California State Auditor

BUREAU OF STATE AUDITS

Department of Health Services:

It Needs to Better Control the Pricing of Durable Medical Equipment and Medical Supplies and More Carefully Consider Its Plans to Reduce Expenditures on These Items

December 2002
2002-109

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CALIFORNIA STATE AUDITOR

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December 12, 2002 2002-109

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Department of Health Services' (department) purchasing and contracting practices for durable medical equipment (DME), medical supplies, and hearing aids under the California Medical Assistance Program (Medi-Cal).

This report concludes that the department's cost control procedures have been ineffective in reining in spending for items with no maximum allowable prices (unlisted items). For example, the department lacks tools, such as current price and item comparison tables, that would allow it to ensure that it pays the lowest possible price for items that meet the medical needs of Medi-Cal beneficiaries.

The department has not ensured that it does not approve expenditures for unlisted DME items that should be charged under listed codes at a lower cost. Further, the department has delayed price updates for its medical supplies for an average of 15.5 years. In addition, many of the department's product codes may be obsolete. Better control of its costs is key especially given the increase in enrollments and the decrease in one of the department's funding sources, the federal medical assistance percentage. Any savings the department can achieve will free up funds that the State can use to support other programs or agencies in a time of state budgetary constraints.

To better control rising costs, the department plans to implement two cost-saving measures. The department hopes to convert its billing codes for some medical supplies to universal product numbers and plans to negotiate contracts with manufacturers of DME and medical supplies in fiscal year 2002–03. While both plans have the potential to reduce costs for the department, both could also result in increased administrative costs and a failure to reduce expenditures if the department does not thoroughly plan before proceeding. For example, for negotiated contracting, the department has not focused on clear objectives and appropriate staffing needs, has not contacted providers and manufacturers to ascertain their willingness to participate, and has not addressed the problem of how to determine reasonable prices.

Respectfully submitted,

Elaine M. Howle

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State Auditor

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SUMMARY

Audit Highlights . . .

Our review of the Department of Health Services' (department) purchasing and contracting practices for durable medical equipment (DME) and medical supplies under the California Medical Assistance Program (Medi-Cal) revealed that:

- ☑ *While the number of beneficiaries and related expenditures are increasing, federal funding for Medi-Cal is likely to decrease by $222 million in fiscal year 2002–03.*
- ☑ *The department's cost-control procedures have not prevented significant spending increases for unlisted items—those with no established maximum allowable product costs (MAPCs).*
- ☑ *It has been more than 15 years on average since the department last updated the MAPCs for many medical supplies.*
- ☑ *The department's inadequate planning for two initiatives it believes will reduce its DME and medical supply costs—converting its medical supply billing codes to universal product numbers and negotiating contracts with manufacturers—may undermine their success.*

Medicaid, a federal program funded and administered in partnership with the various states, provides health insurance to low-income families and to the aged, blind, and disabled. The Department of Health Services (department) administers California's Medicaid program, the California Medical Assistance Program (Medi-Cal), which provides medical assistance to 6.02 million beneficiaries in California. Medi-Cal's overall expenditures have risen sharply, 56 percent, since fiscal year 1993–94. While the department's expenditures for medical supplies have decreased, its expenditures for durable medical equipment (DME) and hearing aids have increased significantly from 1998 to 2001. Only some of this increase can be attributed to the increased number of beneficiaries utilizing the program's services. These increases, accompanied by the likely reduction in one of the department's two main funding sources, the federal medical assistance percentage, of approximately $222 million for fiscal year 2002–03, make it imperative that the department control costs to the program. Because the State's General Fund must pick up the difference between Medi-Cal's total direct program costs and the percentage the federal government reimburses Medi-Cal, savings on DME and medical supplies will translate into savings that the General Fund can use for other programs in a time of increasing budget constraints.

To ensure that Medi-Cal pays fair and reasonable prices for DME, medical supply, and hearing aid purchases, the department uses cost-control features such as requiring prior authorization on DME items over $100, setting maximum payment amounts for products, and conducting audits of providers of Medi-Cal services and products. However, expenditures for items with no established maximum payment amounts (unlisted items), have increased significantly, and they have driven much of the increase in DME expenditures. Unlisted wheelchairs have been a major contributor. For example, the department's policies require wheelchair providers to document why they are billing under a code that does not specify a maximum amount that can be paid (an unlisted code) instead of listed codes with maximum allowable product costs (MAPCs). The policy also requires providers to document that the requested wheelchair was the lowest-cost item among comparable wheelchairs that will meet

the patient's needs. However, the department has not enforced these policies. In fiscal year 2001–02, the department paid an average of $3,121 for wheelchairs with unlisted codes compared to $622 for wheelchairs with listed codes.

Also, the department has limited the effectiveness of establishing maximum prices because it has not updated the prices for many of its medical supplies for more than 15 years, even though technological improvements in manufacturing these items may have caused the market prices of some of these items to go down. Both in updating prices and in authorizing purchases of unlisted items, the department lacks price comparison data to determine reasonable costs for items and price. It also lacks item comparison tables to determine which items with varying catalog prices are functionally equivalent. Consequently, staff in the department's field offices who review authorization requests for unlisted items cannot ensure that they are authorizing the lowest-cost item that meets the patient's medical needs.

Another barrier to ensuring fair costs, the department's billing codes, developed some years ago, do not give enough detailed information on products that providers are billing for. Thus, the codes fail to specify exactly which items Medi-Cal is covering. Because of this lack of product specificity, the department can neither ensure that beneficiaries are getting the quality they need nor can it control expenditures. In fiscal year 2001–02, the department paid providers $9.9 million for at least 14 types of waterproof sheets from various manufacturers. However, the same billing code was used for a waterproof sheet that costs 42 cents as one that costs $55, so the department risks paying the higher price but receiving the cheaper product.

To control rising costs, the department plans to implement two cost-saving measures. First, the department hopes to convert its billing codes to universal product numbers (UPNs), barcode numbers typically used for inventory purposes, initially only for its medical supplies. The department believes that UPNs may give it more relevant and current information on price and product descriptions, putting the department in a more favorable position for controlling or lowering prices through negotiations or competitive bids with providers and manufacturers. However, while the department is moving cautiously and piloting a limited number of medical supplies with these codes, it will need to thoroughly address the limitations of UPNs and the costs of implementation if it hopes to successfully use them to pay for all medical supply claims.

Second, the department plans to negotiate contracts with manufacturers of DME and medical supplies in fiscal year 2002–03. Among other savings, the department hopes to save $9 million by negotiating lower prices with manufacturers for blood glucose test strips. However, the department has not focused on clear objectives and appropriate staffing needs, has not contacted providers and manufacturers to ascertain their willingness to participate, and has not addressed the problem of how to determine reasonable prices.

Finally, while the department is not planning to engage in competitive bidding, we reviewed Medicare and other states' efforts at competitive bidding for DME or medical supply items. Although Medicare has had success with its competitive bidding pilot programs in two states, three of four state Medicaid agencies we contacted did not report success with competitive bidding, and the only state that had success with competitive bidding used it to acquire oxygen supplies for fewer than 5,000 beneficiaries.

RECOMMENDATIONS

To ensure that it receives a fair and reasonable price for DME, medical supplies, and hearing aids, the department should:

- Enforce existing policies requiring wheelchair providers to justify unlisted wheelchairs and analyze its payments for unlisted DME and medical supplies to determine whether it should establish maximum allowable product costs for any of these items.

- Develop tools, such as functional equivalence and price comparison tables, for its field office staff to use in comparing prices among similar items for unlisted DME, medical supplies, or hearing aids.

- Regularly review and update prices for items with established maximum allowable product costs.

In order to realize savings for Medi-Cal, the department should continue to develop and use a UPN structure and negotiated contracts for its DME and medical supply items. However, the department should ensure that it adequately plans and considers possible limitations of its efforts. Further, the department should bring manufacturers and providers into its planning sessions as soon as possible.

AGENCY COMMENTS

The department concurs with our findings and recommendations. It believes the report provides additional guidance to consider as the department implements corrections and cost controls to its policies and procedures related to purchasing DME, medical supplies, and hearing aids. In addition, the department stated it is in the process of implementing negotiated contracting for DME and medical supplies in order to improve its cost controls. ■

INTRODUCTION

BACKGROUND

The Department of Health Services (department) administers the State's Medicaid program, the California Medical Assistance Program (Medi-Cal). Medicaid is a federal program, funded and administered through a state and federal partnership, to provide health insurance to certain low-income people who lack health insurance, including low-income families with children, and to people on Supplemental Security Income who are aged, blind, or disabled. The department directly administers Medi-Cal by doing the following:

- Formulating policy that conforms to federal and state requirements.
- Negotiating and monitoring vendor contracts to provide outreach and enrollment in dental care and managed care programs as well as to provide payment for Medi-Cal claims.
- Reviewing and updating changes to allowable products and prices.
- Auditing providers and claims.

The U.S. Department of Health and Human Services—Centers for Medicare and Medicaid Services[1] provides regulatory oversight of Medi-Cal by reviewing the state plan and approving and monitoring waivers of federal requirements.

To qualify for Medi-Cal, beneficiaries must meet the program's income, deprivation, and property criteria, as well as institutional status, residence, and citizenship requirements. Medi-Cal relies on local county welfare or social services departments to make eligibility determinations. According to data submitted to the department by California's counties, as of April 2002, 6.02 million people were enrolled in and eligible for Medi-Cal in California.

[1] Formerly the Health Care Financing Administration; it was renamed on July 1, 2001.

CALIFORNIA'S MEDI-CAL RECEIVES FUNDING FROM TWO MAIN SOURCES

The principal funding sources for Medi-Cal are the State's General Fund revenues and matching federal funds. The latter are calculated using the federal medical assistance percentage, which determines how much of the State's direct program costs the federal government will pay. The federal government calculates the federal medical assistance percentage annually using a formula that compares the State's average per-capita income level with the national per-capita income average. Thus, the federal government reimburses states[2] with a higher per-capita income level, such as California, at a smaller share of their direct costs than it reimburses states with a lower per-capita income level. By law, the federal medical assistance percentage cannot be lower than 50 percent or higher than 83 percent. In fiscal year 2001–02, the federal medical assistance percentages for all states varied from 50 percent to 76.8 percent, and averaged 59.5 percent overall, with California's percentage being 51.4 percent. The General Fund pays the direct program costs not covered by the federal government; for fiscal year 2002–03, the General Fund is expected to pay more than $10 billion out of almost $27 billion in expenditures.

Besides covering the federal medical assistance percentage of direct costs, the federal government also pays a share of each state's indirect costs of administering the Medicaid program. The federal government matches most administrative costs at 50 percent, paying higher percentages for certain activities, such as developing mechanized claims processing systems.

CALIFORNIA'S MEDI-CAL PROVIDES A VARIETY OF BENEFITS

Medi-Cal provides comprehensive health coverage for eligible beneficiaries in California through managed care or fee-for-service plans. As of April 2002, about 50.4 percent of the 6.02 million Medi-Cal eligible recipients participated in a managed care plan, and about 49.6 percent were in the fee-for-service plan. Each managed care plan receives a monthly fee, or capitation payment, from the State for every enrolled recipient in return for providing all of the covered care needed by these beneficiaries. Under the fee-for-service plan, beneficiaries may obtain services

[2] The federal medical assistance percentage is also given to the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

from any provider that agrees to accept Medi-Cal payments. Medi-Cal then reimburses these providers for each furnished examination, procedure, service, or item. Other services Medi-Cal provides to eligible California residents include skilled nursing care, hospice care, and detoxification.

Another federal program—Medicare—provides health insurance to people age 65 or older, some people under age 65 with disabilities, and people with permanent kidney failure requiring dialysis or a transplant. For recipients eligible for both Medicare and Medi-Cal benefits, Medi-Cal covers the annual Medicare deductible of $100 and coinsurance of 20 percent, while Medicare covers 80 percent of the approved charges after payment of the $100 annual deductible.

In addition to covering pharmaceuticals and the services of physicians, nurses, and hospitals, Medi-Cal covers some costs of durable medical equipment (DME), medical supplies, and hearing aids that licensed practitioners have prescribed within the scope of their normal duties. A licensed practitioner must prescribe DME, which must meet criteria set forth in state regulations (see textbox). DME can include canes, crutches, wheelchairs, bathroom equipment, hospital beds, traction devices, oxygen and respiratory equipment, and blood glucose monitors. Medi-Cal requires prior authorization for certain DME items or under certain circumstances. For example, the department requires prior authorization when the cumulative cost of items in a DME group, such as the Hospital Beds Group or the Bathroom Equipment Group, exceeds $100 within a calendar month. Also, the department requires prior authorization, regardless of the dollar amount of the individual item or cumulative cost of items in a group, if the item is not in the department's list of approved items or if the department does not have a maximum allowable product cost (MAPC) on file.

Durable Medical Equipment (DME) Must Meet the Following State Criteria:

- Can withstand repeated use.
- Serves a medical purpose.
- Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital abnormality.
- Is appropriate for use in or out of the patient's home.

Source: California Code of Regulations, Title 22, Section 51160

Medical supplies can include bandages, contraceptive supplies, diabetic testing supplies, feeding tubes, gloves, hypodermic needles, incontinence supplies, catheters, and waterproof sheets, among other items, but they do not include common household items or articles of clothing. Until September 2002, under state regulations, Medi-Cal reimbursed medical supply providers for most items at a rate of 125 percent of the provider's

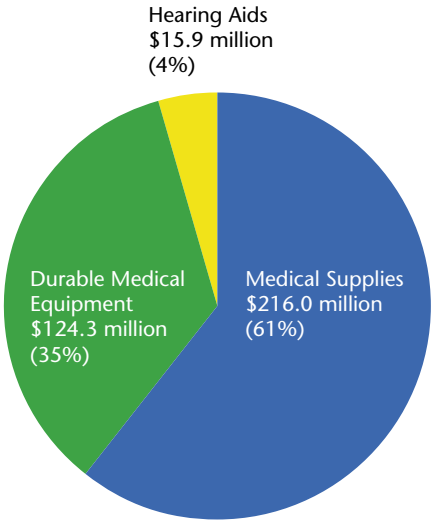
average wholesale cost and for incontinence supplies at a rate of 140 percent of the provider's average wholesale cost. After September, legislation lowered the reimbursement percentages to 123 percent and 138 percent, respectively. Prior authorization is required for medical supplies not included in the medical supplies section of the department's manual for providers or for selected supplies used for a clinical condition other than that specified for the item.

Finally, Medi-Cal reimburses hearing aid providers for hearing aids, accessories, and related services, when prescribed by an otolaryngologist (a physician specializing in the ear, nose, or throat) or the beneficiary's primary care physician. Medi-Cal requires prior authorization for the purchase or trial period rental of hearing aids, and for repairs that cost more than $25 each.

As shown in Figure 1, the department paid more than $356 million for DME, medical supplies, and hearing aids in calendar year 2001, with 61 percent of the money going for medical supplies.

FIGURE 1

Medi-Cal Spent More Than $356 Million for DME, Medical Supplies, and Hearing Aids in Calendar Year 2001



MEDI-CAL'S PROVIDERS, FIELD OFFICES, AND FISCAL INTERMEDIARY PLAY KEY ROLES IN PROVIDING DME AND MEDICAL SUPPLIES TO BENEFICIARIES

Many individuals and entities participate in delivering medical items to Medi-Cal beneficiaries, as shown in Figure 2 on the following page. To receive DME, medical supplies, or hearing aids, beneficiaries first must visit licensed practitioners, such as doctors, dentists, or podiatrists, who must prescribe the items.

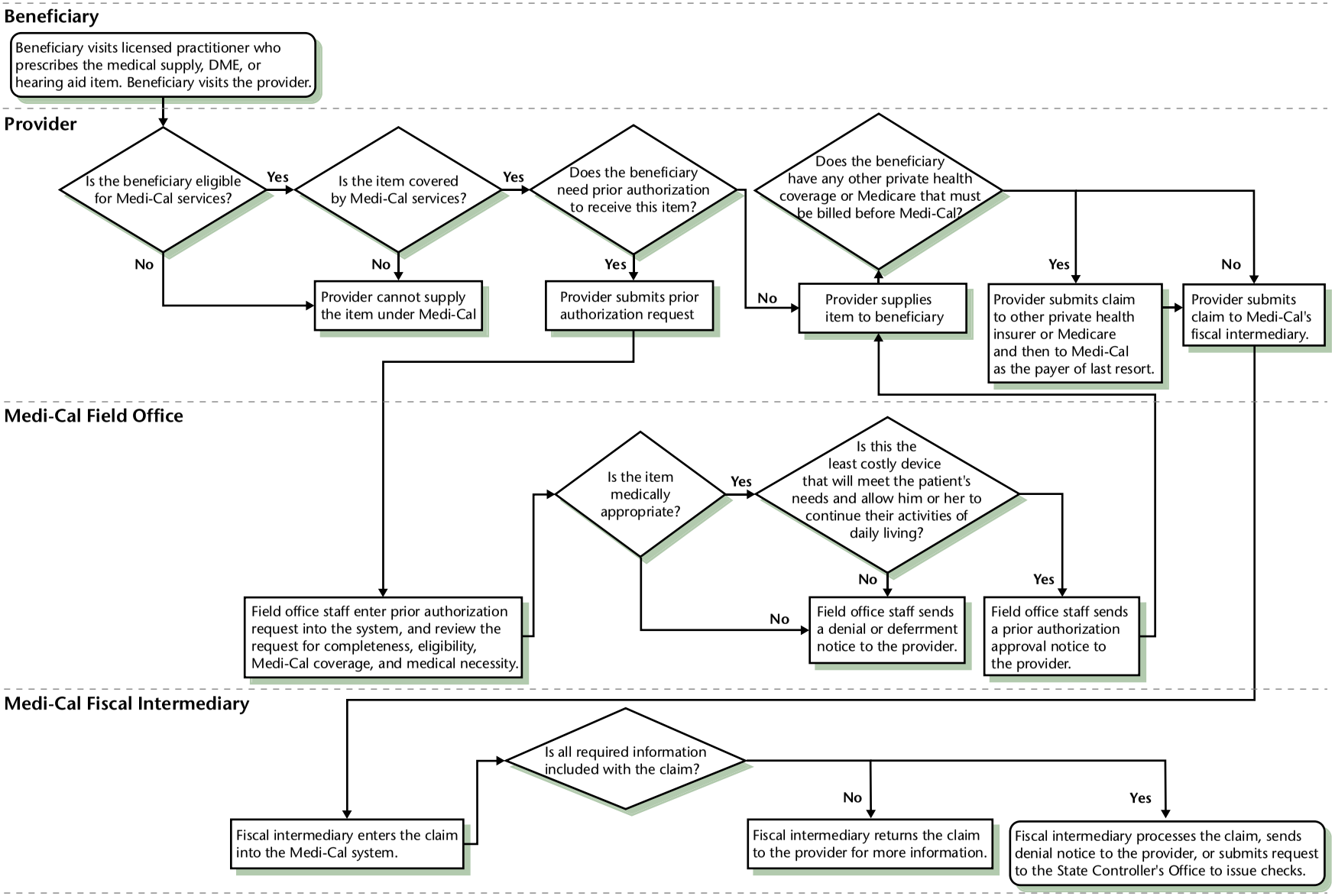
Then, authorized providers, such as medical-supply stores, pharmacies, or hospitals, supply the items that licensed practitioners have prescribed to the beneficiaries. These providers verify beneficiary eligibility, Medi-Cal coverage of the item, and determine whether they must obtain authorization before providing the item. Selected items, such as those not included on the department's list of approved items, or that do not have MAPCs set by the department, must receive authorization before providers can issue these items to beneficiaries. When the department requires prior authorization, providers must submit prior-authorization requests to one of three department field offices for processing.

Staff at the department's field offices review requests for prior authorization and either reject or approve them. If the item is not in the department's list of approved items, or if the department does not have a MAPC on file, the field office staff must authorize or modify the requested price as supported by provider- or manufacturer-submitted catalogs.

Once providers obtain any needed authorization, they can dispense the items to the beneficiaries. The providers then bill any other third-party payers, such as private insurers or Medicare, before submitting their claims to Medi-Cal. The department contracts with a fiscal intermediary, an independent contractor who is responsible for receiving and processing claims for DME, medical supplies, hearing aids, and other medical services. Fiscal intermediary staff approve claims for medical supplies with no established prices using attachments providers supply with the claims. If a prior authorization accompanies the claim, and the field office staff have negotiated a price with the provider, the department's fiscal intermediary approves payment for the claim based on that price. Otherwise, the fiscal intermediary processes the claim for the lesser of the following:

FIGURE 2

Roles of Beneficiaries, Providers, Department Staff, and the Department's Fiscal Intermediary in Processing Claims



Sources: Department provider manual and interviews with field office staff.

- The amount requested.
- The MAPC from the department's provider manual.
- 123 percent of the provider's average wholesale cost from its catalog pages for most medical supplies, or 138 percent of the provider's average wholesale cost for incontinence supplies.

The State Controller's Office sends out the actual payments to providers.

The department sets Medi-Cal's maximum reimbursement rates for certain covered items, such as DME and hearing aids, in Title 22 of the California Code of Regulations. When the department determines a policy or rate change is needed, it updates its regulations, usually in consultation with staff in the department's Rate Setting section. The department sets rates for medical supplies in its policy manual, and state regulations require the department to update medical supply rates no less than every 60 days. Until September 2002, the department established MAPCs for some medical supplies in state regulations. With the passage of Chapter 1161, Statutes of 2002, however, the department has the authority to change medical supply rates by publishing these rates in its provider bulletins and manuals. However, the department does not have a written policy or other requirement defining how often it should update maximum reimbursement rates for DME or hearing aids.

Examples of Codes

Level I code: 99211, Office or other outpatient visit for the evaluation and management of an established patient, which may not require the presence of a physician.

Level II code: A4245, Alcohol wipes, per box.

Level III code: 9985P, Bandages, non-medicated, operating site dressing, 5 cm by 7.5 cm, unit equal to 100.

Source: American Medical Association Web page, Medicare Region D Supplier Manual, Medi-Cal Provider Manual.

MEDI-CAL HAS FACED RECENT FEDERAL REGULATORY CHANGES

Federal regulations require medical insurance companies and Medicaid agencies to use Health Common Procedure Coding System codes (federally approved codes) for processing medical claims. The federally approved codes identify items and services. Level I codes are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II codes are used primarily to identify products, supplies, and services not included in the level I codes. Each level II code for DME and medical supplies identifies a category of products that Medicare considers to be similar, but does not identify precisely the exact product purchased. As of September 2002, there were national level II codes representing

more than 4,000 separate categories of like items or services that encompassed millions of products from different manufacturers. Finally, level III codes are a subsystem of codes, more specific than level II codes, that various Medicaid state agencies, Medicare contractors, and private insurers have developed for their specific programs or local areas of jurisdiction.

Congress enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with the goal of improving the efficiency and effectiveness of the nation's health care system. HIPAA requires, in part, that the federal government adopt standards for electronic coding systems that Medicare, Medicaid state agencies, and private insurers use for reporting health care transactions in order to standardize these transactions. In August 2000, the federal government published regulations to implement HIPAA coding requirements. The regulations provided for the elimination by October 2002 of level III codes in favor of the federally approved level I and level II codes. This action was intended to eliminate the confusion of using level III codes developed by various medical insurance companies and Medicaid agencies. However, the Administrative Simplification Compliance Act enacted by Congress in December 2001 extended this deadline to October 16, 2003.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to provide independently developed and verified information related to the purchasing and contracting practices of Medi-Cal. Specifically, the audit committee asked that we review the department's policies and procedures for DME, medical supplies, and hearing aid purchases, and that we review approaches used by other programs or agencies to establish alternatives that may result in cost savings.

To understand Medi-Cal and its policies, we reviewed relevant federal and state laws and regulations, as well as Medi-Cal policies and provider manuals. We also interviewed staff at the department, provider groups, other states, and outside insurance companies to understand the viewpoints of all stakeholders in the purchasing process. To understand the department's cost controls for expenditures related to DME, medical supplies, and hearing aids, we held discussions with the department's audit staff.

To analyze the department's current policies and procedures for processing Medi-Cal prior authorizations for DME, medical supplies, and hearing aids, we visited the three field offices responsible for processing prior authorizations for these items. While at the field offices, we observed staff processing the claims and held discussions with relevant staff to determine each field office's procedures.

To assess the department's system for establishing MAPCs, we reviewed copies of all policy letters used to initiate changes to the department's fiscal intermediary's claims processing system, including rate updates, over the past three years. Further, we held discussions with department staff who research and help to establish these rates.

To determine whether the department's payments for DME, medical supplies, and hearing aids were accurate, we tested a sample of 90 claims, 30 for each product type. In selecting our claims, we determined the six items for which the department had made the greatest expenditures in each category for fiscal year 2001–02, and then we pulled our test claims equally from these items. We compared the prices paid for these claims to the department's established MAPCs, and investigated any exceptions with the department's fiscal intermediary.

To confirm that the department has not overpaid for items by renting items that it should have purchased, we obtained data from the department for all rentals over the past three fiscal years and compared total rental prices to the amounts needed to purchase these items. Similarly, to confirm that the department has not overpaid for items by servicing them instead of purchasing new items, we obtained records on expenditures for service and maintenance costs. However, because service and maintenance costs are billed under their own product codes, and are not linked as modifiers to a particular DME, medical supply, or hearing aid item, as are rental indicators, we could not compare service and maintenance fees to the costs associated with purchasing new items.

To assess the effectiveness of the department's plans to control expenditures for DME, medical supplies, and hearing aids, we discussed these plans with department staff. We reviewed Medicare, department, and other agency reports on efforts by agencies in other states to engage in competitive bidding and to use universal product numbers (UPNs), and we contacted experts from Cal-PERS and California's three largest health maintenance

organizations (HMOs) to gain an understanding of the requirements to successfully engage in competitive bidding for these items. Further, we surveyed 10 of California's largest HMOs and preferred provider organizations to determine their use and understanding of UPNs and competitive bidding. However, we only received responses from five of these companies—CalOPTIMA, Cigna Health Care of California, Kaiser Foundation Health Plan, Local Initiative Health Authority for Los Angeles County, and PacifiCare of California. The other plans either declined to participate or did not submit their survey responses in a timely manner.

Finally, we contacted other state Medicaid agencies and Medicare to understand their cost-saving strategies. ■

AUDIT RESULTS

REDUCTIONS IN FEDERAL FUNDING AND INCREASING ENROLLMENT OBLIGE THE DEPARTMENT TO BETTER CONTROL PROGRAM COSTS

The Department of Health Services (department) is facing increased pressure to reduce program costs for the California Medical Assistance Program (Medi-Cal). One of the department's two main funding sources—federal reimbursement—is shrinking. Simultaneously, enrollments in Medi-Cal are increasing, as are the department's expenditures for durable medical equipment (DME) and hearing aids. Of the $26.9 billion in projected expenditures for fiscal year 2002–03, the department will receive an estimated $16.8 billion from federal medical assistance percentage payments and intergovernmental transfers, with the remainder—$10.1 billion—coming from the State's General Fund. Because the General Fund must make up for the federal cuts in funding, the department must control program costs, especially during this time of state budgetary constraints. Any department savings will translate into savings for the General Fund, which will free up resources to support other programs or agencies.

California's Medi-Cal faces an estimated loss in federal revenues of $222 million in fiscal year 2002–03, revenues that the State's General Fund will have to make up.

As described earlier, the department receives funding from the federal medical assistance percentage. However, federal medical assistance percentages are based on per capita income and do not consider numbers of eligible beneficiaries, leading to disparities in federal funding. A recent report by the Medi-Cal Policy Institute found that while California has 14 percent of the nation's low-income residents, it receives only 11 percent of available federal funding for Medicaid. The department's funding issues will worsen in fiscal year 2002–03, when the federal government lowers California's federal medical assistance percentage from 51.4 percent to 50 percent, the sharpest drop in almost a decade, returning California to the lowest level since fiscal year 1995–96. Because of this decrease, California's Medi-Cal faces an estimated loss in federal revenues of $222 million in fiscal year 2002–03. These are revenues that the General Fund will have to make up.

While the department's federal revenues are decreasing, the cost to serve the increasing number of beneficiaries using Medi-Cal services is rising sharply. A report by the Legislative Analyst's Office (LAO)

Medi-Cal's caseload increased from 5.4 million beneficiaries in April 2001 to 6.02 million beneficiaries in April 2002—an increase of more than 11 percent in one year alone.

projected an increase in enrollments due to the department's policy decisions that simplified the enrollment process. Medi-Cal's caseload increased from 5.4 million beneficiaries in April 2001 to 6.02 million in April 2002—an increase of more than 11 percent in one year alone. Also, if California's unemployment rate increases as a result of the recession, the number of people who depend on Medi-Cal may increase further.

Moreover, California's aging population is driving up the average cost for Medi-Cal beneficiaries. A March 2002 report by the National Conference of State Legislatures estimated that California's senior population would double over the next 28 years. Recently, the LAO noted that the average cost per person for elderly and disabled beneficiaries is much higher than the average cost per person for families and children on Medi-Cal. As a result, almost two-thirds of Medi-Cal's spending is for the elderly and disabled, although they account for about one-fourth of the total Medi-Cal caseload. Elderly and disabled persons also tend to be high users of DME, medical supply, and hearing aid products. For example, the most recent survey published by the Agency for Healthcare Research and Quality reported that people age 65 or older had almost twice the medical equipment and supplies expenditures as people under age 65.

Future increases in beneficiaries and decreased federal funding will only sharpen the department's fiscal problems, especially in light of a significant growth in Medi-Cal expenditures over the past several years. A recent report by the Medi-Cal Policy Institute found that Medi-Cal's total expenditures have increased from $17.2 billion in fiscal year 1993–94 to a projected $26.9 billion, or a 56 percent increase, in fiscal year 2002–03. Moreover, the department's expenditures for DME and hearing aids have increased significantly. From calendar year 1998 through 2001, the department's expenditures for DME rose by 70 percent, to $124.3 million, while hearing aid expenditures rose by 57 percent, to $15.9 million. Medical supply expenditures decreased during this period by 6.3 percent, to $216 million.

THE DEPARTMENT'S CURRENT COST CONTROLS ARE INSUFFICIENT TO CONTROL SPIRALING COSTS

In its daily operations, the department uses many cost-control procedures, such as prior authorizations and maximum prices, to ensure that the State does not overpay for DME, medical supplies, and hearing aids. However, these procedures are not

Although the department employs many of the same cost-control procedures used by other states, these procedures are not adequately controlling costs for many items, from blood glucose test strips to wheelchairs.

adequately controlling costs for many items, from blood glucose test strips to wheelchairs. For unlisted items—those that lack maximum allowable product costs (MAPCs)—the department lacks the tools to identify functionally equivalent items and to compare providers' prices. Furthermore, for listed items, the department does not keep its MAPCs current and may be missing out on possible savings. For example, the department risks missing out on more than $900,000 in possible savings for blood glucose test strips from one manufacturer. Also, in fiscal year 2001–02, the average per-unit cost the department paid for wheelchairs with unlisted price codes was five times more than it paid for those with listed codes. As explained later, the department plans to improve its billing codes to have more complete and current information on product pricing, and it is also moving toward negotiating contracts to lower its costs for medical supplies and DME. However, the department's plans are incomplete and unfocused, with several serious obstacles to implementing the new programs. Meanwhile, with state revenues falling, the General Fund must pay for cost increases with money that could be used for other programs.

The Department's Cost-Control Procedures Are Similar to Those Used by Other States

We found that the department employs many of the same cost-control procedures used by other states. For example, as shown in the Table on the following page, the department and all the states we contacted establish MAPCs for selected items, use prior authorizations for selected items to determine medical necessity, conduct audits, and use rentals instead of purchasing items whenever possible. In some instances, the department's procedures exceed those used by other states. However, some states use procedures that the department might consider to help it better control Medi-Cal costs.

Similar to some other states, the department has established for some DME and medical supply items MAPCs that prevent the department from paying above a set price for specific products. However, there is no set MAPC for some items covered by the department. For these unlisted items, the department relies on the providers to submit catalog prices, wholesale costs, or retail prices as a basis for reimbursement. The department lacks tools that would allow staff to identify less expensive alternatives that would meet beneficiaries' needs.

TABLE

The Department Uses Procedures Similar to Five Other Medicaid Agencies but Could Do More to Control Costs

	California	Florida	Illinois	New York	Texas	Washington
Set maximum allowable product costs for selected DME and medical supply items.	●	●	●	●	●	●
Use prior authorizations to establish the medical necessity for selected DME or medical supply items.	●	●	●	●	●	●
Conduct audits and pursue cost recovery in instances where providers overcharged or fraudulently billed the department.	●	●	●	●	●	●
Use rentals whenever possible to avoid expensive purchases.	●	●	●	●	●	●
Engage in competitive bidding or price negotiations with providers and/or manufacturers in order to seek lower prices and/or concurrence on maximum allowable product costs.	❍	●	●	●	●	●
Perform analyses of utilization data to determine factors causing prices to increase.		●		●		●
Perform research in order to expand the number of items for which their agency has set maximum allowable product costs.	❍		●	●	❍	●

Sources: Interviews with staff at state Medicaid agencies, and state Medicaid agencies' Web pages.

● State is performing this task.

❍ State plans to perform this task in the future.

All the states we contacted use MAPCs for at least some of the DME and medical supply items they cover. Texas's Medicaid agency, in an effort to control rising costs, is working to establish MAPCs for more of its unlisted items to reduce unnecessary expenditures. Similarly, as discussed later, California is exploring a new billing code structure that it believes would allow it to do the same.

To address the problem of unlisted items, New York has implemented procedures that the department could potentially use to reduce costs. For those items without MAPCs, New York's Medicaid agency caps reimbursements for these items at the lower of 150 percent of the provider's acquisition cost or the usual and customary price charged to the general public. If it were to adopt regulations similar to New York's, in which providers submit their cost data instead of their retail catalog prices, the department might ensure it is not paying exorbitant amounts for unlisted items. For example, during the course of another audit, our auditors found a claim submitted by a wheelchair provider in fiscal year 2001–02 that included the provider's

If the department were to establish cost caps and require providers to submit their actual cost data, it could avoid paying exorbitant amounts for unlisted items, such as the $5,530 it paid for one wheelchair in fiscal year 2001–02 that cost the provider only $2,400.

acquisition cost. In this instance, the department paid $5,530 for the unlisted wheelchair, or 230 percent of the provider's $2,400 cost. New York also establishes its MAPCs by researching prices for individual items in price categories and then discussing proposed MAPCs with providers to achieve provider concurrence on MAPCs. By doing this, New York ensures that providers are more willing to accept the rates and that fraudulent charges to the Medicaid programs are reduced, freeing up funds for legitimate uses.

Another New York agency procedure the department might consider is a mechanized system to track and control the number of items each patient is allowed. As the Introduction explains, the department requires providers to obtain a prior authorization for selected items before Medi-Cal will make a reimbursement. Before making these prior authorizations, the department's field office staff review each beneficiary's history to determine past usage and ensure that beneficiaries are not receiving more than the maximum number of units allowed under the department's coverage policies. For example, it would not approve more than $165 of incontinence supplies per beneficiary per month. New York's Medicaid agency has recently automated much of this work by instituting a voice-activated recognition system. When physicians call this automated system to request prior authorization for certain DME and medical supplies, the system tracks the number of units that have been requested and approved, and it limits the number of supply items physicians can order for a particular patient. Only if a request exceeds the State's cap for the number of items that can be distributed in a set time period will an authorization specialist review the beneficiary's use of the past item. By using this system, New York is able to reduce the workload for its authorization specialists. If California were to convert to this system, its field office staff might have more time to review other types of prior authorizations or to research product cost information. This could lower the department's costs in some cases.

In another cost-control measure, the department's audits division performs routine audits of its Medi-Cal providers and internal audits of the department's organizations to ensure that various internal controls are operating and effective. The department's audits unit also operates a Medi-Cal fraud hotline that allows anyone who has observed or has knowledge of suspicious health care activities, including beneficiary and provider fraud and abuse, to phone in a tip. The department has the authority to place sanctions on providers, such as withholding reimbursement for their claims pending the outcome of

investigations, or suspending the provider from the Medi-Cal program. Further, the department's audits unit works closely with the California Department of Justice and the Federal Bureau of Investigation to assist federal and state prosecuting attorneys in Medi-Cal fraud cases. According to the department's Web page, from July 2000 to February 2002, 323 Medi-Cal providers received criminal convictions for fraud. While all states we contacted have some audit functions, two states have recently increased their efforts to alleviate fraud. However, our limited review noted that California's Medi-Cal audits include as many, if not more, procedures than those performed by other states.

Another cost-control measure employed by the department involves equipment rental. Because of the high cost of oxygen and oxygen-related supplies, the department initially authorizes only rentals for these and other high cost items for four months. After the four months, physicians must submit justification for the item's continued use. Field office staff re-evaluate beneficiaries to determine whether their need is likely to be ongoing, and therefore the items should be purchased, or if the need is temporary, and rentals are more appropriate. The department's regulations require that, with the exception of life support equipment such as ventilators and other equipment that requires ongoing service, an item is considered to be purchased when the total of the rental payments equals the MAPC. Although, as discussed later, field office staff have misinterpreted this regulation, it is similar to policies established by the other states. For example, Illinois's Medicaid agency prefers to rent equipment whenever possible to ensure that it has not purchased a piece of equipment that a beneficiary will need for short-term use.

As discussed later, the department is attempting to implement two new cost controls to reduce expenditures for DME and medical supplies. Nevertheless, we noted some other state Medicaid agencies' polices and procedures that the department may wish to consider. For example, Florida has begun to analyze utilization data to determine factors contributing to cost increases for DME and medical supplies. Moreover, we found that three states—Illinois, New York, and Texas—seek input from the provider communities on areas such as establishing

MAPCs or cost reduction. Texas recently issued a request for information, soliciting providers to voluntarily submit prices that are either equal to, or lower than, current costs.

The Department's Cost Controls Are Inadequate to Ensure the Lowest Possible Prices for Many DME, Medical Supplies, and Hearing Aid Items

Although the department has implemented the previously discussed cost controls to ensure that costs are contained, these controls have done little to rein in its spending on unlisted items, those for which the department has no MAPC and has not determined the lowest available prices. In evaluating prices of unlisted items, the department's field office staff lack tools, such as current price and item-comparison tables, to confirm that providers are charging the State the price they charge the general public. Even when the department has MAPCs, it may pay higher-than-necessary amounts for some items because it has not updated most of its prices to take advantage of price reductions from manufacturers' competition. In the last three years, the department has updated the MAPCs for only seven of thousands of product codes. Further, it has delayed an average of 15.5 years in updating its medical supply rates. By not ensuring that it pays the lowest possible prices, the department is spending more of the General Fund moneys than necessary. For example, the department risks paying more than $900,000 too much for blood glucose test strip products from one manufacturer in fiscal year 2002–03 because it has failed to update its prices every 60 days as required by state regulations.

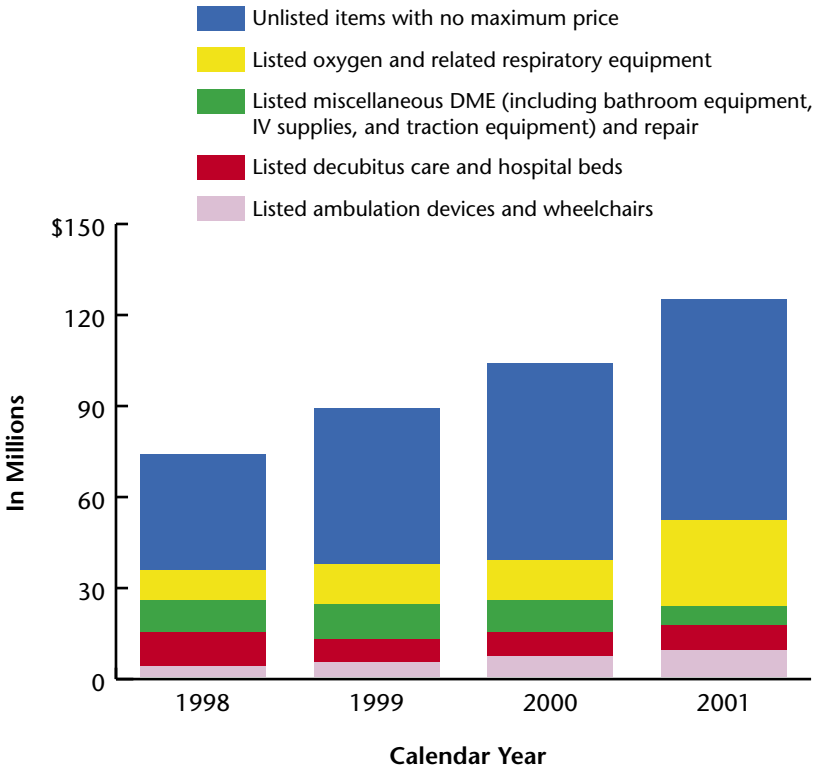
In evaluating prices of unlisted items, the department's field office staff lack tools, such as current price and item-comparison tables, to confirm that providers are charging the State the price they charge the general public.

The Department Lacks Adequate Cost Controls Over Its Expenditures for Unlisted Items

Because expenditures for unlisted DME and medical supplies are increasing significantly, the department needs to take action to better control them. As shown in Figure 3 on the following page, the department's payments for unlisted DME items—those with no established maximum allowable prices—accounted for most of the increases in expenditures for all DME. From calendar year 1998 through 2001, expenditures for unlisted DME increased by $34.3 million, or 89.4 percent, while as a percentage of total DME expenditures, unlisted DME spending increased from 52.4 percent to 58.5 percent.

FIGURE 3

Increase in Expenditures for Durable Medical Equipment by Product Category Calendar Year 1998 Through 2001



Similarly, expenditures for unlisted medical supplies have increased, though total medical supply expenditures have decreased in recent years. In 2001, the department paid 11.1 percent **less** for medical supplies *with* established maximum prices, but 27.5 percent **more** for medical supplies *without* such prices than it did in 1998. From 1998 through 2001, unlisted medical supplies as a percentage of total dollars spent on medical supplies increased from 12.6 percent of all dollars spent to 17.1 percent, although these unlisted items remained only about 11 percent of all medical supply items purchased during that time period.

Our analysis of the department's expenditures showed that some of this increase is due to increased usage, possibly as a result of the increased number of beneficiaries enrolled in the program. However, because the rate of increase in dollars spent for unlisted DME and medical supply items was greater than the rate of increase in the number of units purchased, we cannot attribute the entire increase solely to a larger number of beneficiaries.

Department staff attributed the growth in expenditures for unlisted items to the department's obsolete code structure. Because many of the department's codes were created in the early 1990s, staff reported that many codes no longer represent items currently on the market. However, we noted that weaknesses in the department's authorization process might have contributed to the dramatic increase in expenditures for these items. These weaknesses include the department's decision to have field office staff stop reviewing claims for cost, a lack of cost comparison information, and field office staff's departures from established policies.

Field office staff at various Medi-Cal field offices throughout the State process and review prior-authorization requests for DME, medical supplies, and hearing aids for medical necessity, pricing items for unlisted items using provider- or manufacturer-submitted catalogs. State regulations require providers and manufacturers to provide Medi-Cal with rates that do not exceed the price they charge to the general public. Department staff stated that until December 1997, the field offices reviewed authorization requests for cost; however, the department instructed its field office staff to eliminate this time-consuming step. State law requires the department to render decisions on requests for authorization in a timely manner—an average of five working days. Without established MAPCs for many DME items, and lacking cost-comparison tools such as functional equivalence tables that would allow field office staff to compare requested items to other items that perform the same essential functions, field office staff have no quick and easy way to determine if prices for requested items are reasonable. Because they lack this information, the field office staff must rely on their experience and judgment to determine whether amounts are appropriate. Although California's regulations also require the department to pay for only the lowest-cost items that meet the medical needs of the patient, the primary focus of field office staff in approving a service or product is on maintaining the patient's daily living activities. If beneficiaries are able to function independently, Medi-Cal can avoid expensive hospice or nursing home care. Because the department lacks cost-comparison tools that will allow its field office staff to make meaningful comparisons of the requested items with other available products, field office staff tend to approve a product regardless of cost as long as it is medically necessary.

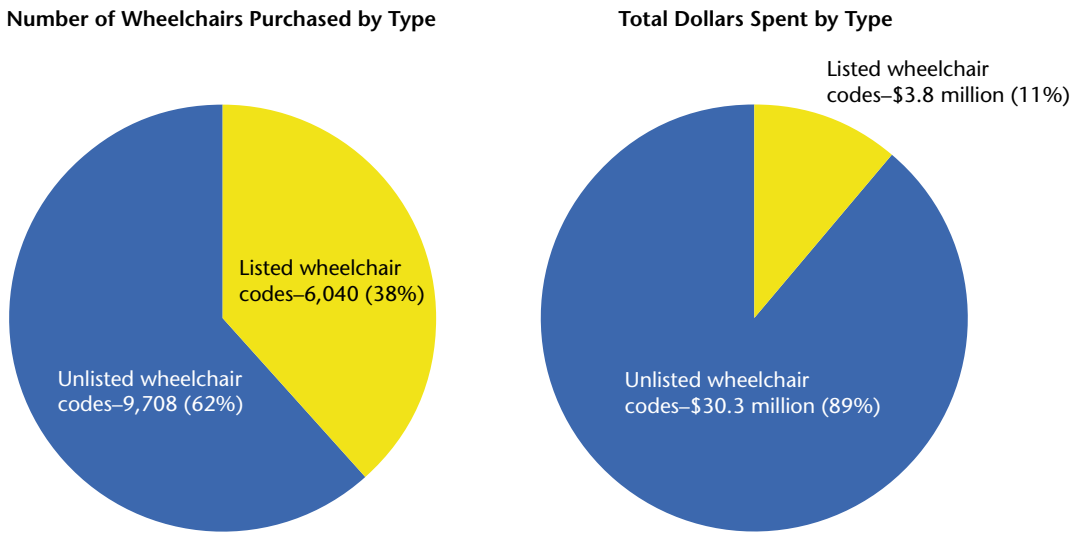
Field offices reviewed claims for cost until December 1997, when, according to department staff, they were instructed to eliminate this time-consuming step.

In addition, field office staff do not ensure that providers use listed codes whenever possible or justify why they do not. By not doing so, the department may pay more for an unlisted item

than it would pay for another listed or unlisted item that meets the patient's needs. In fiscal year 2001–02, the department paid an average of $622 for wheelchairs with listed codes, but it paid an average of $3,121 for unlisted wheelchairs, more than five times the average for the listed items. Further, as shown in Figure 4, wheelchairs with listed codes and MAPCs were 38 percent of the almost 16,000 wheelchairs purchased, but only 11 percent of total expenditures.

FIGURE 4

Wheelchairs With Listed Codes Made Up 38 Percent of the 16,000 Wheelchairs Purchased in Fiscal Year 2001–02, but Only 11 Percent of Total Expenditures for Wheelchairs



According to the department, it has not updated its MAPC for listed wheelchairs since 1985 (17 years ago). Consequently, it believes that it is not fair to compare the amounts paid for unlisted wheelchairs to listed wheelchairs. However, we disagree with the department's position because we do not believe that out-of-date MAPCs are solely responsible for the discrepancy in these average costs. As we discuss later, the department's lack of adequate cost-comparison tools and failure to enforce existing cost-control procedures also contribute to the rising cost of unlisted wheelchairs.

Wheelchairs have many components that can be modified to best fit the individual beneficiary. For example, seat width and depth, back height and angle, and adaptations for amputees can be modified or added to a wheelchair to properly fit a patient. If

wheelchairs are not properly fitted, they may result in pressure sores, poor posture, and pain. The list of approved wheelchair items includes both standard and custom fitted wheelchairs. Custom fitted wheelchairs are available with numerous factory modifications and accessories that alter them to meet a beneficiary's need. Many of these modifications are also on the department's approved list. While the department acknowledged in June 1998 that there had been advances in wheelchair technology, it also stated that the listed codes for custom fitted wheelchairs and associated modifications and accessories were still valid. Further, in June 1998, the department issued a policy statement mandating that its field office staff may approve unlisted wheelchairs only if providers document the following:

- Why a listed code cannot be used for the equipment the patient needs.
- Why the requested wheelchair is the lowest-cost item among other comparable brands or types that meet the patient's medical needs.
- Why the requested wheelchair is the most appropriate item to address the patient's functional limitations and medical needs.

However, it appears that field office staff do not require providers to document these factors. Instead, staff appear to have been following the guidance issued in an April 1998 memorandum that, pending issuance of the policy statement, directs staff to approve requests for prior authorization for all wheelchairs as long as the requests are accompanied with a physician prescription. The memorandum also directs staff to allow the use of unlisted codes for all wheelchairs and components. Our sample of DME claims included four with requests for prior authorization for unlisted wheelchair purchases that had been approved by field office staff from November 2001 through March 2002. None of the providers had documented why a listed code could not be used or that the wheelchair was the lowest-cost item among others that could meet the patients' needs. As a result, the department may be paying more than necessary for customized wheelchairs.

Although its June 1998 policy statement requires field office staff to ensure that providers justify why a listed code could not be used in place of an unlisted code, staff are following an earlier memorandum that allows the use of unlisted codes for all wheelchairs and components.

The Department Overpaid for Some Rentals

Further, our review of a sample of DME rentals authorized by field office staff over the past three years found that in almost all instances the department saved money by renting, rather than purchasing, the equipment. However, for stationary

Because they misunderstood state regulations, field office staff authorized $12.4 million in rentals for stationary volume ventilators that would have cost $4.1 million had the department purchased these items.

volume ventilators, field office staff authorized rentals for 620 beneficiaries for an average of 22.2 months per beneficiary, and a total cost of $12.4 million. Had the department purchased these items, it would have paid $4.1 million, resulting in a possible savings of $8.3 million to the department. Field office staff stated that regulations require them to approve only rentals of ventilators and prohibit them from purchasing them, which we found to be a misunderstanding of the regulations. Although ventilators are exempt from the regulatory requirement that the items be considered paid once the amount of rental payments equal the purchase price, state regulations do not prohibit the department from purchasing these items.

The Department Has Not Kept Its Codes and Prices Current and May Not Be Receiving the Lowest Rates Offered by Providers or Manufacturers

The department has been lax in updating its prices for items with an MAPC, and it may not be getting the same rates offered by providers or manufacturers to the general public. Because the department does not keep its codes and prices current, it is not taking advantage of technological improvements or efficiencies in manufacturing that allow price reductions for these items. On the other hand, updating MAPCs may increase costs if the department's prices are grossly out of date. However, higher MAPCs may also result in improved quality and selection as well as increased numbers of providers and manufacturers willing to participate in Medi-Cal.

A 1998 report by the General Accounting Office noted that Medicare payments for some medical devices were excessive because, even though improved technology and materials have made some items less costly, some of these less costly models are not listed in the federally approved codes. As a result, providers may bill for these items using federally approved codes with higher maximum payment amounts than would have been approved for the newer items. Since the 1970s, technology improvements for a DME item, blood glucose monitors, have made monitors not only easier and less painful to use, but also less expensive. The average price for a monitor in the 1970s was $500; in the 1990s, the average price was about $100. Currently, monitors cost between $60 and $100, and with rebates and trade-ins, the monitor price can be as low as $35 to $75. Some are given away free by physicians' offices. The department's MAPCs for these items range from $60 to $443. The flip side

of this discussion is that technology improvements can also lead to price increases. As the healthcare industry adopts new technologies, the department is likely to see rising costs initially when it acquires these newer items for its beneficiaries.

The department has been lax in updating its MAPCs for DME, medical supplies, and hearing aids. For example, to update the MAPCs for items with listed prices, the department issues an operational instruction letter (instructional letter) to its fiscal intermediary. Over the last three years, the department issued only 10 instructional letters related to DME, medical supplies, or hearing aids. However, only 4 of those instructional letters actually updated a price on file, and those updates affected the MAPC for only seven of thousands of product codes for DME, medical supplies, and hearing aids. The department may be hampered in updating DME and hearing aid rates on a timely basis because these rates are established in regulations. In order to change these rates, the department must initiate and obtain approval for a change to the regulations, which can be a lengthy process.

Moreover, state regulations require the department to update its medical supply rates no less than every 60 days. However, on average, for those medical supply product codes billed during fiscal year 2001–02, the department allowed 5,720 days, or about 15.5 years, to elapse between price updates. Department staff stated that they are aware the department does not comply with regulations for updating medical supplies, but they said that staffing limitations have forced them to make judgments on the importance of completing tasks. However, these decisions may be costing the department significant sums. For example, in fiscal year 2001–02, the department spent about $28.3 million for more than 16 million units of 50-count blood glucose test strips and more than 2.4 million units of 100-count blood glucose test strips from one manufacturer. In July 2002, because of a change to the product, the department reduced MAPCs for this manufacturer of blood glucose test strips to 85 cents per unit for its 50-count test strips and 79 cents per unit for its 100-count test strips. However, in November 2002, we found medical supply companies on the Internet offering this same manufacturer's products for 80 cents per unit for the 50-count test strips and 75 cents per unit for the 100-count test strips. If the department purchases the same number of strips in fiscal year 2002–03, it could save an additional $911,000 by making sure to update its prices.

Despite state regulations requiring the department to update medical supply rates no less than every 60 days, on average the department allowed about 15.5 years to elapse between price updates for medical supply product codes billed in fiscal year 2001–02.

The Department's Billing Codes Lack Specific Product Information

The department's cost controls also fail to moderate the excessive spending that may result from using billing codes that do not clearly show which items are being purchased. The department uses billing codes it developed several years ago to process its claims for DME, medical supplies, and hearing aid items. Because these codes are general, describing a product type, but not a specific product, they do not sufficiently identify the products that providers bill for. Without the needed product information, Medi-Cal beneficiaries may receive items of far less value than suggested by the price the department pays. For example, each of the six billing codes for which the department spent the most on medical supplies in fiscal year 2001–02 represented between 7 and 23 distinct items. For one product code, 9947A, "Rubber Waterproof Sheets," the department paid $9.9 million in fiscal year 2001–02 for at least 14 different types of sheets from various manufacturers. The average price Medi-Cal paid for these products was $40.14 per sheet, with prices ranging from 42 cents to $55 per item. Because the billing codes do not specify the specific sheet that providers are supplying, the department risks paying $55 for a 42 cent sheet.

Because its billing codes do not specifically identify the items being purchased, beneficiaries may be getting items of far less value than suggested by the price—for example, the department may be paying $55 for a 42 cent sheet.

As discussed in the next section, the department hopes to remedy the problem of overly general billing codes by converting its medical supply items to UPN codes, which contain more detail on the products they identify and will allow it to establish more MAPCs for selected unlisted items. Because of the added detail, however, the number of UPN codes for medical supply items is huge and may require more time and money to use and maintain than the department is planning.

THE DEPARTMENT HAS NOT FULLY CONSIDERED THE CHALLENGES AND COSTS OF IMPLEMENTING ITS COST-SAVING PLANS

To combat the rising costs of DME and medical supply items, the department plans to implement two cost-saving measures in the near future. First, the department hopes to convert its medical supply codes from the current federally required billing code structure to the more detailed UPN codes to gain more relevant and timely information on the products it pays for, initially by implementing these codes for a limited number of blood glucose test strips. Eventually, should it succeed in implementing UPNs for this limited number of items, the department hopes to convert all its medical supply and some DME and hearing aid

billing to these codes. While holding some promise for reducing expenditures, this conversion from thousands of federal codes to millions of UPN codes may prove more daunting than the department realizes. Second, the department plans to implement negotiated contracts for some DME and medical supply items. For such contracts to succeed, the department needs to more carefully plan for staffing needs, better clarify its objectives, and lay the groundwork for provider and manufacturer cooperation. Although both plans could potentially reduce the department's costs, both could also increase expenditures if the department fails to properly plan and support these actions—yet the department's plans remain vague, incomplete, and unfocused.

The Department Is Unprepared to Convert to a UPN Billing Code System

The department's current billing structure is insufficient to allow it to determine exactly what items it is paying for or to adequately control its expenditures. Because many billing codes are obsolete and many newer products may not correspond with existing codes, providers submit claims with billing codes that have no department-established MAPCs. As previously discussed, this has led to a sharp increase in expenditures for unlisted items. To address this increased spending, the department plans to convert some medical supplies within the next two years to a new billing code structure that uses UPN codes. However, this conversion plan is largely incomplete, so we cannot determine whether the department has fully taken into account the possible costs and limitations of the new billing codes. Apparently, the department has not addressed potential problems of converting to the UPN codes, which are not contained in a reliable and complete database, have not been used by any other agency, are not easily converted to Medicare's federally approved codes (necessary for cross-billing), and are likely to be difficult to maintain pricing for.

Although the department hopes to convert to UPN codes for billing within the next two years, its conversion plan is largely incomplete and we cannot determine whether the department has addressed potential problems associated with converting to UPNs.

The Department Plans to Acquire More Information in Order to Negotiate Rebates and Lower Rates for Its Medical Supply Purchases

As discussed in the Introduction, the department has until October 16, 2003, to implement the regulations the federal government issued in August 2000 that require all insurance providers and Medicaid agencies to convert to level II codes for billing DME, medical supplies, and hearing aids. However, level II codes generally contain far less detail than the department's current codes, which would only worsen the

department's ability to know what it is paying for. Therefore, the department plans to seek a waiver to allow it to convert to a more detailed billing code structure for medical supplies. In place of the level II codes, the department wants to implement the UPN codes for paying claims.

As discussed on page 28, the department's billing codes lack specific product information. Without more detail on products, providers can bill for an expensive item but deliver a similar item that actually costs much less. Thus, the billing codes fail to ensure that Medi-Cal beneficiaries are getting products of a quality to justify what the department pays for them.

Historically, UPNs have primarily been used for inventory control. The UPN codes information electronically—the manufacturer name, the item or product number, a description, a unit of measure, and quantity—in both number and bar-code formats. The bar code can be electronically scanned for inventory control. A central authority does not issue UPNs. Two coding councils coordinate the distribution of manufacturer identification codes; manufacturers and labelers then issue the UPNs within the formats specified by the two councils. UPNs do not include prices, nor do they contain data elements that would allow electronic grouping of similar or identical items for analysis. Nevertheless, the level of specificity contained in the UPNs has the potential to give the department the information it needs to negotiate lower rates with providers, to participate in rebate and discount opportunities from manufacturers, and to address concerns with increased expenditures for unlisted items. The department believes it will be able to save $30 million per year by implementing a manufacturer rebate program with the data it obtains from using UPNs.

The department hopes to save $30 million per year by implementing a rebate program with the data it obtains from UPNs.

In 1993, the department prepared a report in response to a legislative request that it explore the concept of contracting for durable medical equipment and supplies. In this report, the department identified a cost-reduction measure of establishing codes and prices for custom wheelchairs in order to eliminate manual pricing for many unlisted items. The department is now taking steps to address this manual pricing issue by implementing UPN billing codes for medical supplies. The department's DME and hearing aid units do not plan to use UPNs and will use level II codes. Initially, the department will concentrate on a limited number of medical supply products in its pharmacy system, such as glucose test strips.

The department's pharmacy database has a field that can be easily adapted to accommodate the UPNs for these test items. In the future, should the UPN test project prove successful, the department might convert all medical supplies, and possibly DME and hearing aid items with UPNs, to this billing code system as well, according to department staff.

To use the UPN codes, the department must submit a waiver request to the Centers for Medicare and Medicaid Services (CMS). Staff at the CMS reported that the federal government would like to have California serve as a pilot program to determine the cost and feasibility of using UPNs to pay all claims. The department hopes to receive supplemental funding from the federal government to offset its initial set-up costs (federal law allows payment of up to 90 percent of costs for design, development, or installation of mechanized claims processing and information retrieval systems). The department estimates that its initial costs, after the federal government pays its share, will be $700,000.

Simultaneously, the department is considering contracting with a national vendor for a medical products database. This database contains product information for approximately 800,000 products, including prices for approximately 20 percent of these items. The vendor will provide a conversion table matching federally approved codes to UPNs for those products in the database with UPNs. The department's main interest in this database, however, is that the system contains functional equivalence tables to group like items that perform the same functions. The department hopes to use these functional equivalence tables in negotiating prices, because without such tables, the department approves various products with a wide range in prices. For example, as discussed earlier, the department paid from 42 cents to $55 per unit for sheets covered by one product code. The large price variation may be because the items are not functionally equivalent, even though they fall under the same code, or it could be because some manufacturers are willing to produce these items at a lower cost than other manufacturers. Because the department has no way to determine whether other, less expensive items are functionally equivalent, it approves payments for billed items if it believes they meet the beneficiary's medical needs. With the tables, and the price data the department hopes to collect from manufacturers and providers, the department would be able to choose the least expensive type of item that meets the patient's needs in the same manner as the other items in that functional equivalence group.

A medical products database offered by a national vendor contains functional equivalence tables that the department could use to choose the least expensive item that meets the patient's needs.

The Department Has Not Considered Some Disadvantages of Converting Its Billing System

Although the department is moving cautiously by implementing UPNs for a limited number of medical supply items, its long-range goals of converting to UPNs for all medical supply items may prove more difficult than the department believes. To successfully use UPNs for all its medical supply items, the department needs to fully consider and address the major drawbacks of the UPN billing code system. The only known database of UPNs is incomplete and has errors. Crossover claims between Medi-Cal and Medicare may be difficult to process because the UPNs and federally approved codes are hard to correlate. Also, data for the UPNs is limited, so the department will not only have to establish prices for each UPN, but it will have to update prices and MAPCs for millions of UPNs that are represented by thousands of federally approved codes. Adding to the challenge, manufacturers often see no reason to meet the UPN standards or even to report UPN data. As it plans for this transition, the department must consider the extra employees it may need and how much it may have to spend to overcome these problems with adopting a UPN billing code system.

The department may have problems converting to UPNs because of inherent problems with the UPNs themselves. UPNs are not uniform. Currently, two councils develop standards for UPNs, yet neither council has enforcement power to compel its members—manufacturers and product labelers—to comply with its standards for issuing UPNs or to report the UPNs to a central database. Only one of the councils maintains a database of UPNs, and this database is not comprehensive. A June 2001 report by a Medicare consultant found that this database contained only 40 percent to 60 percent of all DME, medical supply, and hearing aid products. In fact, the other council no longer supports the UPN database maintained by this council, and it has reported that the database has an approximate 10 percent error rate. The consultant's report also found that many manufacturers see no advantage in adhering to UPN standards, while others see no advantage in reporting UPNs for their products. Finally, neither council has enumerated all DME, medical supplies, or hearing aid items, and neither has collected product descriptions from manufacturers that would allow the department to easily establish Medicaid coverage, coding, or pricing determinations for those items that have a UPN.

The two councils that issue UPNs lack enforcement power to require manufacturers to adhere to council standards in issuing UPNs, or to report UPNs to a central database.

Further, the department cannot look to other entities for guidance with UPNs, since apparently no agency or department currently uses UPNs to pay Medicaid or Medicare claims. The primary purpose of UPNs has always been to facilitate inventory control rather than to bill claims. Although both the U.S. Department of Defense and the U.S. Department of Veterans Affairs use UPNs for inventory control, both use federally approved codes for processing claims. Because the department will be the first organization to use these codes for processing claims, it will have to develop policies and procedures without any prior lessons learned or assistance from other groups or agencies.

Moreover, because it has beneficiaries who receive both Medicare and Medi-Cal benefits, the department will need to develop a table that converts UPN codes to federally approved codes to use the UPNs for paying claims for beneficiaries with both Medicare and Medi-Cal coverage. Providers will also need to maintain two separate billing code structures: federally approved codes for billing Medicare and other health insurance plan claims and UPNs for billing Medi-Cal claims.

A Medicare consultant and industry representatives agree that UPNs and federally approved codes can be difficult to correlate: multiple UPNs can convert to one federally approved code; multiple federally approved codes can correspond to one UPN; and some federally approved codes have no UPNs assigned to their products.

Unfortunately, reports by a Medicare consultant and industry representatives agree that UPNs and federally approved codes can be difficult to correlate. For example, multiple UPNs can convert to one federally approved code, multiple federally approved codes can convert to one UPN, and in many instances, no UPNs exist for certain federally approved codes. The Medicare consultant found a wheelchair UPN that met criteria for two federally approved codes: K0003, "Light-Weight Wheelchairs," and K0004, "High-Strength Light-Weight Wheelchairs." The consultant also noted that one federally approved code, E0570, "Nebulizer with Compression," matched 59 UPN-coded products. As a result, the department or its database vendor will need to perform additional work to sort UPNs into appropriate and defendable categories. Because product descriptions in the department's system may be insufficient to allow the department to easily create the code conversion table, the department or its database vendor may need to obtain and review additional product data, such as company catalogs, or discuss item specifications with providers and manufacturers, all of which can be time-consuming and expensive.

The Medicare consultant's report estimated that if Medicare were to convert to UPNs, it would require four to six years for implementation, if no other priorities interfered. Moreover, in

its draft waiver, the department stated that UPN use would be voluntary, so any manufacturers who prefer federally approved codes may continue to use them.

Further, if the department is to successfully use UPNs for processing all claims, it will need to establish and maintain an adequate registry or claims system database. Specifically, the department will need to develop a methodology to identify and link or group functionally equivalent items, a way to update the registry or database with price and product descriptions on a regular basis, and it may need state regulations requiring manufacturers to report data to the department on a periodic basis. However, manufacturers may be reluctant to do this and may fight efforts by the department to issue these regulations. For example, a June 2001 report by a Medicare consultant found that manufacturers have been historically reluctant to provide price data because prices vary among customers depending on order size and purchases for a time period. Moreover, representatives from the potential database vendor noted that it is common to see price variations on the same product of up to 100 percent depending on who is buying the item, and variations of 500 percent to 1,000 percent for functionally equivalent items.

Although the department expects to obtain a conversion table matching federally approved codes to UPNs if it contracts for a medical products database, the vendor's database lacks UPNs for 80 percent of its 800,000 items.

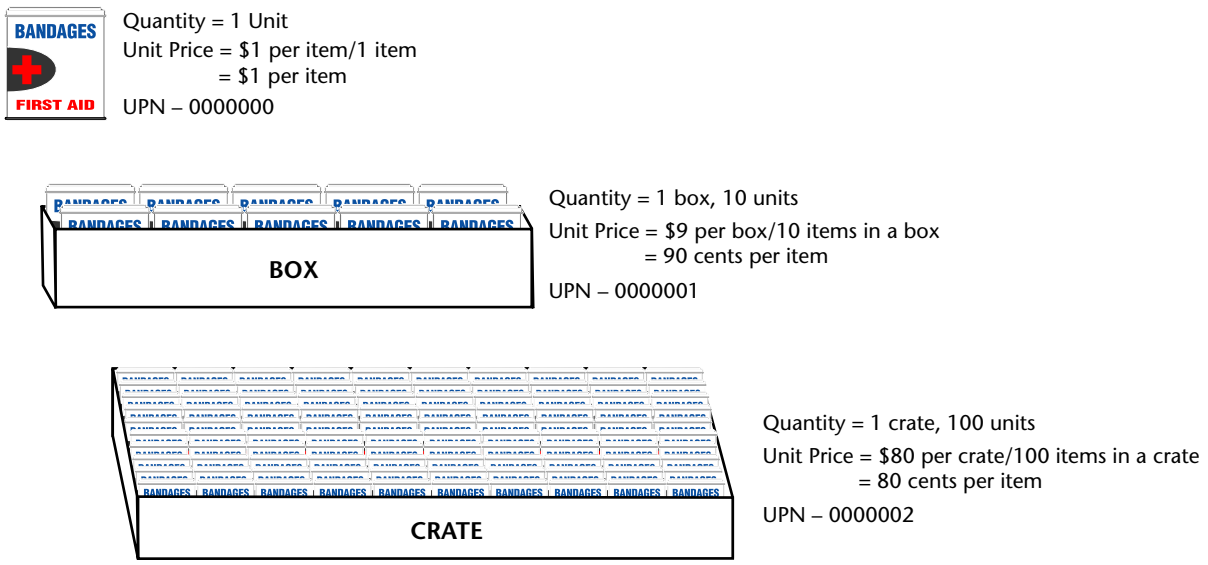
As stated earlier, if the department contracts for a medical products database, it expects the vendor to provide it with a conversion table that matches federally approved codes to UPNs for those products in the database with UPNs. However, the vendor the department is considering reported that its existing database lacks UPNs for 80 percent of its 800,000 items. Also, this vendor's database uses a unique number, not a UPN, to track each item, although vendor staff said they could convert the tracking numbers to UPNs. The vendor's representatives stated that their company would have to collect UPN and price information from manufacturers and labelers, but it estimated that the fees to do so would be nominal—$15,000 per manufacturer. Department staff said that manufacturers would bear this cost, but the department has not conferred with manufacturers on this subject.

Because of the limited data currently available for UPNs, the department will incur more administrative costs to keep price and coverage determinations up to date for enumerated items. Also, there are significantly more UPNs than federally approved codes to track. The 4,000 level II federally approved codes for DME and medical supplies represent millions of products

from different manufacturers. Moreover, as shown in Figure 5, a single, unique product can have multiple UPNs and prices assigned to it based on its packaging.

FIGURE 5

Depending on Its Packaging, a Product Can Have Various UPNs and Multiple Prices



The department will have to track these multiple prices, and UPNs, then determine the maximum allowable cost. The department will also see increased staffing costs to track negotiated or contracted prices with manufacturers, as well as any rebate or discount agreements for purchasing these products. A March 2002 planning document by the department calls for two additional staff to implement the UPN codes and to track contracts and rebates. However, the department could not provide any cost projections or analysis to prove that two staff would be sufficient. Given the department's failure to properly maintain prices and descriptions for the almost 2,300 DME, medical supplies, and hearing aid product codes it used in fiscal year 2001–02, we are skeptical that the department will be able to keep its system up to date for millions of product codes.

Providers who want to participate may have increased training and investment requirements as well. Providers who do not already use bar codes will need to invest in hardware and software to use UPNs for billing claims. Specifically, providers

who do not already use UPNs will need to purchase bar code scanners, computer equipment, and bar code printers. The department believes that providers are familiar with UPNs and generally use UPNs to reorder supplies. However, we surveyed 11 providers who together supplied $19.9 million (19 percent) of the top six medical supplies purchased in fiscal year 2001–02. We found that 9 do not use bar codes in their business and do not have computer or scanning equipment that would allow them to use bar codes. One of the 9 providers reported that he did not believe it would be difficult for his firm to switch to UPNs. For the other 8 providers who were not prepared, a switch to UPNs may represent an unexpected burden. Smaller providers are more likely to be affected by the switch and may cease providing items for Medi-Cal beneficiaries, disproportionately affecting service for beneficiaries in rural areas, who tend to rely on smaller providers.

Although the department believes most providers already use UPNs, our survey of 11 providers found 9 that do not.

Finally, the department will not necessarily get the full advantage of lower prices simply by implementing the UPNs. In addition to implementing the new codes, the department will need to analyze and use the information provided by the new codes to ensure that it is not overpaying for items, for example, paying $55 for a 42 cent sheet. Also, the department may realize additional savings once it uses the additional data provided by these codes to negotiate lower prices or discounts with manufacturers or providers. However, in order to achieve these savings, the department will need to constantly update prices for its medical supply items. With the passage of legislation in September 2002, medical supply rates are no longer tied to regulations, so the department has more freedom to update these rates on a regular basis. As discussed earlier, however, the department is not meeting even the current requirement that it update medical supply rates every 60 days, so it will need to be more vigilant about updating prices in the future. Further, because DME and hearing aid rates are still contained in regulations, price changes for these items are a laborious and time-consuming process that is not occurring frequently.

Department staff acknowledge many limitations of the UPN billing code system. However, the chief of the Medi-Cal contracting section stated that because no better code system appears to exist at this time, the department wants to proceed with the UPNs in hope that the additional information provided by these codes will allow the department better control over its costs.

The Department Is Unprepared to Negotiate Contracts for DME and Medical Supplies

The LAO estimated that by competitively bidding for DME and clinical laboratory services, the department could save the General Fund almost $17 million. However, the department believes that rather than competitive bidding, negotiated contracts with providers can reduce costs for the department's DME expenditures. Further, the department hopes to save $9 million by negotiating lower prices with manufacturers for blood glucose test strips, a medical supply item. Nonetheless, the department lacks thorough planning about how to approach negotiating with manufacturers or providers or how to select from among them for contracting. This lack of focus has the potential to ruin any cost savings, increase expenditures for unnecessary administrative expenses, and possibly reduce beneficiaries' quality of and access to healthcare. Issues the department has not addressed include the possible lack of cooperation by providers and manufacturers; exactly what staff are needed and what objectives they should pursue; and how to ascertain and update reasonable pricing. Also, while savings have apparently been achieved in two Medicare competitive bidding pilot projects, competitive bidding has not worked well in some other states' Medicaid agencies.

The department's lack of focus or planning for negotiated contracting could ruin its hopes for cost savings and possibly reduce beneficiaries' quality of and access to healthcare.

The Department Needs to Better Plan Its Staffing Needs for Contract Negotiation

According to a report by the National Conference of State Legislatures, states can use selective contracting or competitive bidding as cost-saving alternatives for purchasing Medicaid services and products. In competitive bidding, states require providers to submit bids and compete with one another to offer services or products, while selective contracting involves contracting with a limited number of providers to supply certain agreed-upon services or products for beneficiaries. The department plans to evaluate products on five criteria—safety, efficacy (how well the product works), essential need, misuse potential, and cost. Based on its evaluation, the department will present a price offer to the manufacturer, who may accept, reject, or present a counteroffer to the department's price within a time frame established by the department. Either selective contracting or competitive bidding could allow the department to use market forces to lower payment levels. However, either purchasing method might result in an inadequate supply of providers or lower overall quality of care for beneficiaries, especially if the department does not have

the capacity to guarantee choice under a selective contracting arrangement, or to develop or monitor quality measures. Further, for selective contracting or competitive bidding, negotiations can be burdensome and administrative costs high.

Although authorized under state law to contract for DME since 1993, the department's staffing decisions have not supported such contracting. The department's chief of the Medi-Cal policy section says a lack of staff has prevented the department from contracting for DME in the past; now the department plans to acquire 15 more employees to work on contracting, but it lacks a specific strategy to use the new staff.

In May 2002, the department submitted a budget change proposal to the Department of Finance requesting 5 additional staff positions to assist with contracting for both clinical laboratory services and DME. Ultimately, the Department of Finance approved the 5 positions, and 10 more positions after the department verified that 5 would not be enough.

Although its budget change proposal called for the department to finalize its work plan and schedule for contracting by July 1, 2002, as of October 22, 2002—nearly four months later—the department has yet to develop a written plan for negotiations.

The budget change proposal called for the department to finalize its work plan and schedule for contracting by July 1, 2002, but the department has no written plan as of October 22, 2002. Lacking adequate planning for entering into negotiations, department staff could not describe any detailed plans for how to use the additional staff, or how the department plans to engage in contract negotiations. Although it wants to hire another 5 to 15 new employees, the department has no idea whether this is a reasonable number of employees to perform contract negotiations for both clinical laboratory services and DME. Further, the department needs to identify the parties it wants to contract with. Department staff stated that they would attempt to negotiate contracts with manufacturers rather than providers; however, they have not spoken to any manufacturers of DME items.

The Department Lacks Tools to Allow It to Contract for DME Items

The department lacks the tools to effectively contract for DME items. In its budget change proposal, the department stated that for DME items, it plans to focus on oxygen and oxygen-related supplies, and on items that are unlisted, such as unlisted wheelchairs, because its fiscal intermediary had reported that these items were driving the majority of the department's increase in expenditures. Further, the department reasoned that because there are only a handful of wheelchair manufacturers,

the process for contracting with these manufacturers would be simpler than for other items. In contrast, field office staff told us that wheelchairs are technical and complex items to purchase because of all the dimensions—such as width, depth, back height, center of gravity, and angle—that must be considered when fitting a wheelchair to a beneficiary's needs.

The department's lack of tools such as cross-reference tables may prevent contracting staff from determining which models of wheelchairs can be included together for contracting purposes.

Because the department lacks tools such as cross-reference tables to allow it to determine which wheelchairs are functionally equivalent to others, contracting staff may be unable to determine which models of wheelchairs perform the same essential functions as other models and can be included together for contracting purposes. In order to contract for these items, department staff will have to develop cross-reference tables, which could prove to be costly and time-consuming. Nevertheless, we agree that contracts for unlisted items and oxygen and oxygen-related supplies could help the department contain its rising costs.

The Department Has Not Planned for the Difficulty of Determining Reasonable Prices in Contract Negotiation

To successfully engage in negotiated contracting, the department will need to ascertain the reasonability of prices, something the department has not properly planned for. In its negotiated contracting, the department will have to rely on manufacturers and providers to supply product and service descriptions and prices. However, the department hopes to negotiate contracts with manufacturers for items without existing MAPCs, such as unlisted wheelchairs, yet it lacks cost-control tools for determining whether the prices submitted by manufacturers and providers are reasonable and are for functionally equivalent items.

The department cannot easily rely on past expenditures to determine if a price is reasonable, because payments in unlisted categories vary widely. For example, our review of payments for unlisted wheelchairs in fiscal year 2001–02 found that they ranged from less than $100 to more than $19,000 per item.[3] The department will need to spend considerable time and effort to determine which items providers have billed in these product codes, ensure that they are functionally equivalent, and then determine reasonable prices to evaluate contracts or to negotiate lower prices with contractors. Further, the department will need to set up and monitor contracts, which can be burdensome

[3] Some of the low dollar payments in this category could represent Medi-Cal's portion of Medicare crossover claims or inaccurately coded requests.

and increase administrative costs. Because the department has not written any of its plans, conducted cost-benefit analyses, or devised ways to address monitoring or pricing, we cannot confirm that the department has seriously considered and planned for these possible complications.

The department hopes to save $9 million by negotiating contracts with manufacturers of blood glucose test strips, but it has yet to formalize its plans or adequately document how it will proceed with contracting.

Separately, the department's medical supply unit also plans to negotiate contracts with manufacturers of medical supplies for four items typically sold at a pharmacy, hoping to save $9 million by obtaining lower prices for blood glucose test strips. State law enacted in September 2002 requires the department to engage in these demonstration contracts. Although it seems better prepared than DME for contracting, and was better able to articulate its plans, the department's medical supply unit also has not formalized its plans and lacks documentation of how it will proceed with contracting. Therefore, we cannot determine whether the medical supply unit has considered possible difficulties with negotiating contracts.

While Competitive Bidding Can Reduce Costs, It Has Not Worked Well in Some Other States' Medicaid Agencies

Although Medicare pilot programs in Florida and Texas show promise of reducing costs by using competitive bidding for DME and medical supplies, other states' Medicaid agencies report little success with competitive bidding. Strong opposition from providers and provider groups has derailed attempts to save money by Medicaid agencies in Florida and Texas. Likewise, the department faced lawsuits when it last tried to use competitive bidding for medical supplies in 1998, and California's industry organization for home medical equipment providers has joined in support of a national fight against competitive bidding.

Beginning in 1999, Medicare instituted competitive bidding for DME and medical supply purchases in two pilot programs in Florida and Texas. While Medicare is still completing its projects and is awaiting data to complete its final analysis, initial data seems to indicate that Medicare will save on program costs, maintain access and quality, preserve competition, and successfully administer programs. Medicare's second-year report cited estimated savings of 17 percent to 33 percent for the competitively bid items. Even after including estimated administrative costs of $4.8 million, Medicare expects the two pilot programs to have saved $3.7 million by December 2002.

While Medicare appears to have successfully used competitive bidding in two demonstration projects, only one of four state Medicaid agencies we contacted has had even limited success.

However, outside of pilot programs, competitive bidding attempts by Medicaid agencies in Florida and some other states have encountered significant resistance from providers. For example, we interviewed staff in Medicaid agencies in four states—Minnesota, Florida, Texas, and Vermont—and only Minnesota reported success with competitive bidding for DME or medical supplies. However, Minnesota's contractor serves fewer than 5,000 beneficiaries for oxygen. Another state, Vermont, was unsuccessful in using competitive bidding because it was unable to obtain valid bids for the proposed contract items. Two states in our survey faced significant opposition from providers and provider groups in their efforts to use competitive bidding for medical supplies or DME. For example, Florida's Agency for Health Care Administration tried to contract for respiratory equipment and hospital beds in 11 districts and intended to have contracts in place by July 2002. Florida issued notification of its request for proposal (RFP) on its Web site, but it did not prepare by holding discussions with providers or provider groups, or submit its RFP to the providers or provider groups. Due to provider protests in 7 of the 11 districts, Florida thinks contracts in the 7 districts will be delayed until January 2003, if the contracts go through at all.

Also, Texas's Health and Human Services Commission devised and issued a RFP for DME and medical supplies on May 15, 2002, intending to begin one or more contracts by November 1, 2002. After receiving numerous complaints from DME vendors, Texas rescinded the RFP on July 5, 2002. Then, Texas created a task force with providers and Medicaid clients and asked it to develop viable alternatives to competitive bidding by September 2002. In September 2002, as a result of this task force's recommendations, Texas requested that providers and manufacturers submit pricing information to allow Texas to develop a discounted structure for certain DME and medical supply items. In its request for information, Texas is only accepting price quotes that are equal to or lower than its current MAPCs. However, the state also warned providers that if the prices did not result in anticipated savings, Texas might reopen competitive bidding.

These states' experiences are particularly significant given the department's history with competitive bidding. In December 1998, the department attempted to engage in competitive bidding for incontinence medical supplies. However, because of the lawsuits

filed by various providers, the department withdrew the RFP and is continuing to use many of the same rates it established for these products in the mid-1990s.

Industry groups support providers in opposing competitive bidding. In May 2002, 13 home medical equipment and supply industry organizations sent an open letter to the chair of the House Committee on Ways and Means protesting national competitive bidding for home medical equipment and supplies by Medicare. These industry groups stated that they believe competitive bidding results in a lower standard of care for Medicare beneficiaries because it restricts access to services and limits beneficiary choice. Also, the industry groups said that because it excluded small businesses from the marketplace, competitive bidding could cause unwarranted harm to these businesses. Despite these beliefs, as discussed earlier, reports on Medicare's competitive bidding demonstration projects seem to indicate that competitive bidding has maintained access and quality and has preserved competition in the market.

Although department staff hope to contract with manufacturers, they have not spoken to any manufacturers to gauge their willingness to participate in contract negotiations.

California's primary industry organization for home medical equipment providers, the California Association of Medical Product Suppliers (CAMPS), supports the fight against national competitive bidding. Our discussions with the executive director of CAMPS revealed that CAMPS and its members are firmly opposed to competitive bidding for medical supply products when it involves providers rather than manufacturers. As stated earlier, department staff said they would attempt to contract with manufacturers rather than providers; however, they have not spoken to any manufacturers of DME items to gauge their willingness to participate in negotiating contracts.

RECOMMENDATIONS

To ensure that it receives a fair and reasonable price for DME, medical supplies, and hearing aids, the department should:

- Analyze its payments for unlisted DME and medical supplies to determine whether it should establish maximum allowable product costs for any of these items.

- Analyze periodically its expenditures to determine utilization of high-dollar items and possible causes for increases in expenditures.

- Consider developing a voice-activated authorization system for straight-forward transactions to free staff time for more complex prior authorizations or cost analyses.

- Develop tools, such as functional equivalence and price comparison tables, for its field office staff to compare prices among similar items for unlisted DME and medical supplies.

- Cap reimbursement for unlisted items at the lesser of a department-determined percentage of the provider's cost (for example, 150 percent of cost) or the provider's usual and customary cost charged to the general public, and require providers to submit their cost information with claims for reimbursement.

- If the department does not wish to set this cap and require providers to submit cost information, it should enforce its requirement that providers of unlisted wheelchairs document why the wheelchair cannot be billed under listed codes and that the recommended wheelchair is the least costly of alternative items that meet patient needs.

- For those items for which it has established maximum allowable product costs, the department should ensure it reviews and updates these rates on a regular and frequent basis.

- Clarify its rental policies with its field office staff to ensure that overpayments for DME rentals are not occurring.

To enable the department to become more responsive to changes in prices, the department should seek legislation to remove prices for DME and hearing aid items from regulations.

In order to realize future cost savings for Medi-Cal, the department should continue to develop and use a universal product number structure for medical supplies and contract negotiations for its DME items. However, the department should ensure that it adequately plans and considers possible limitations of its efforts. Further, the department should bring manufacturers and providers into its planning sessions as soon as possible.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: December 12, 2002

Staff: Ann K. Campbell, CFE, Audit Principal
Celina M. Knippling
Ron Sherrod, CPA

Agency's comments provided as text only.

Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

November 25, 2002

Ms. Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for forwarding for review and comment a draft copy of the Bureau of State Audits' report entitled, "State of California: Durable Medical Equipment in the Medi-Cal program." Enclosed is the Department of Health Services' response to the review findings and recommendations. The Department has begun taking steps to address the issues raised in the Bureau's report.

If you require further information concerning the Department's contract activities with the purchasing and contracting of durable medical equipment in the Medi-Cal program, please contact Assistant Secretary, Peter Harbage at 654-3301. You may also contact Diana M. Bontá R.N., Dr. P.H., Director of the Department of Health Services, at (916) 657-1425.

Sincerely,

(Signed by: Grantland Johnson)

GRANTLAND JOHNSON

Enclosure

* California State Auditor's comments begin on page 53.

Department of Health Services
714 P Street
Sacramento, California 95814

November 25, 2002

Ms. Elaine M. Howle
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for forwarding your draft of the Bureau of State Audits' report entitled, "State of California: Durable Medical Equipment in the Medi-Cal program." The Department of Health Services (Department) appreciates your review of this portion of the Medi-Cal program and your recommendations for improvements. Enclosed is the Department's response to the review findings and recommendations. The Department agrees with the recommendations of the report.

The Davis Administration is committed to providing quality services to Medi-Cal beneficiaries while protecting taxpayer dollars. Medi-Cal has been recognized as one of, if not the most, cost effective Medicaid health care delivery systems in the nation. In fact, while Medi-Cal covers 32 of the 34 optional Medicaid benefits, second only to Wisconsin, and has broad eligibility coverage, it has the lowest per capita expenditures in the nation. The ability to provide such a wide range of services to Medi-Cal beneficiaries at a low cost is a function of the Department's efforts to purchase services at lower prices, strong utilization control programs, an effective claims processing system, and a strong anti-fraud program.

The Department recognized that durable medical equipment (DME) services are an area in which the State could achieve program savings through better business practices and still provide quality services to Medi-Cal beneficiaries. In the May Revision to the fiscal year (FY) 2002-2003 Governor's Budget, the Department proposed a significant effort to contract for DME services to control costs while protecting patient care. The Legislature adopted this proposal in the FY 2002-03 budget, which included funding for additional staff to develop, implement, and monitor a new DME contracting program. The contracting process, along with significant changes in benefit administration, will result in significant savings to the Medi-Cal program.

Once implemented, the Department estimates yearly savings of approximately $19 million ($9.5 million General Fund) for DME contracting and approximately $17 million ($8.5 million General Fund) for medical supply contracting.

The Department is in the process of implementing these changes. We are giving strong consideration to patterning the DME contracting program after the already successful Medi-Cal Contracting Section Drug Rebate Program. The Department is currently hiring additional staff to expand the contracting function and has obtained hiring freeze exemptions in order to fill these positions.

If you require further information concerning the Department's contract activities with the purchasing and contracting of Durable Medical Equipment in the Medi-Cal program, please contact me at (916) 657-1425.

Sincerely,

(Signed by: R.R. Bayquen for)

Diana M. Bontá, R.N., Dr. P.H.
Director

Enclosure

DEPARTMENT OF HEALTH SERVICES (DHS)
RESPONSE TO BUREAU OF STATE AUDITS REPORT:
"State of California: Durable Medical Equipment in the Medi-Cal Program"

RECOMMENDATIONS

Following are DHS' comments specific to the draft audit recommendations.

To ensure that it receives a fair and reasonable price for medical supplies, hearing aids, and durable medical equipment, DHS should:

- **Perform analyses of its payments for unlisted DME and medical supplies to determine whether it should establish maximum allowable product costs for any of these items.**

  DHS concurs. Electronic Data Systems (EDS), the Medi-Cal fiscal intermediary, has provided DHS with annual data on trends in DME expenditures for each of the past seven years. DHS analyzes these data when formulating policies and applying utilization controls to DME items. In addition, as part of the Medi-Cal fiscal intermediary contract, EDS' Cost Containment Unit meets regularly with DHS to review concepts and proposals to contain DME costs. Additionally, DHS analyzes Medi-Cal payments for unlisted medical supplies to determine if DHS should set maximum allowable product cost for any of these items.

  This recommendation suggests that the State review DME products to determine additional products that should no longer be billed under the unlisted procedure code but instead should have it own procedure code and rate. This will be very difficult given limitations in how procedure codes are created especially after the adoption of the new Health Insurance Portability and Accountability Act (HIPAA) requirements. Based on HIPAA, DHS can no longer create its own local codes for these DME products. Instead, DHS must either use generic national codes that would make better pricing impossible or move to a new coding structure that is federally approved. DHS is proceeding to resolve this issue as part of its HIPAA effort.

- **Analyze periodically its expenditures to determine utilization of high-dollar items and possible causes for increases in expenditures.**

  DHS concurs. DHS will evaluate the possibility of expanding beyond existing efforts with EDS to analyze expenditures to determine root causes. These increased efforts will be contingent on the availability of staff.

  DHS routinely reviews expenditure data to determine changes in payment patterns. DHS uses several new computer systems to assist in this review. This includes the Medi-Cal Management Information/Decision support system that allows both State and contract staff to track payment changes. Further, DHS uses two new systems from EDS, which allows DHS to track payment changes on a weekly basis and over time. An example of a recent

success in this area was a review of expenditure data in 2000 for incontinent products. In this case, DHS spotted a $60 million jump in payments in this category that we determined to be due to provider fraud. Through the concerted efforts of DHS, staff was able to reduce this fraud and obtain ongoing savings for the State and federal governments.

- **Consider developing a voice-activated authorization system for straightforward transactions to free up staff resources for more complex prior authorizations or cost analyses.**

  DHS concurs. DHS has to address better utilization control enforcement on the $165 incontinent product limit, but disagrees that this would free up staff resources. This recommendation is relevant in enforcing limits on the number of services a Medi-Cal beneficiary can receive in a month. DHS has three limits that apply to this recommendation: services that require a MEDI authorization, the limit that a beneficiary can only have six prescriptions per month without prior authorization, and the $165 per month incontinent product limit. The MEDI authorization system already uses a voice-activated system and also uses more efficient point of service and personal computer authorization systems. A voice-activated system could not be used for the six-prescription limit, and is not needed as this limit is enforced through an on-line drug processing system. The $165 limit does not utilize this technology and providers could use a voice-activated system. DHS has already explored ways to simplify verification for the $165 limit and determined that the significant investment of funds and staff time needed to create the system outweighed the potential benefit. Instead, DHS developed a less costly way to implement this control using the claims processing system to check claims for beneficiaries who exceed this limit by using multiple providers. DHS anticipates implementing this change within the next couple of months. While this change will better control program expenditures, it will not free up staff resources.

- **Develop tools, such as functional equivalence and price comparison tables, for its field office staff to use in comparing prices among similar items for unlisted DME and medical supplies.**

  DHS concurs. In fact, through policy statements; e.g., #88-3 (Negotiated TAR Pricing) and #98-6 (Unlisted Wheelchairs and Accessories), the Medi-Cal Policy Division (MCPD) has already provided field office staff with functional equivalence and price comparison information, and authority to negotiate pricing with providers. In addition, the Medi-Cal Operations Division (MCOD) provides field staff with instruction notices that provide such information; e.g., oxygen delivery system cost comparisons based on oxygen flow rates. DHS hopes that through our new contracting process we will be able to establish guaranteed provider acquisition costs for many DME items.

As background, in August 1996, a DME Manual was transmitted to the Medi-Cal field offices that contained a vast amount of information devoted to wheelchairs, wheelchair accessories, seating and positioning devices. The purpose of the manual was to facilitate the TAR approval process by providing consultants with price, wheelchair features and warranty information. It has been extremely difficult, however, to obtain accurate wholesale and retail pricing information from providers and manufacturers for various DME items. Moreover, while wheelchair manufacturers have conducted evaluations of their own and their competitors' products for almost 30 years, this information has been virtually inaccessible to those who prescribe wheelchairs and consumers *(J Rehabil Res Dev 1990:Clin Suppl 2:86-7 and Axelson P. et al. A guide to wheelchair section: how to use the ANSI/RESNA wheelchair standards to buy a wheelchair. Washington, D.C.: Paralyzed Veterans of America, 1994).*

- **Cap reimbursement for unlisted items at the lesser of a department-determined percentage of the provider's cost (e.g. 150 percent of cost) or the provider's usual and customary cost charged to the general public, and require providers to submit their cost information with claims for reimbursement. If the department does not wish to set this cap, it should enforce its requirement that providers of unlisted wheelchairs document why the wheelchair cannot be billed under listed codes and that the recommended wheelchair is the least costly of alternative items that meet patient needs.**

DHS concurs that the least costly alternative that meets the patient's need should be approved. This will occur once the DME contracting program has resolved the current issues related to defining a "custom wheelchair" vs. a "noncustom wheelchair," the appropriate procedure codes to use for these chairs, and the proper rates to pay for these chairs. To implement this requirement fully without resolution of this issue would create significant access problems for Medi-Cal beneficiaries to obtain wheelchairs both at home and in nursing facilities. In 1998, Medi-Cal attempted to implement this requirement without having resolved these core issues and it resulted in considerable beneficiary access issues that culminated in several legislative hearings on this issue.

Wheelchair purchasing poses unique challenges for DHS to balance the need of providing high-level beneficiary care while controlling costs. For example, without adequate DME pricing information from manufacturers and providers, it is difficult to implement this requirement. DHS hopes that our contracting efforts will enable us to obtain this needed information. Field office staff adjudicates DME items on a TAR on a "line-by-line" basis, considering available medical justification and the least costly service to meet the needs of the patient. Additionally, DME providers include relevant comparable DME products/pricing. However, due to expansion in technology, the DME universe is large and the provider information submitted may not be the most competitive information.

Modifying the State's policy on paying for wheelchairs has been very difficult as we must balance complex pricing and coding issues with the ability of a beneficiary to obtain a wheelchair that meets his or her medical needs. DHS has made several attempts to improve the pricing and these have been met with significant provider and consumer opposition.

Our proposal to contract for DME products is being designed to address these issues so that the State will be able to fully enforce this policy.

- **For those items for which it has established maximum allowable product cost, the department should ensure that it reviews and updates these rates on a regular and frequent basis.**

  DHS concurs. DHS makes every effort to update prices on a regular basis. We agree that there is an opportunity to improve on the frequency of these updates. However, there are a number of challenges that need to be overcome. For example, much of the pricing information provided to DHS by manufacturers is not an accurate reflection of true product cost. In many cases, manufacturers may produce three or more different catalogs for different provider types, each with a different price for the exact same item. Sorting through this information is exceptionally staff intensive. In addition, DHS has also determined that the true and actual price for many of these items is significantly lower than the reported price.

- **Clarify its rental policies with its field office staff to ensure that overpayments for DME rentals are not occurring.**

  DHS concurs. DHS will issue guidance clarifying rental policies.

- **To enable DHS to become more responsive to changes in prices, the department should seek legislation to remove prices for DME and hearing aid items from regulations.**

  DHS concurs that such legislation has the potential to be helpful. This change was proposed by DHS in the last budget process for medical supplies and adopted by the Legislature. We agree that this concept has applicability to DME as well and we analyze the costs and benefits of legislation that gives DHS the same authority it obtained for medical supplies.

- **In order to realize future cost savings for the Medi-Cal program, DHS should continue in its current efforts to develop and use a universal product number structure for medical supplies and contract negotiations for its DME items. However, DHS should ensure that it adequately plans and considers possible limitations of its efforts. Further, DHS should bring manufacturers and providers into its planning sessions as soon as possible.**

DHS concurs. DHS will continue ongoing efforts to develop a universal product number structure for medical supply items. Plans are in process to meet with provider associations and manufacturers of DME to obtain their input, suggestions and support with our contracting efforts. DHS recognizes from the experience of other state Medicaid programs in their attempts to contract for services, as well as from our previous attempts to place controls and limits on these services, that adequate provider participation and representation is a necessary ingredient. DHS agrees that early and frequent participation by stakeholders is paramount to the success of our contracting effort.

COMMENTS

California State Auditor's Comments on the Response From the Department of Health Services

To provide clarity and perspective, we are commenting on the response by the Department of Health Services (department) to our audit report. The numbers below correspond to the numbers we placed in the margins of the department's response.

1. As we state on page 37 of our report, the department's contracting efforts do have the potential to allow the department to use market forces to lower payment levels. However, the department's current poor planning and lack of focus could also result in a failure to achieve cost savings, increased expenditures for unnecessary administrative expenses, and a possible reduction in beneficiaries' quality of and access to healthcare.

2. While the department is in the process of implementing two cost-saving efforts, including negotiated contracting, these efforts are already behind schedule. As reported on page 29, the department has not finalized its conversion plan for universal product number (UPN) billing codes. Further, as discussed on page 38 of our report, although the department's budget change proposal called for it to finalize its work plan for negotiated contracting by July 1, 2002, as of October 22, 2002, the department had yet to develop written plans for how it will proceed.

3. We saw no evidence that the department uses the information provided by its fiscal intermediary to identify items for which it should establish maximum allowable product costs (MAPCs), or to identify and target items or groups of items for increased expenditure controls. As it acknowledges on page 49 of its response, the department has established utilization controls for only one medical supply item—incontinence supplies.

4. The department is incorrect. The conversion to generic national codes will not make better pricing impossible as the department asserts. For some product categories, including wheelchairs, these national codes provide much more detail than do the department's current codes.

- While we did see evidence that the department's fiscal intermediary is tracking expenditures for various product codes and categories, we saw no evidence to support the department's assertion that it uses the information provided by its fiscal intermediary to analyze expenditures to determine causes of increasing costs or changes in payment patterns. As discussed on pages 21 and 22 of our report, the department's cost controls have done little to rein in its spending for unlisted items, items for which expenditures have been increasing significantly over the past four years.

- The department overstates its efforts. Although the department identified both the problem and its solution in April 2000, it has yet to implement the solution. Specifically, state law requires the department to establish utilization controls limiting expenditures for incontinence medical supplies to no more than $165 per-beneficiary per-month. However, the department's system applies the limit on a per-provider, per-beneficiary basis. As a result, the department found it was paying, on average, 10 different providers for the same beneficiary. The department determined that adding an edit to its system to convert its utilization control from a "per-provider, per-beneficiary" basis to a "per-beneficiary" basis would correct the problem; however, it has yet to implement this solution more than two and one-half years later.

- The department is incorrect. Neither the policy statements described by the department, nor the department's durable medical equipment (DME) manual give its field offices any functional equivalence or pricing comparison information, nor had the department at the time of our review provided its field office staff any information with wheelchair prices. As further described on page 23 of our report, our review of the department's field offices found that staff lack any functional equivalence or price comparison tables. Moreover, field office staff have not performed cost-comparisons among alternatives since December 1997. Although we did observe that some field office staff negotiate rates with providers, as we state on page 23, field office staff must rely on their experience and judgment to determine if amounts being billed are appropriate.

- We believe the department's efforts to obtain these prices have been lacking. As described on page 25, even though the department's policy requires providers to document that the wheelchairs being requested are the lowest-cost item among comparable alternatives, the department stopped requiring

providers to supply this information in April 1998. Prices for unlisted DME items, including unlisted wheelchairs, have increased significantly since this time.

- The department's policy statements, provider manual, and state regulations already define custom versus non-custom wheelchairs. The department needs to resolve the difference between what its current policies dictate and what it is requiring its field office staff to actually do. As stated on page 25 of our report, the department is not following its current policies and requiring providers to submit justification for why a listed code cannot be used in place of an unlisted code, or provide evidence that the item requested is the least costly item among alternatives.

- The department is incorrect. As stated on page 25 of our report, providers are not supplying this information, and the department is not enforcing its own policies requiring providers to do so.

- We question the sufficiency of the department's efforts. The department has made only three attempts to contain wheelchair expenditures in the past 11 years, none of which has been successful, and it has not updated its rates for some DME items with MAPCs for 17 years. Further, the department is ill-prepared to begin contracting for DME items, as discussed on page 37 of our report.

- The department is incorrect. As stated on page 27 of our report, the department has allowed on average more than 15 years to elapse between price updates for its medical supplies. Further, as discussed on page 24, the department has not updated prices for some of its DME items for 17 years.

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