional open provider enrollment approach. Through competitive bidding and pricing, DME and supplies would be provided by a smaller base of enrolled providers who practice volume purchasing, and who are able to provide DME and supplies at a lower cost to the state.

## KEY PRINCIPLES, OPTIONS AND RECOMMENDATIONS

The Council identified the following key principles, implementation options, and recommendations regarding the development of a competitive bidding program for setting prices of DME and supplies for the FFS and PCCM components of Texas Medicaid program.

### PRINCIPLES

Because any changes to the current procurement and delivery model for DME and medical supplies could impact thousands of Medicaid beneficiaries, the Texas Health Care Policy Council believes the following principles should be considered during the development of any competitive bidding process.

- ✦ The implementation model for the Competitive Bidding Process Initiative (Initiative) should be simple and transparent to bidding suppliers and beneficiaries.
- ✦ One goal of the competitive bidding process should be to manage the utilization of DME and medical supplies and contain costs.
- ✦ The Initiative should target FFS and PCCM beneficiaries and should not include aged and disabled beneficiaries that are provided services under a waiver.
- ✦ The Initiative should ensure Medicaid beneficiaries have access to an array of quality DME and medical supplies provided through multiple vendors and distribution channels, with particular attention to accessibility for rural beneficiaries.
- ✦ The Initiative should be implemented statewide and should not be limited to specific geographic criteria or regions.
- ✦ Beginning the Initiative with standard, selected DME and supplies (e.g., incontinence supplies) that could be provided without individualized measurements and assessments (e.g., as would be required for specialized wheelchairs or hospital beds) may be the best way to demonstrate the value of a competitive bidding process.
- ✦ Identification and maintenance of standards for quality and accountability for those DME and medical supplies subject to competitive bidding are essential.
- ✦ In addition to the development of a competitive bidding process, the state should continue to research and identify other models to manage utilization and contain costs.

OPTIONS

1. Implement a Competitive Bidding Process Affecting the FFS, PCCM, and Waiver Populations in All Texas Counties
2. Implement a Competitive Bidding Process Affecting Only the FFS and PCCM Populations in All Texas Counties
3. Implement a Competitive Bidding Process Affecting FFS and PCCM Populations for Selected Medical Supplies in All Texas Counties

RECOMMENDATIONS

1. Implement a Competitive Bidding Process Affecting FFS and PCCM Populations for Selected Medical Supplies in All Texas Counties: The policy paper outlines three options for implementation of a competitive bidding option for DME and medical supplies in Texas. The Council recommends the Health and Human Services Commission (HHSC) implement Option 3 in accordance with the key principles outlined above. The Council further recommends HHSC consider the use of online, reverse auctions as the mechanism to set prices.

Under the third option, a competitive bidding model would be put in place for select medical supplies and would only impact FFS and PCCM populations. Waiver clients would not be included. Approximately seven months of technical effort would be required for implementation at an approximate cost of \$216,000. Depending on how the competitive bidding model is designed, implemented, and administered, costs could increase.

Hypothetical savings range from \$1.5-\$6.1 million in General Revenue.

2. Track and Study DME and Supplies Utilization in Counties with Non-Capitated and Capitated Models of Care: The Council believes the establishment of the Integrated Care Management (ICM) Administrative Services Operator (ASO) model in the Tarrant and Dallas service delivery areas of the state provides an opportunity to track and compare DME and supplies utilization and costs before and after ICM implementation in a non-capitated environment. Similarly, HMO providers in the Nueces service delivery should also track DME utilization so the state can compare utilization before and after implementation of STAR and STAR-PLUS capitated managed care.

# CONTAINING COSTS FOR DURABLE MEDICAL EQUIPMENT (DME) AND MEDICAL SUPPLIES IN THE TEXAS MEDICAID PROGRAM

## OVERVIEW OF TEXAS MEDICAID BENEFITS FOR DME AND SUPPLIES

DME benefits and medical supplies are provided to Medicaid beneficiaries for both acute care and long-term care needs.

### ACUTE CARE

The Medicaid Program Provider Procedures Manual identifies DME supplies and services that require prior authorization for Medicaid payment. Authorization for DME and medical supplies is available in acute care Medicaid through either the Home Health (HH) program or the Comprehensive Care Program (CCP). The HH program is available to all Medicaid beneficiaries and provides a wide range of DME (e.g. ventilators, wheelchairs, and nebulizers). The HH program also authorizes the purchase of medically related supplies (e.g. wound care supplies, feeding tubes, and incontinence supplies). CCP is only available to Medicaid beneficiaries under the age of 21 years and provides all DME items and supplies permitted under federal law in whatever amount, duration, and scope that is medically necessary beyond the limits established in the HH program.

Medicaid beneficiaries access DME services and supplies through their treating or prescribing physician and can obtain DME services and supplies from any Medicaid DME vendor. The existing provider base in Texas for DME and supplies in Medicaid includes 3,753 vendors. Medicaid-enrolled medical professionals must complete a form in order to request DME and supplies through either the HH or CCP program. This form must be signed by the requesting Medicaid provider and transmitted by fax or mail to the Texas Medicaid and Health care Partnership (TMHP) when the beneficiary is in either the fee-for-service (FFS) or Primary Care Case Management (PCCM) program, or to the beneficiary's Health Maintenance Organization (HMO) when the beneficiary is a member of a capitated managed care model of care.

The DME or supply request is received by either TMHP or the HMO (as appropriate), and reviewed. Prior authorization is issued if the request adequately documents that the items are covered benefits, medically necessary, and requested in quantities appropriate to the medical needs of the beneficiary. TMHP authorizes payment to private entities that are enrolled as DME vendors in Texas Medicaid. Following authorization approval, DME and medical supply vendors provide items to the beneficiaries and submit claims for the items to either TMHP or the HMO, as appropriate. The claims submission must contain the valid prior authorization number (PAN) that was issued to the provider when the request was approved. Claims lacking the valid PANs are rejected. Claims with valid PANs are adjudicated and may be paid if all other information on the claim is valid.

DME and supplies must meet the following requirements to qualify for reimbursement under the HH program.

- ★ The beneficiary received the equipment as prescribed by the physician.
- ★ The equipment has been properly fitted to the beneficiary and/or meets the beneficiary's needs.
- ★ The beneficiary, the parent or guardian of the beneficiary, and/or the primary caregiver of the beneficiary has received training and instruction regarding the equipment's proper use and maintenance.
- ★ The equipment or supplies must be medically necessary due to illness or injury or to improve the functioning of a body part, as documented by the physician in the beneficiary's plan of care or request form.
- ★ The equipment or supplies must be prior authorized by TMHP for rental or purchase of supplies for most equipment. Some equipment does not require prior authorization. Prior authorization for equipment rental can be issued for up to six months based on diagnosis and medical necessity. If an extension is needed, requests can be made up to 60 days before the start of the new authorization period with a new request form.
- ★ The equipment or supplies must meet the beneficiary's existing medical and treatment needs.
- ★ The equipment must be considered safe for use in the home.
- ★ The equipment must be provided through an enrolled DME home health provider or supplier.

## LONG-TERM CARE

There are three ways in which DME and supplies are provided to aged and disabled Medicaid beneficiaries:

1. through waiver programs;
2. in nursing facilities; and
3. in intermediate care facilities for persons with mental retardation (ICF/MR).

## WAIVER PROGRAMS

Waiver programs provide specific services to selected populations including some services not otherwise available in Medicaid. Waivers are granted by CMS, the federal authority that oversees state Medicaid programs. The Department of Aging and Disability Services (DADS) operates seven 1915 (c) waiver programs.

- ★ Community Based Alternatives (CBA).
- ★ Community Living Assistance and Support Services (CLASS).
- ★ Consolidated Waiver Program (CWP).
- ★ Deaf/Blind with Multiple Disabilities (DBMD).
- ★ Home and Community-based Services (HCS).
- ★ Medically Dependent Children's Program (MDCP).
- ★ Texas Home Living (TxHmL).

DME and medical supply policies and processes vary across these programs. DADS is currently in the process of streamlining these programs to make them more consistent as part of its work on Senate Bill 1188, 79th Legislature, Regular Session, 2005. Section 531.084 (b)(5) directs HHSC to examine the possibility of using fee schedules, prior approval processes, and alternative service delivery options to ensure appropriate utilization and payment for Medicaid services, and implement if cost effective. DADS is leading this effort related to waiver services and supplies.

In all the waiver programs, there is an interdisciplinary team (IDT) that is comprised of the beneficiary, the waiver program case manager, as well as anyone the beneficiary chooses to invite to participate. The IDT is responsible for approving the beneficiary's waiver service plan, including identifying the need for any DME and medical supplies. Each service plan has an overall spending limit, or cap, which must be observed. Each waiver program has a list of allowable DME and medical supply items for that program. The services are not however limited to those on the list.

A waiver service provider is responsible for the purchase of the DME or supplies for the beneficiary. Where possible and appropriate, the waiver service provider is expected to utilize Medicaid or Medicare acute care home health benefits before using waiver funds for the expenditure. A DADS employee must authorize the purchase in the majority of cases.

The point at which prior approval is needed varies across the 1915 (c) waiver programs and depends on the cost of the DME. For example, prior approval is not required in the DBMD, HSC, or TxHmL programs if the item is under a specified cost, or if it is not designated as an item needing prior approval. In HCS and TxHmL, items over \$500 must receive prior approval and an assessment must be conducted by the appropriate professional to verify the need for the DME. The provider also must obtain three bids and seek reimbursement through the Medicaid or Medicare acute care program. For CBA, CLASS and CWP, if the cost of the DME is estimated to be over \$500, DADS requires the provider to get written specifications from an appropriate licensed professional to ensure the item being purchased is appropriate for the consumer.

For all of the waivers, the estimated cost of the DME is entered into one of two DADS beneficiary authorization systems, either the Service Authorization System (SAS) for the legacy Department of Human Services (DHS) waivers or the Client Assignment and Registration (CARE) system for the legacy Mental Health and Mental Retardation (MHMR) waivers. Registration of the DME or medical supply in SAS or CARE is required in order for the provider claim to be processed.

To be paid for the DME or supply, the waiver provider submits DME or medical supply claims to TMHP. The claim amount must be no greater than the actual cost of the DME/supply. In the CBA, CWP, CLASS, and TxHmL programs, the provider is also reimbursed a requisition fee for each DME or supply claim. The requisition fee is a flat dollar amount to reimburse waiver providers for costs incurred in purchasing the item, paying the DME vendor, delivering the item, etc.

The specifications are used to develop the bid requests from the DME vendors. In these cases, the provider can submit a claim for a specification fee to cover these costs, in addition to the requisition fee. The waiver provider is not reimbursed for requisition or specification fees in the MDCP, DBMD, or HCS programs.

## NURSING FACILITIES

In nursing facilities, a physician assesses the resident to determine the resident's need for DME and medical supplies. Facilities are expected to provide DME and supplies to meet the needs of their residents. The cost of DME or supplies is included in the nursing facility daily rate, which is billed through the CMS/TMHP system. In other cases when residents desire specialized equipment for their exclusive use, the purchase of the equipment is the responsibility of the residents.

## INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION (ICF/MR)

The physician and therapist authorize the purchase of DME and supplies based on an assessment of a beneficiary's medical needs. With a limit of \$5,000 per client per year, DADS will pay a provider for the actual cost of a beneficiary's DME for persons in non-state operated facilities. This amount is above and beyond the ICF/MR daily rate. DADS must approve the purchase in advance and the provider must subsequently submit a voucher to DADS for the cost of the equipment.

For persons in state-operated facilities (i.e., state schools), the cost of the DME is included in the daily reimbursement rate. Prior to incurring these expenses, the state schools seek reimbursement from the Medicaid or Medicare acute care home health benefit, if available and appropriate.

## OVERVIEW OF THE CMS DMEPOS DEMONSTRATION

Under Balanced Budget Act 1997 authority, CMS planned and implemented the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Demonstration to test the use of competitive bidding to set prices for DMEPOS for Medicare beneficiaries. San Antonio was included in the CMS demonstration from 2000-2002. Five DME product categories were included.

1. Oxygen Equipment and Supplies.
2. Hospital Beds and Accessories.
3. Wheelchairs and Accessories.
4. General Orthotics.
5. Nebulizer Drugs.

Each product category was considered a separate competition, thus suppliers were required to submit separate bids for each product category. Seventy-nine firms submitted a total of 169 bids. Overall, 65 percent of suppliers that submitted bids won demonstration status (i.e., they could participate) in at least one product category. At the end of the bid evaluation process, multiple demonstration suppliers were selected in each category to promote competition for patients and a new fee schedule was determined. Demonstration suppliers were reimbursed according to this new fee schedule, minus the 20 percent beneficiary co-payment and any applicable deductible. Overall, the demonstration reduced charges in San Antonio by \$4.6 million during its 23 months of operation, or 20.5 percent for each year of the demonstration project.

The demonstration design included a number of features intended to promote and maintain beneficiary access as described below.

1. Multiple winners were selected in each product category to encourage competition among winning bidders.
2. Supplier capacity was taken into account in the bid evaluation process in an effort to ensure that selected suppliers had enough capacity to serve the entire area.
3. The Bid Evaluation Panel also examined the financial viability of firms in the competitive range to reduce the risk of bankruptcies that could cause access problems for beneficiaries.
4. Finally, transition policies allowed some non-demonstration suppliers to continue serving their existing patients during the demonstration under specific circumstances.

Palmetto Government Benefits Administrators (GBA), the durable medical equipment regional carrier for CMS Region C, was responsible for implementing and administering the demonstration on a day-to-day basis. In this role, Palmetto GBA was responsible for the functions outlined below.

- ✪ Designing the demonstration.
- ✪ Soliciting and evaluating bids.
- ✪ Processing claims.
- ✪ Responding to inquiries and complaints about the demonstration.

CMS staff was responsible for the following functions.

- ✪ Maintaining oversight responsibility for the demonstration.
- ✪ Reviewing all documents and Palmetto GBA decisions.
- ✪ Making final decisions about demonstration design and policy.

Additional considerations are summarized below.

- ✪ All claims submitted had to be screened by Palmetto GBA to determine whether they were demonstration claims.
- ✪ A procedure manual was developed specifically for the demonstration.
- ✪ CMS staff received intensive training.
- ✪ Internal education seminars were held for all Palmetto GBA staff to educate them about the demonstration.

Major cost categories included the following.

- ✪ Personnel.
- ✪ Computer software and upgrades necessary to accommodate the revised claims processing.
- ✪ Overhead costs.
- ✪ Publishing and mailing materials for beneficiaries and suppliers.

While suppliers frequently expressed opposition to the competitive bidding demonstration, problems were relatively minor and reflect one of the benefits of conducting demonstration projects: the ability to learn from the demonstration and apply the lessons of the demonstrated system when applied on a wider scale.

## MEDICAID MODELS OF CARE AND DME COST CONSIDERATIONS

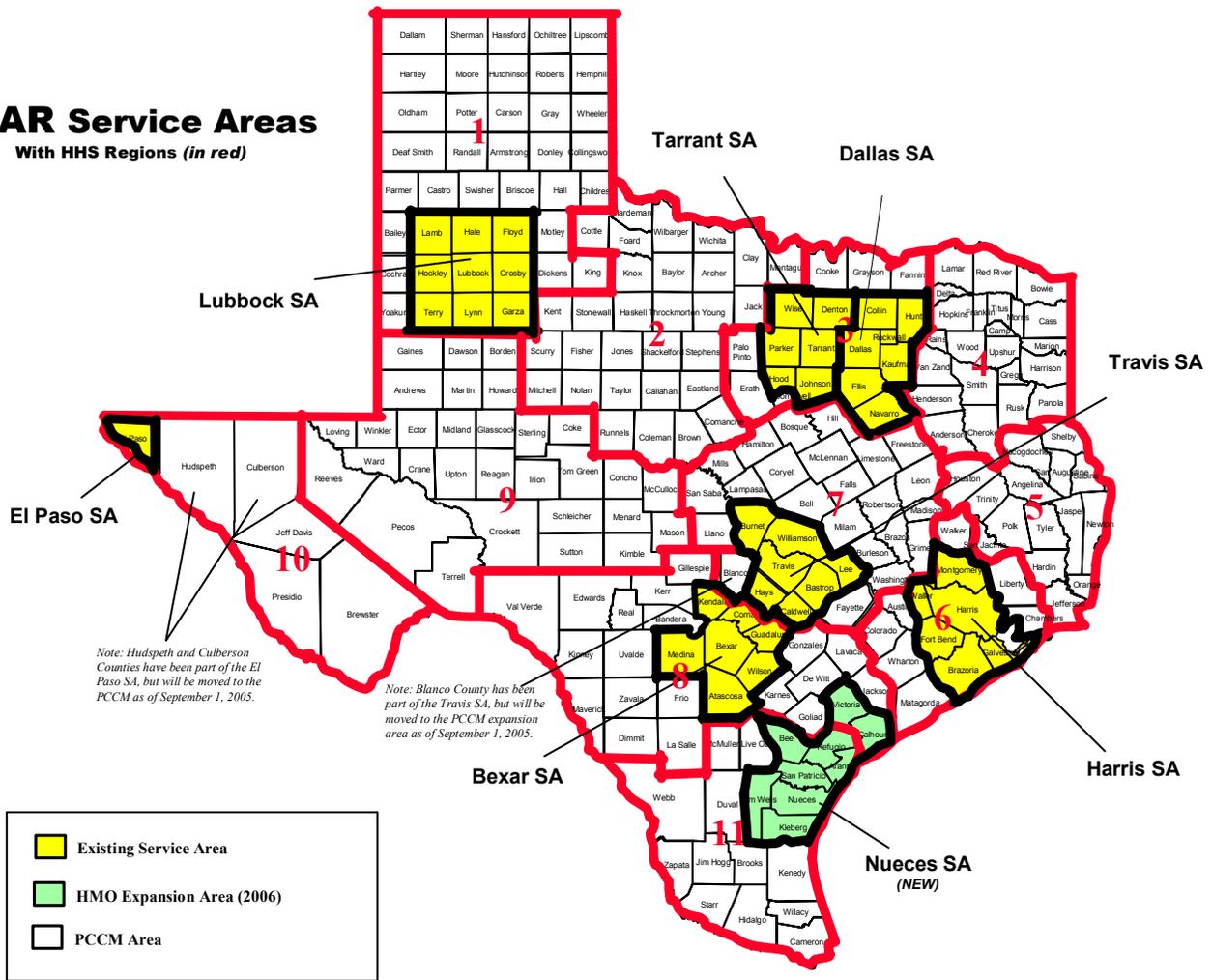
Most, but not all, of the state’s Medicaid beneficiaries are included in one of several managed care models. These models include: (1) the State of Texas Access Reform (STAR) program; (2) the STAR+PLUS program; and (3) the Primary Care Case Management (PCCM) program. The STAR and STAR+PLUS programs are primarily located in urban counties, or regions, of the state. Services in these programs are provided by contracted health maintenance organizations (HMOs) that are paid a capitated rate by the state. The HMOs pay providers based on rates the HMOs negotiate with their providers. The PCCM program is primarily located in 197 rural counties, or regions, of the state, and pays for services using fee-for-service (FFS) rates with claims paid for through the state’s claims administrator, the Texas Medicaid and Health care Partnership (TMHP). Table 1 provides Medicaid case load information by program type for fiscal years 2006-2010.

TABLE 1  
MEDICAID CASE LOAD BY PROGRAM TYPE  
NUMBERS AND PERCENTAGES  
FISCAL YEARS 2006-2010

	STAR	STAR+PLUS	TOTAL FOR CAPITATED MANAGED CARE MODELS	PCCM	TOTAL FOR ALL MANAGED CARE MODELS	FFS	TOTAL OF ALL MEDICAID BENEFICIARIES
FY 2006	809,418	57,320	866,738	970,931	1,837,669	932,599	2,770,268
FY 2007	1,060,358	122,551	1,182,909	754,938	1,937,847	848,502	2,786,349
FY 2008	1,134,851	158,485	1,293,336	732,521	2,025,857	852,094	2,877,951
FY 2009	1,182,404	164,271	1,346,675	764,245	2,110,920	883,600	2,994,520
FY 2006	29.2%	2.1%	31.3%	35.0%	66.3%	33.7%	100.0%
FY 2007	38.0%	4.4%	42.4%	27.2%	69.6%	30.4%	100.0%
FY 2008	39.4%	5.5%	44.9%	25.5%	70.4%	29.6%	100.0%
FY 2009	39.5%	5.5%	45.0%	25.5%	70.5%	29.5%	100.0%

# STAR Service Areas

With HHS Regions (in red)



HHSC, Health Plan Operations  
July 2005

## STAR HMO Service Areas

Bexar	Bexar
	Atascosa
	Coma;
	Guadalupe
	Kendall
	Medina
	Wilson
Lubbock	Lubbock
	Crosby
	Floyd
	Garza
	Hale
	Hockley
	Lamb
	Lynn
	Terry

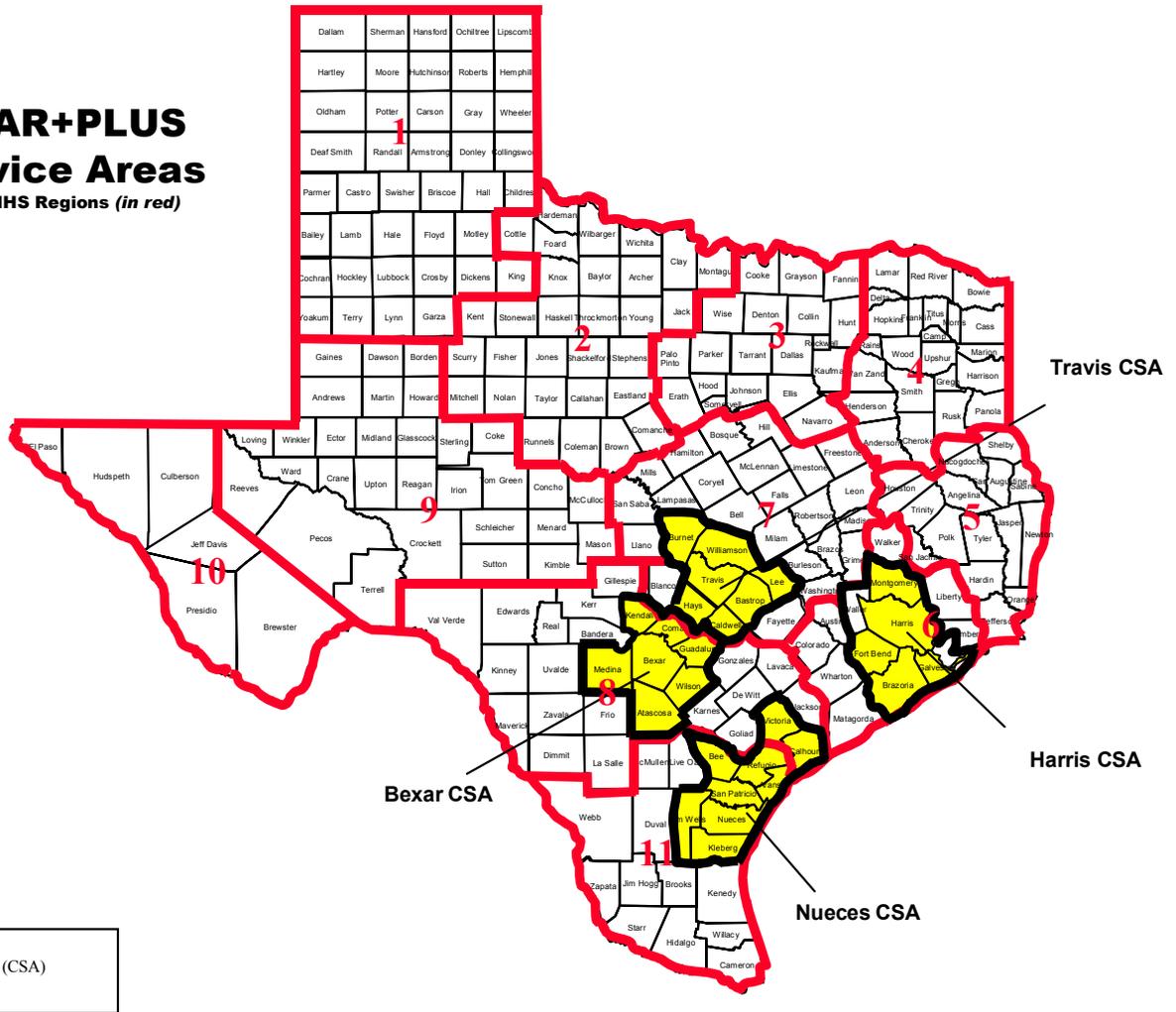
Dallas	Dallas
	Collin
	Ellis
	Hunt
	Kaufman
	Navarro
	Rokwall
Harris	Harris
	Brazoria
	Fort Bend
	Galveston
	Montgomery
	Waller
El Paso	El Paso

Tarrant	Tarrant
	Denton
	Hood
	Johnson
	Parker
	Wise

## New STAR Service Area

Nueces	Aransas
	Bee
	Calhoun
	Jim Wells
	Kleberg
	Nueces
	Refugio
	San Patricio
	Victoria

**STAR+PLUS  
Service Areas**  
with HHS Regions (in red)



STAR+PLUS HMO Service Areas

Bexar	Bexar	Harris	Harris	Travis	Travis	Nueces	Aransas
	Atascosa		Brazoria		Bastrop		Bee
	Comal		Fort Bend		Burnet		Calhoun
	Guadalupe		Galveston		Caldwell		Jim Wells
	Kendall		Montgomery		Hays		Kleberg
	Medina		Waller		Lee		Nueces
	Wilson				Williamson		Refugio
							San Patricio

In September 2006, the STAR program expanded to Nueces County under an HMO model; all managed beneficiaries in Texas' urban areas are now in an HMO. Beginning in January 2007, aged, blind, and disabled (ABD) beneficiaries in selected counties will be included in the STAR+PLUS model of care. In FY 2008, 45 percent of the Medicaid population will be covered by the STAR and STAR+PLUS capitated models of care. In particular, DME and supplies for ABD clients (i.e., the populations with the largest demand for these services) will be managed by HMOs. ABD clients in the Dallas and Tarrant service areas will be enrolled in another managed care model, the Integrated Care Management (ICM) model as that program development is finalized and implemented. This model will use the existing FFS reimbursement system, but will have managed care-like functions managed by an administrative services organization (ASO) contracted to manage that program. In addition to the 45 percent of Medicaid enrollees whose DME will be managed through a capitated model, ICM clients' care (estimated at 81,000 in 2005) would have their DME managed through the ICM model of care.

Table 2 indicates the top-10 counties in the state with the highest costs for DME and supplies for state fiscal year (FY) 2005. These 10 counties represented 59 percent of the state's total costs for DME and supplies in 2005. Seven of the 10 counties (shaded below and representing 41 percent of total DME in 2005) are included in Medicaid managed care models of care and therefore would have DME managed and paid for by HMOs. DME and services in Hidalgo, Cameron, and Webb Counties are reimbursed according to FFS rates. Except for Harris County (where the STAR+PLUS program manages care for adult aged and disabled populations, including DME needs, through HMOs), expenditures for adults were higher than expenditures for children.

TABLE 2  
TOP-10 COUNTIES WITH THE HIGHEST COSTS FOR DME AND SUPPLIES, 2005

County	Children	Adults	Total
1. Harris*,**	\$15,899,460	\$11,206,887	\$27,106,347
2. Hidalgo*****	\$7,307,124	\$14,977,981	\$22,285,105
3. Dallas*,****	\$7,475,740	\$10,332,280	\$17,808,020
4. Bexar*,***	\$7,224,957	\$9,776,175	\$17,001,132
5. Cameron*****	\$3,436,602	\$7,035,844	\$10,472,446
6. El Paso*	\$3,789,283	\$5,816,575	\$9,605,859
7. Tarrant*,****	\$3,759,140	\$5,206,980	\$8,966,120
8. Webb*****	\$2,225,404	\$2,937,046	\$5,162,450
9. Nueces*,***	\$1,937,661	\$2,616,428	\$4,554,088
10. Travis*,***	\$1,879,712	\$2,252,195	\$4,131,907
Subtotal	54,935,083	72,158,391	127,093,474
Other Counties	38,304,395	51,796,627	90,101,021
Total Cost for All Counties	\$93,239,478	\$123,955,018	\$217,194,495

\* HMOs manage the care of the Medicaid population in this county through the STAR program.

\*\* This county also provides managed care services through the STAR+PLUS program.

\*\*\* This county is included in STAR+PLUS expansion, which is expected to be implemented in January 2007.

\*\*\*\* This county will be included in the ICM model of care.

\*\*\*\*\* These counties are managed by the PCCM program.

Harris County's DME data reflects the inclusion in Harris County of ABD populations in HMOs in the STAR+PLUS program. Notably, Hidalgo County has the second-highest DME expenditures of any county statewide, yet ranked fourth in number of Medicaid enrollees in that same year.

In an effort to better understand DME and supplies utilization for FFS and PCCM populations, Table 3 presents a comparison of DME claims with Medicaid eligible individuals for the top-10 counties with the highest number of paid claims. The data provides information for both children and adults.

## CHILDREN

Of the ten counties, Cameron County, followed closely by Hidalgo County, had the highest percentage of DME and supplies utilization among Medicaid eligible children at 10.8 and 10.0 percent, respectively. These counties do not have capitated managed care to help control costs. Tarrant and Dallas Counties had the lowest percentage of DME and supplies utilization among Medicaid eligible children at 3.8 and 4.1 percent, respectively. These counties will be included in the ICM model of care when it becomes operational in 2007.

## ADULTS

Overall, utilization of DME services and supplies among Medicaid eligible adults was much higher than it was for children. Starr County had the highest percentage of DME and supplies utilization among Medicaid eligible adults at 50.2 percent; Hidalgo County followed at 40.8 percent. Costs in both of these counties are not controlled by capitated managed care. Tarrant and Dallas Counties had the lowest percentage of DME and supplies utilization among Medicaid eligible adults at 18.7 and 19.1 percent, respectively.

TABLE 3  
 TOP-10 COUNTIES WITH THE HIGHEST NUMBER OF PAID CLAIMS FOR DME AND SUPPLIES  
 CAPARISON OF DME CLAIMS WITH MEDICAID ELIGIBLE INDIVIDUALS  
 FFS AND PCCM CHILDREN AND ADULTS  
 FISCAL YEAR 2005

COUNTY	CHILDREN				ADULTS			
	# OF PAID CLAIMS	# OF PEOPLE THAT GENERATED CLAIMS	# ELIGIBLE FOR MEDICAID SERVICES	% OF PEOPLE GENERATING CLAIMS COMPARED TO # ELIGIBLE FOR MEDICAID SERVICES	# OF PAID CLAIMS	# OF PEOPLE THAT GENERATED CLAIMS	# ELIGIBLE FOR MEDICAID SERVICES	% OF PEOPLE GENERATING CLAIMS COMPARED TO # ELIGIBLE FOR MEDICAID SERVICES
1. Hidalgo	102,708	15,198	138,345	10.0	289,254	17,300	42,360	40.8
2. Harris	138,732	17,956	351,591	5.1	189,719	18,285	94,344	19.4
3. Bexar	66,388	9,048	157,649	5.7	191,834	12,513	53,765	23.3
4. Dallas	54,009	8,713	210,160	4.1	162,422	10,544	55,103	19.1
5. Cameron	46,779	7,973	73,518	10.8	145,250	8,965	23,503	38.1
6. El Paso	31,344	5,943	110,303	5.4	119,258	8,857	34,102	26.0
7. Tarrant	29,623	4,285	113,133	3.8	93,485	6,190	33,054	18.7
8. Webb	22,867	3,234	40,821	7.9	56,743	3,681	11,216	32.8
9. Starr	8,158	1,342	15,664	8.6	64,870	2,958	5,895	50.2
10. Nueces	19,635	2,519	36,072	7.0	49,914	3,604	14,191	25.4

## MEDICAID RATES FOR DME AND SUPPLIES

To better understand costs for DME and supplies, it is helpful to understand the current method for setting reimbursement prices for those items.

Providers are reimbursed the lower of their billed charges or the published Medicaid fee for DME and supplies. For DME and expendable supplies other than nutritional products that have no established fee, TMHP manually prices these items based on the manufacturer's suggested retail price (MSRP) less 18 percent (if documentation of the MSRP is submitted by the provider). If there is no MSRP available, reimbursement is made at an established percentage of the provider's invoice cost. Nutritional products that require manual pricing are priced at 89.5 percent of the average wholesale price (AWP). Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 Texas Administrative Code (TAC) §355-8021 (b)-(c). THSteps, the Early Periodic Screening, Diagnosis, and Treatment program for children in Texas, is reimbursed for DME and expendable supplies in accordance with 1 TAC §355-8441 (4)-(5).

Rate comparison analysis between Medicaid and Medicare was conducted on the DME and supplies items targeted in the CMS DMEPOS demonstration. Comparisons are difficult since not all items used in Medicare are appropriate or used in Medicaid. Further, required coding changes implemented in 2005 make comparisons by code difficult.

#### OXYGEN EQUIPMENT AND SUPPLIES

On average, Medicaid rates are higher than Medicare rates for these items. There may be opportunities to develop cost-efficiencies for these types of products.

#### HOSPITAL BEDS AND ACCESSORIES

Many of the items included in the CMS pilot are not items included as Medicaid benefits. For those items that are included as Medicaid benefits, Medicaid rates are, on average, lower than Medicare rates.

#### WHEELCHAIRS AND ACCESSORIES

None of the items included in the CMS pilot are coded as current benefits of the Medicaid program. Thus, rate comparison is not applicable. The Medicaid program does provide wheelchairs and accessories as benefits of the program, but under different codes.

#### GENERAL ORTHOTIC

Medicaid rates are lower than Medicare rates for all of the items included in this category.

#### NEBULIZER DRUGS

Only one of the items included in the CMS pilot is considered a benefit of the Medicaid program. However, the Medicaid rate is higher than the Medicare rate.

## UTILIZATION AND COST CONSIDERATIONS FOR LONG-TERM CARE WAIVER PROGRAMS

To better understand DME and supplies utilization and costs for long-term waiver programs, staff conducted analysis by county and waiver type. Approximate utilization and cost estimates for all waiver types identified 53,290 individuals in waiver programs in FY 2005 at a total cost of over \$892.5 million. However, much of the cost for waiver programs comes from attendant care services, not from DME and supplies.

Approximately 70 percent of all waiver program clients received DME and supplies at a cost of over \$32 million. This cost represented 3.6 percent of overall waiver-related program costs. The CBA and CWP waivers comprised the highest percentage of utilization by clients. DME and supplies for the CBA waiver program comprised 6.4 percent of all waiver-related costs, while the same services for the CWP comprised 5.9 percent of all waiver-related costs. However, it is expected that about 7 percent of CBA clients statewide are projected to move into an HMO model of care, therefore reducing future cost expenditures for their DME and supplies.

## RECOMMENDATIONS

When DME and supplies totals for waiver populations (\$32 million) are added to statewide totals for DME and supplies for FFS and PCCM populations (\$217 million), it is estimated that the state spent approximately \$249 million in All Funds (AF) for DME and supplies in FY 2005.

To better control DME and supplies utilization and costs, consider the following recommendations.

### IMPLEMENT A COMPETITIVE BIDDING PROCESS FOR TEXAS MODELED AFTER THE DEMONSTRATION PROGRAM CMS IMPLEMENTED IN SAN ANTONIO.

While the goal of such a process would be to better control utilization and costs for all DME and supplies statewide, the following options may be considered for initial implementation.

#### OPTION 1 – IMPLEMENT A COMPETITIVE BIDDING PROCESS AFFECTING THE FFS, PCCM, AND WAIVER POPULATIONS IN ALL TEXAS COUNTIES

Option 1 includes implementation of a competitive bidding model for all DME purchased for all Medicaid (including waiver) enrollees whose DME will not be managed through a capitated model or the ICM model. Approximately 2,700 distinct DME and supply items would be considered in this competitive bidding option. FY 2005 DME and supplies costs for these three populations were over \$249 million in AF.

#### HYPOTHETICAL COSTS TO IMPLEMENT OPTION 1

Additional staff would be necessary to implement system changes. However, it is undetermined at this time how much effort, or how many necessary systems changes, would be required to implement this option. A further consideration is that depending on how the competitive bidding model is designed, implemented, and administered, additional costs may be incurred.

#### HYPOTHETICAL SAVINGS FROM THE IMPLEMENTATION OF OPTION 1

Hypothetical savings for implementation of Option 1 range from \$4.9-\$19.9 million in general revenue (GR). The option would target all populations throughout the state receiving all types of DME and supplies, except beneficiaries covered by a capitated managed care model. For a comparison of hypothetical savings estimates for this option with other proposed options, please see Table 4.

#### OPTION 2 – IMPLEMENT A COMPETITIVE BIDDING PROCESS AFFECTING ONLY THE FFS AND PCCM POPULATIONS IN ALL TEXAS COUNTIES

Option 2 and its considerations are similar to those of Option 1, however waiver populations would not be included in the competitive bidding model. It is undetermined whether waiver programs could be subject to a competitive bidding model. CMS has instructed the state to encourage open enrollment for providers and to increase choices for consumers. Waiver programs and services for DME and supplies are currently being reviewed by DADS in the broader context of work on Senate Bill 1188, 79th Legislature, Regular Session, 2005.

Option 2 would be a competitive bidding model for all DME purchased for FFS and PCCM Medicaid enrollees throughout the state whose DME will not be managed through a capitated model or the ICM model. There are approximately 2,700 distinct DME and supply items to be considered in this competitive bidding option. FY 2005 DME and supplies costs for these populations were over \$217 million in AF. In FY 2008 and 2009, 55.1 and 55 percent, respectively, of Medicaid beneficiaries will be in FFS and PCCM models of care.

#### HYPOTHETICAL COSTS TO IMPLEMENT OPTION 2

Additional staff would be necessary to implement system changes. However, it is undetermined at this time how much effort, or how many necessary systems changes, would be required to implement this option. A further consideration is that depending on how the competitive bidding model is designed, implemented, and administered, additional costs may be incurred.

#### HYPOTHETICAL SAVINGS FROM THE IMPLEMENTATION OF OPTION 2

Hypothetical savings range from \$4.3-\$17.4 million in GR. All types of DME and supplies for FFS and PCCM beneficiaries across the state would be targeted for these savings. For a comparison of hypothetical savings estimates for this option with other proposed options, please see Table 4.

#### OPTION 3 – IMPLEMENT A COMPETITIVE BIDDING PROCESS AFFECTING FFS AND PCCM POPULATIONS FOR SELECTED MEDICAL SUPPLIES IN ALL TEXAS COUNTIES

Option 3 would affect FFS and PCCM populations in counties throughout the state by providing a competitive bidding model comprised of just some of the approximately 2,700 DME and supplies available to beneficiaries. Waiver clients would not be included. Beginning the initiative with standard, selected DME and supplies (e.g., incontinence supplies) that could be provided without individualized measurements and assessments (e.g., as would be required for specialized wheelchairs or hospital beds) provides the state with the opportunity to test the competitive bidding premise before expanding it to all DME and supplies. These selected items are also amenable to mail order and delivery to beneficiaries.

#### HYPOTHETICAL COSTS TO IMPLEMENT OPTION 3

Focusing on selected items in this competitive bidding model would contain some of the administrative and staff costs expected for implementation. Approximately seven months of technical effort would be required for implementation of Option 4 at an approximate cost of \$216,000. Depending on how the competitive bidding model is designed, implemented, and administered, costs could increase.

#### HYPOTHETICAL SAVINGS FROM THE IMPLEMENTATION OF OPTION 3

Hypothetical savings range from \$1.5-\$6.1 million in GR. For a comparison of hypothetical savings estimates for this option with other proposed options, please see Table 4.

TABLE 4  
ESTIMATED COST SAVINGS FOR DME AND SUPPLIES  
BASED UPON FY 2005 COSTS\*

Options	FY 05 Costs for All Types of DME and Supplies	5%		10%		20%	
		All Funds	General Revenue	All Funds	General Revenue	All Funds	General Revenue
FFS/ PCCM/ Waiver	\$249,279,127	\$12,463,956	\$4,985,583	\$24,927,913	\$9,971,165	\$49,855,825	\$19,942,330
FFS/PCCM (-) Waiver Population	\$217,194,494	\$10,859,725	\$4,343,890	\$21,719,449	\$8,687,780	\$43,438,899	\$17,375,560
Selected Medical Supplies**	\$77,394,315	\$3,869,716	\$1,547,886	\$7,739,431	\$3,095,773	\$15,478,863	\$6,191,545

\* Amounts rounded to the nearest dollar.

\*\* a complete list of costs for these items is currently incomplete, as staff focused on the top-75 items referenced in Appendix 2.

#### ADDITIONAL IMPLEMENTATION CONSIDERATIONS

Implementation of a DME initiative will require the following:

- ★ Development of a DME proposal and procurement model, including specifications required to prepare, draft, and finalize a Request for Proposals (RFP). These activities will take approximately four months to complete. One model that could be considered is reverse auctions. Reverse auctions are an online mechanism that enables vendors of commodity items to bid against one another in real time. Under this model, an agency sets a top price, and pre-qualified vendors compete against one another to lower their price to secure the business. This process has shown significant procurement savings in Texas and other states, and could be set up to award multiple winners.
- ★ Once model specifications are completed, HHSC approvals must be sought and a 1915(b) waiver may need to be developed and approved by CMS. These activities will take approximately seven months to complete.
- ★ When the RFP has been drafted and approved, it must be issued to the public, after which time HHSC must select and approve vendors, develop and implement system change specifications, and design and complete readiness reviews. These processes will take approximately seven months to complete.

The entire development process could take approximately 17-18 months to complete.

## INSTRUCT THE ICM ASO TO TRACK DME UTILIZATION AND COSTS.

The establishment of the ICM model in the Tarrant and Dallas service delivery areas of the state provides an opportunity to track and compare DME and supplies utilization and costs before and after ICM implementation in a non-capitated environment.

## INSTRUCT THE HMO PROVIDERS IN THE NUECES SERVICE DELIVERY AREA TO TRACK DME UTILIZATION.

Tracking should begin with September 2006 so the state can compare utilization before and after implementation of STAR and STAR+PLUS capitated managed care.

## CONCLUSIONS

Opportunities exist to improve the efficiency and cost-effectiveness of DME and supplies purchase in Texas. Various possibilities exist about which populations and areas of the state to target with a competitive bidding initiative. Similarly, estimates of hypothetical cost savings for the initiative also vary. Overall, a competitive bidding approach could make it possible for the state to negotiate rates with providers so that both costs and utilization could be controlled.

# APPENDIX 1

## 2005 DME DATA BY DOLLAR AMOUNT

Procedure Code	Procedure Description	TOS	Sum Allowed Qty	Sum Paid Amt
E1220	WHLCHR SPECIAL SIZE/CONSTRC	J	2,762.00	18,642,898.67
A4527	ADULT SIZE BRIEF LG EACH	9	15,024,176.40	12,403,876.53
A4554	DISPOSABLE UNDERPADS	9	27,009,472.10	11,025,335.19
A4253	BLOOD GLUCOSE/REAGENT STRIPS	9	256,743.00	7,138,628.33
E1399	DURABLE MEDICAL EQUIPMENT MI	J	19,574.00	6,751,125.79
A4535	DISP INCONT LINER/SHIELD EA	9	16,661,941.90	4,812,733.42
E0570	NEBULIZER WITH COMPRESSION	J	45,961.00	4,792,884.41
A4526	ADULT SIZE BRIEF MED EACH	9	6,907,726.40	4,677,574.54
A4528	ADULT SIZE BRIEF XL EACH	9	5,049,983.00	4,614,431.56
B4035	ENTERAL FEED SUPP PUMP PER D	9	459,959.00	4,503,402.37
NSPU3	NUTRITIONAL SUPPLEMENT 3*	9	5,237,719.30	3,624,002.13
A4532	CHILD SIZE BRIEF LG EACH	9	3,945,619.40	3,283,743.24
A4523	ADULT SIZE DIAPER LG EACH	9	4,537,053.60	2,932,172.04
A4522	ADULT SIZE DIAPER MED EACH	9	4,211,081.30	2,541,520.00
E1210	WHLCHR MOTO FUL ARM LEG REST	J	600.00	2,219,943.29
K0108	W/C COMPONENT-ACCESSORY NOS	J	5,112.00	2,171,131.74
E0260	HOSP BED SEMI-ELECTR W/ MATT	J	1,230.00	2,170,150.29
NSPU9	NUTRITIONAL SUPPLEMENT 9*	9	753,726.10	2,060,579.65
B4150	ENTERAL FORMULAE CATEGORY I	9	4,295,311.30	1,924,917.54
A4335	INCONTINENCE SUPPLY	9	626,888.90	1,869,407.70
A4353	INTERMITTENT URINARY CATH	9	289,432.00	1,821,847.19
A4530	CHILD SIZE DIAPER LG EACH	9	3,284,717.70	1,695,312.38
A4259	LANCETS PER BOX	9	126,242.00	1,405,967.77
A4351	STRAIGHT TIP URINE CATHETER	9	907,888.00	1,374,948.25
B9998	ENTERAL SUPP NOT OTHERWISE C	9	206,075.70	1,248,532.15
A4524	ADULT SIZE DIAPER XL EACH	9	1,640,461.00	1,123,926.30
A4534	YOUTH SIZE BRIEF EACH	9	1,943,680.40	1,117,951.30
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM, (INCLUDES HOSES AND VE	J	111.00	1,112,279.40
L1960	AFO POS SOLID ANK PLASTIC MO	9	3,217.00	1,091,073.53
A4624	TRACHEAL SUCTION TUBE	9	456,889.00	1,054,238.88
E0601	CONT AIRWAY PRESSURE DEVICE	J	707.00	860,728.36
E1213	WHEELCHAIR MOTORIZED W/ DET	J	253.00	845,897.51
A4521	ADULT SIZE DIAPER SM EACH	9	1,450,252.00	829,630.73
NSPU2	NUTRITIONAL SUPPLEMENT 2*	9	1,563,594.60	758,835.04
E1236	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	J	202.00	746,535.04
A4533	YOUTH SIZE DIAPER EACH	9	1,056,637.50	608,256.41
E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	J	124.00	571,889.69
A4531	CHILD SIZE BRIEF SM/MED EACH	9	886,523.00	552,859.86
L1970	AFO PLASTIC MOLDED W/ANKLE J	9	1,374.00	546,060.25

Procedure Code	Procedure Description	TOS	Sum Allowed Qty	Sum Paid Amt
A9900	SUPPLY/ACCESSORY/SERVICE	9	46,943.00	533,408.82
E1340	REPAIR FOR DME, PER 15 MIN	9	40,065.50	512,743.73
B9002	ENTERAL INFUSION PUMP W/ ALA	J	488.00	463,123.67
A6250	SKIN SEAL PROTECT MOISTURIZR	9	45,521.50	462,826.78
E0630	PATIENT LIFT HYDRAULIC	J	396.00	456,627.28
A4352	COUDE TIP URINARY CATHETER	9	91,386.00	428,783.22
K0549	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY >350 POUNDS, BUT	J	91.00	419,800.42
E0192	PAD WHEELCHR LOW PRESS/POSIT	J	1,576.00	417,275.07
A4525	ADULT SIZE BRIEF SM EACH	9	664,560.60	382,832.10
E1011	PED WC MODIFY WIDTH ADJUSTM	J	184.00	363,698.55
E1211	WHEELCHAIR MOTORIZED W/ DET	J	92.00	336,079.50
E0607	BLOOD GLUCOSE MONITOR HOME	J	6,963.00	335,356.91
E0265	HOSP BED TOTAL ELECTR W/ MAT	J	173.00	325,153.95
A4629	TRACHEOSTOMY CARE KIT	9	75,163.00	314,036.43
N5PU5	NUTRITIONAL SUPPLEMENT 5*	9	321,085.70	311,593.03
S8101	HOLDING CHAMBER OR SPACER FOR USE WITH AN INHALER OR NEBULIZER WITH MASK	9	8,397.00	306,456.09
A4245	ALCOHOL WIPES PER BOX	9	557,247.10	286,939.08
B4154	EF SPEC METABOLIC NONINHERIT	9	233,470.80	271,815.92
A4670	AUTO BLOOD PRESSURE MONITOR	9	5,544.00	271,788.79
K0544	SGD W MULTI METHODS MSG/ACCS	J	80.00	263,941.42
E0784	EXT AMB INFUSN PUMP INSULIN	J	60.00	258,404.76
N5PU7	NUTRITIONAL SUPPLEMENT 7*	9	127,933.70	252,376.51
L2275	PLASTIC MOD LOW EXT PAD/LINE	9	3,065.00	250,924.43
E044C	OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON-INVASIVELY	J	88.00	249,870.00
E0445	OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON-INVASIVELY	J	242.00	240,778.58
L1940	AFO MOLDED TO PATIENT PLASTI	9	745.00	216,182.21
E1230	POWER OPERATED VEHICLE	J	106.00	213,196.51
K0083	22 NF GEL CELL BATTERY EACH	J	1,558.00	211,018.83
L2036	KAFO PLAS DOUB FREE KNEE MOL	9	206.00	207,098.32
B4152	EF CALORIE DENSE>/=1.5KCAL	9	287,116.20	205,088.38
B4153	EF HYDROLYZED/AMINO ACIDS	9	116,966.10	198,186.66
L3000	FT INSERT UCB BERKELEY SHELL	9	1,704.00	195,656.13
S1015	IV TUBING EXTENSION SET	9	19,987.00	193,725.89
A4327	FEM URINARY COLLECT DEV CUP	9	5,081.00	184,324.41
L2270	VARUS/VALGUS STRAP PADDED/LI	9	5,801.00	179,515.72
E1260	WHEELCHAIR LIGHTWT FOOT REST	J	201.00	\$178,257.80

\* 100 CALORIES = 1 UNIT

## APPENDIX 2

### 2005 DME DATA BY QUANTITY PROVIDED

Procedure Code	Procedure Description	TOS	Sum Allowed Qty	Sum Paid Amt
A4554	DISPOSABLE UNDERPADS	9	27,009,472.10	11,025,335.19
A4535	DISP INCONT LINER/SHIELD EA	9	16,661,941.90	4,812,733.42
A4527	ADULT SIZE BRIEF LG EACH	9	15,024,176.40	12,403,876.53
A4526	ADULT SIZE BRIEF MED EACH	9	6,907,726.40	4,677,574.54
NSPU3	NUTRITIONAL SUPPLEMENT 3*	9	5,237,719.30	3,624,002.13
A4528	ADULT SIZE BRIEF XL EACH	9	5,049,983.00	4,614,431.56
A4523	ADULT SIZE DIAPER LG EACH	9	4,537,053.60	2,932,172.04
B4150	ENTERAL FORMULAE CATEGORY I	9	4,295,311.30	1,924,917.54
A4522	ADULT SIZE DIAPER MED EACH	9	4,211,081.30	2,541,520.00
A4532	CHILD SIZE BRIEF LG EACH	9	3,945,619.40	3,283,743.24
A4530	CHILD SIZE DIAPER LG EACH	9	3,284,717.70	1,695,312.38
A4534	YOUTH SIZE BRIEF EACH	9	1,943,680.40	1,117,951.30
A4524	ADULT SIZE DIAPER XL EACH	9	1,640,461.00	1,123,926.30
NSPU2	NUTRITIONAL SUPPLEMENT 2*	9	1,563,594.60	758,835.04
A4521	ADULT SIZE DIAPER SM EACH	9	1,450,252.00	829,630.73
A4533	YOUTH SIZE DIAPER EACH	9	1,056,637.50	608,256.41
A4351	STRAIGHT TIP URINE CATHETER	9	907,888.00	1,374,948.25
A4531	CHILD SIZE BRIEF SM/MED EACH	9	886,523.00	552,859.86
NSPU9	NUTRITIONAL SUPPLEMENT 9*	9	753,726.10	2,060,579.65
A6402	STERILE GAUZE <= 16 SQ IN	9	666,839.00	77,473.03
A4525	ADULT SIZE BRIEF SM EACH	9	664,560.60	382,832.10
A4335	INCONTINENCE SUPPLY	9	626,888.90	1,869,407.70
A4245	ALCOHOL WIPES PER BOX	9	557,247.10	286,939.08
A4529	CHILD SIZE DIAPER SM/MED EA	9	528,426.00	156,800.84
B4035	ENTERAL FEED SUPP PUMP PER D	9	459,959.00	4,503,402.37
A4624	TRACHEAL SUCTION TUBE	9	456,889.00	1,054,238.88
A6216	NON-STERILE GAUZE<=16 SQ IN	9	433,974.00	21,070.47
NSPU5	NUTRITIONAL SUPPLEMENT 5*	9	321,085.70	311,593.03
A4353	INTERMITTENT URINARY CATH	9	289,432.00	1,821,847.19
B4152	EF CALORIE DENSE>/=1.5KCAL	9	287,116.20	205,088.38
A4253	BLOOD GLUCOSE/REAGENT STRIPS	9	256,743.00	7,138,628.33
B4154	EF SPEC METABOLIC NONINHERIT	9	233,470.80	271,815.92
B9998	ENTERAL SUPP NOT OTHERWISE C	9	206,075.70	1,248,532.15
A4209	5+ CC STERILE SYRINGE&NEEDLE	9	155,293.00	64,400.18
A4450	NON-WATERPROOF TAPE	9	129,210.00	10,252.36
NSPU7	NUTRITIONAL SUPPLEMENT 7*	9	127,933.70	252,376.51
A4259	LANCETS PER BOX	9	126,242.00	1,405,967.77
NSPU4	NUTRITIONAL SUPPLEMENT 4*	9	122,577.50	101,360.53
B4153	EF HYDROLYZED/AMINO ACIDS	9	116,966.10	198,186.66
NSPU6	NUTRITIONAL SUPPLEMENT 6*	9	95,536.40	156,673.50
A4352	COUDE TIP URINARY CATHETER	9	91,386.00	428,783.22
A4629	TRACHEOSTOMY CARE KIT	9	75,163.00	314,036.43
A7003	NEBULIZER ADMINISTRATION SET	9	72,137.00	176,064.96

Procedure Code	Procedure Description	TOS	Sum Allowed Qty	Sum Paid Amt
B4100	FOOD THICKENER, ADMINISTERED ORALLY, PER OUNCE	9	66,356.90	68,767.57
A4322	IRRIGATION SYRINGE	9	66,233.00	137,380.25
B4151	ENTERAL FORMULAE CAT1NATURAL	9	64,711.80	83,844.56
A4452	WATERPROOF TAPE	9	64,123.00	18,147.68
A6252	ABSORPT DRG >16 <=48 W/O BDR	9	53,134.40	112,368.83
A4483	MOISTURE EXCHANGER	9	53,115.00	174,972.62
A6266	IMPREG GAUZE NO H2O/SAL/YARD	9	49,394.00	88,524.20
A9900	SUPPLY/ACCESSORY/SERVICE	9	46,943.00	533,408.82
A4324	MALE EXT CATH W/ADH COATING	9	46,267.00	93,038.08
E0570	NEBULIZER WITH COMPRESSION	J	45,961.00	4,792,884.41
A6250	SKIN SEAL PROTECT MOISTURIZR	9	45,521.50	462,826.78
E1340	REPAIR FOR DME, PER 15 MIN	9	40,065.50	512,743.73
A5063	DRAIN OSTOMY POUCH W/FLANGE	9	37,629.00	68,646.73
A6426	CONF BANDAGE S >=3<5" W/ROLL	9	35,605.00	62,607.49
A7015	AEROSOL MASK USED W NEBULIZE	9	33,491.00	59,613.58
A4215	STERILE NEEDLE	9	33,140.00	5,204.69
A4402	LUBRICANT PER OUNCE	9	32,902.00	39,676.90
B4034	ENTER FEED SUPKIT SYR BY DAY	9	30,693.00	154,956.32
A5061	POUCH DRAINABLE W BARRIER AT	9	28,379.00	71,133.33
A7002	TUBING USED W SUCTION PUMP	9	27,726.00	80,721.92
S8181	TRACH TUBE HOLDER	J	26,046.00	74,077.32
A4414	OSTOMY SKNBARR W FLNG <=4SQ	9	25,303.00	122,666.87
A4930	STERILE, GLOVES PER PAIR	9	24,768.00	12,069.85
A6223	GAUZE >16<=48 NO W/SAL W/O B	9	23,776.00	39,669.31
B4036	ENTERAL FEED SUP KIT GRAV BY	9	23,275.00	156,463.13
A6209	FOAM DRSG <=16 SQ IN W/O BDR	9	22,724.00	149,341.00
A6446	CONFORM BAND S W>=3" <5"/YD	9	21,102.00	8,626.36
A4213	20+ CC SYRINGE ONLY	9	20,879.00	7,219.91
NSPU8	NUTRITIONAL SUPPLEMENT 8*	9	20,843.60	41,220.37
S1015	IV TUBING EXTENSION SET	9	19,987.00	193,725.89
A4927	GLOVES	9	19,605.50	48,483.17
E1399	DURABLE MEDICAL EQUIPMENT MI	J	19,574.00	\$6,751,125.79

\* 100 CALORIES = 1 UNIT



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