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

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.*

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Department of Health Services' response as of January 2004

The Joint Legislative Audit Committee asked us to examine 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). We found that the department's cost control procedures have been ineffective in reining in spending for items with no maximum allowable prices (unlisted items). In addition, the department has failed to ensure 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, and many of its product codes may be obsolete. Finally, the department's inadequate planning for two initiatives it believes will reduce its DME and medical supply costs may result in increased administrative costs and a failure to reduce expenditures.

Finding #1: The department's cost control procedures have been ineffective in reining in spending for unlisted items.

The department's expenditures for unlisted DME and medical supplies have increased significantly over the past four years, and its cost control procedures have done little to rein in these expenditures. Specific areas our audit identified include:

- The department's payments for unlisted DME items accounted for most of the increases in expenditures for all DME. From 1998 through 2001, expenditures for unlisted DME increased by $34.3 million, or 89.4 percent. Similarly, the department's expenditures for unlisted medical supplies increased, even 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.

- Although state regulations require providers and manufacturers to provide Medi-Cal with rates that do not exceed the price they charge to the general public, in December 1997, the department instructed its field office staff to discontinue reviewing authorization requests for cost.

- Field office staff lack cost-comparison tools, such as functional equivalence tables, that would allow them to compare requested items to other items that perform the same essential functions. Because they lack this information, the field office staff must rely on their experience and judgment to determine whether amounts are appropriate. Further, 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 tends to approve a product regardless of cost as long as it is medically necessary.

- We found that other states have some procedures that the department may wish to consider adopting. For example, we found that New York's Medicaid program caps reimbursement for unlisted items at the lesser of 150 percent of the provider's acquisition cost, or the provider's usual and customary charge to the general public. Further, New York uses a voice-activated authorization system to process routine authorization requests and thus free up staff resources to perform other reviews.

- 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 an average of $3,121 for unlisted wheelchairs.

- While the department attributed the large difference in average prices for listed versus unlisted wheelchairs to obsolete maximum allowable product costs (MAPCs)—the department last updated its MAPCs for listed wheelchairs in 1985 (17 years ago)—we found that the department's failure to enforce cost control procedures also contributed to the rising cost of unlisted wheelchairs. For example, the department's June 1998 policy statement requires field

office staff to approve unlisted wheelchairs only if providers document information including why a listed code cannot be used for the equipment the patient needs, and that the requested wheelchair is the lowest cost item among other comparable brands or types that meet the patient's medical needs. However, field office staff apparently approve requests for prior authorization for all wheelchairs as long as the requests are accompanied by a physician prescription. Staff also allow the use of unlisted codes for all wheelchairs and components. Consequently, the department may be paying more than necessary for customized wheelchairs.

We recommended that the department should do the following to ensure that it receives a fair and reasonable price for DME, medical supplies, and hearing aids:

- 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 straightforward transactions to free staff resources for more complex prior authorizations or cost analyses.

- Develop tools, such as functional equivalence and price comparison tools, 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 (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 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.

Department Action: Partial corrective action taken.

The department reports that it has taken the following actions:

- The department continues to convert its current billing codes to the national Healthcare Common Procedures Coding System codes (national codes) as required by the federal government for compliance with the Health Insurance Portability and Accountability Act, and has already implemented eight of these national codes for pediatric wheelchairs. It expects to finish converting to the national codes by summer 2004, and once fully implemented, the department will use only national codes for all DME. The national codes clearly define specific products with established Medicare reimbursement rates, which the department will use when reimbursing Medi-Cal providers.
- The department has also sponsored legislation establishing DME maximum reimbursement rates at either 80 percent (non-wheelchairs) or 100 percent (wheelchairs) of the established Medicare rate. Consequently, once it finishes converting its billing codes to the national codes, the department will eliminate its current practice of reimbursing certain billing codes without an established Medicare maximum rate at up to 90 percent of the manufacturer's suggested retail price.
- The department established maximum quantity and frequency limits for 35 additional medical supply items.
- The department changed its pricing policy for medical supplies. Instead of setting reimbursement rates using the highest priced manufacturer's item within a given category, the department now uses the median priced manufacturer's item.
- In some instances, the department has reduced the mark-up a manufacturer can use to establish the average wholesale price from 35 percent above the dealer cost listed in the dealer catalog to 25 percent.
- The department now requires a copy of an approved treatment authorization request to accompany all claims for miscellaneous medical supplies billed to the program using unlisted codes.

- EDS, the Medi-Cal fiscal intermediary, now reviews expenditure data on a weekly basis to determine changes in payment patterns. The department assists with this review. It also uses EDS systems to track payment changes weekly and over time.
- In lieu of creating a voice-activated system, the department developed a less-costly way to implement authorization controls to prevent recipients exceeding the department's limit for selected medical supplies. It established a per-beneficiary, per provider limitation on certain supplies and uses the claims processing system to check claims for beneficiaries who exceed the department's limit by using multiple providers.
- The department is reviewing price data, product specifications, features, and other product information for DME as part of its contracting activities. The department plans to use this data to revamp and update field office tools that staff can use to select the least expensive type of item that meets the patient's needs.
- With the passage of the 2003-04 Budget Trailer Bill, the department changed its reimbursement methodology for all DME. For those items with a maximum allowable rate for California established under the Medicare program (maximum allowable rate), the new reimbursement rates are generally stated as a percentage of the lowest maximum allowable rate. For those DME items without a maximum allowable rate, the reimbursement rate is generally the lower of the amount billed, a percentage of the manufacturer's suggested retail price, or cost plus a percentage markup.

Finding #2: The department overpaid for some rentals.

Field office staff's misunderstanding of regulations may have caused the department to pay $8.3 million more for renting stationary volume ventilators over three years than the department would have paid by purchasing these items. Our review found that the department would have paid $4.1 million if it had purchased these items, rather than the $12.4 million it paid for renting them. 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.

We recommended that the department clarify its rental policies with its field office staff to ensure that overpayments for DME rentals are not occurring.

Department Action: Partial corrective action taken.

The department states that it is currently exploring implementing a "capped" rental reimbursement methodology on some DME items.

Finding #3: 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 MAPCs, and it may not be getting the same rates offered by providers or manufacturers to the general public. Specifically, we found the following:

- While technology improvements have made some items less expensive, the department has been lax in updating its prices for these items, and may be missing out on savings opportunities on these items. For example, the department issued only 10 operational instructional letters to its fiscal intermediary in the past three years. Of these 10 letters, only four 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.

- Although state regulations require the department to update its medical supply rates no less than every 60 days, 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. This could potentially cost the department money. For example, we found that for two product codes the department could save an additional $911,000 by making sure to update its prices in fiscal year 2002–03.

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

Department Action: Partial corrective action taken.

The department states that it hopes its ongoing universal product number (UPN) project will resolve issues with keeping its codes and prices current. The department is continuing to collect data on UPN codes to determine the availability of these codes for DME. Additionally, the department states that its contract renegotiation process will serve as a mechanism for determining if reimbursements need to be adjusted thereby providing the department a process for reviewing and updating rates.

Additionally, with the passage of the 2003-04 budget trailer bill, the department was given the authority to establish maximum allowable reimbursement rates and utilization controls in provider manuals, and is no longer required to promulgate regulations to add, delete, or change a covered service or reimbursement rate.

Finding #4: The department has not fully considered the challenges and costs of implementing its cost-savings plans.

To combat the rising costs of DME and medical supply items, the department plans to implement the following two cost-savings measures in the near future:

- The department hopes to convert its medical supply codes from the current federally required billing code structure to the more detailed universal product number (UPN) codes to gain more relevant and timely information on the products it pays for.

- The department plans to implement negotiated contracts for some DME and medical supply items.

While 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.

For example, the department has not discussed its contract negotiation plans with providers or manufacturers who may prove to be resistant to the department's efforts.

In order to realize future cost savings for Medi-Cal, the department should continue to develop and use a UPN 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.

Department Action: Partial corrective action taken.

The department states that it is continuing its efforts to develop a UPN structure for medical supplies and DME, and plans to thoroughly study the benefits, possibilities, and limitations of using UPNs for billing. The department estimates that this project will take a minimum of two to three years to fully implement. The department further states that it is pursuing an exception from the national coding requirements for DME and medical supplies to allow it to demonstrate the feasibility and cost effectiveness of the UPN as a coding standard.