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Report to the Congress; by Elmer B. Staats, Comptroller General.

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Federal funds provided by the medicaid program are used to purchase medicaid supplies and services, including eyeglasses, oxygen, durable medical equipment, and clinical laboratory services. Each State has primary responsibility for administering its medicaid program. Although the Social Security Act requires that State medicaid programs provide certain basic services to all eligible persons, medicaid coverage for miscellaneous supplies and services is not uniform. Findings/Conclusions: The medicaid program could realize considerable savings if the States used competitively bid or negotiated contracts to purchase medical supplies or services for medicaid recipients. States using direct contract methods obtain supplies at lower prices than those States applying the criteria of usual and customary as permitted by regulations. In three Northeastern States, medicaid was paying higher prices for clinical laboratory services than other purchasers even though the program was a large consumer of such services. Other purchasers take advantage of volume and professional discounts, lower fee schedules, and direct contracting to obtain better prices. The issue of whether direct contracting by States is consistent with freedom-of-choice provisions of the Social Security Act is unclear, but GAO believes that eyeglasses, oxygen, and other items of durable medical equipment can be purchased through competitively awarded contracts without conflicting with provisions of the act. Recommendations: The Administrator of the Health Care Financing Administration should: publish regulations which encourage States to purchase eyeglasses, oxygen, wheelchairs, and other durable medical equipment through competitive bids or competitive negotiation;

expand medicare's proposed lowest charge regulations to include laboratory tests most commonly ordered under medicaid; and require the States to find out what other volume purchasers of laboratory services are paying when developing their fee schedules. To facilitate the competitive procurement of medicaid supplies, the Congress should amend the Social Security Act to specifically exclude eyeglasses, hearing aids, oxygen, and common items of durable medical equipment. (HRS)

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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Savings Available By Contracting For Medicaid Supplies And Laboratory Services

There is considerable evidence that the competitive procurement of supplies, such as eyeglasses and oxygen, and of laboratory tests for Medicaid recipients can result in worthwhile savings. This report presents specific examples of such savings and discusses actions that the Congress and HEW should take to encourage competition.

HRD-78-60

JULY 6, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

To the President of the Senate and the
Speaker of the House of Representatives

Here is our report which describes the initiatives some States have taken to reduce their Medicaid costs for medical supplies and laboratory services through direct contracting methods.

We also discuss the desirability of pending legislation to authorize competitive procurement of laboratory services and recommend more legislation to facilitate the competitive procurement of such items as eyeglasses, oxygen, and wheelchairs.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

SAVINGS AVAILABLE BY CONTRACTING FOR MEDICAID SUPPLIES AND LABORATORY SERVICES

D I G E S T

Under the Medicaid law, recipients are entitled to choose the provider of their health care services. In the past, this provision has been the basis for challenging State or local efforts to competitively contract or otherwise directly provide such equipment items as wheelchairs and laboratory tests, because recipients would be limited in their selection of providers.

For example, in 1975 New York City attempted to contract on a competitive basis for exclusive Medicaid laboratory services which would have reduced its annual costs by about $5 million; however, the contracts were never executed because the project was enjoined in court under the freedom-of-choice issue. (See p. 17.)

Also, the State of Washington's program to operate a medical equipment pool for the loan and reuse of such items by Medicaid recipients has been questioned. (See pp. 23 - 24.)

GAO compared prices paid for eyeglasses, oxygen, and wheelchairs by various States and Federal agencies and found that competitive buying produced worthwhile savings.

--During 1975 California paid $7.2 million for Medicaid eyeglasses based on vendors' usual charges; however, based on Washington's competitively awarded contract prices, the costs would have been about $3.9 million. (See pp. 5 - 6.)

--During 1976, Oregon paid, on the average, $6.15 per 100 cubic feet of oxygen based on vendors' charges; however, under Washington's competitively awarded contract, the comparable price was $3.70. (See p. 10.)

Tear Sheet. Upon removal, the report cover date should be noted hereon.

--Because California usually pays manufacturers' suggested list prices for wheelchairs, its purchases of such items generally averaged about 3 percent under the list prices. The Veterans Administration, through negotiated or competitive purchasing arrangements, acquires wheelchairs for its beneficiaries at prices ranging from 7 to 29 percent lower than list prices. (See pp. 10 - 11.)

State Medicaid programs pay higher prices for clinical laboratory services than other purchasers even though Medicaid is a volume user.

New York, New Jersey, and Massachusetts paid respective fees of $12.50, $7.50, and $10.00 for a battery of tests. Fees were generally based on what a private individual had to pay on the open market. At selected laboratories, for the same tests, the Federal Government paid from $4.40 to $5.25 (see p. 15); physicians paid from $5.20 to $7.00 (see p. 16); and a New York City Family Planning agency, through direct contracting, paid $3.75 (see p. 17).

The Department of Health, Education, and Welfare (HEW) has taken initiatives to encourage savings in acquiring Medicaid supplies and laboratory services, including implementing the lowest reasonable charge criteria for laboratory services which are common to elderly Medicare beneficiaries. Under these criteria, payment under Medicare would be limited to the lowest charge levels consistently and widely available within a geographic area. However, the lists of Medicare tests do not include some tests common to Medicaid. (See pp. 20 - 21.)

Also, the Congress has been considering legislation which would (1) permit competitive bidding for Medicaid laboratory services on an experimental basis and (2) prevent Medicaid from paying a laboratory more than other purchasers for such services. (See p. 25.) GAO believes the Congress should enact such legislation.

The issue of whether or not direct contracting by States, to minimize Medicaid costs, is consistent with the freedom-of-choice provisions of the Social Security Act is still unclear. However, HEW officials, during testimony before the Senate Subcommittee on Monopoly and Anticompetitive Practices of the Select Committee on Small Business in May 1977, said that a State's right to purchase eyeglasses in volume from manufacturers, which were to be furnished to qualified providers, was not in conflict with a Medicaid recipient's right to free choice of providers.

To remove any doubt that competitive purchases of Medicaid supplies are authorized, the Congress should amend the Medicaid law to specifically exclude eyeglasses, hearing aids, oxygen, and selected items of equipment from the freedom-of-choice provision. (See p. 29.)

HEW should

--encourage States to purchase eyeglasses, oxygen, wheelchairs and such common items of equipment competitively to the extent permitted by existing law;

--expand Medicare's lowest charge lists to include laboratory tests common to Medicaid; and

--require States to find out what other volume purchasers of laboratory services are paying when developing their fee schedules.

HEW'S COMMENTS

With respect to the freedom-of-choice issue, HEW distinguishes between centralized competitive purchases of supplies to be furnished to qualified providers and those to be furnished directly to recipients. HEW believes the former situation is consistent with the freedom-of-choice provision, while the latter is not.

HEW agreed that competitive bidding and centralized purchasing of medical supplies and services should be encouraged wherever appropriate. HEW stated that laboratory tests common to Medicaid should be included on Medicaid's lowest charge lists, rather than expanding the Medicare lists. GAO believes that HEW's response meets the thrust of the recommendation. However, GAO believes its recommendation conforms more to the authorizing legislation. (See p. 30.)

HEW agreed that States should look at what other large purchasers of laboratory services are paying before setting their Medicaid fee schedules.

Contents

ABBREVIATIONS

CBC	Complete blood count
GAO	General Accounting Office
GSA	General Services Administration
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
SMA-12	Battery of laboratory tests
SRS	Social and Rehabilitation Service
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

This report discusses the use of Federal funds provided by the Medicaid program to purchase Medicaid supplies and services, including eyeglasses, oxygen, durable medical equipment, and clinical laboratory services.

The Medicaid program is authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396). In this grant-in-aid program, the Federal Government pays part of the costs incurred by the States and Medicaid also provides medical services to individuals unable to pay for such care. The Federal Government pays from 50 to 78 percent of the costs of medical services provided under the program.

Medicaid was administered at the Federal level by the Social and Rehabilitation Service within the Department of Health, Education, and Welfare (HEW) until March 9, 1977, when the Social and Rehabilitation Service was abolished and the Health Care Financing Administration (HCFA) was established.

Each State has primary responsibility for administering its Medicaid program. The nature and scope of a State's program are described in its State plan, which is subject to approval by an HCFA Regional Medicaid Director. The Regional Director is also responsible for determining whether the State program is being administered in accordance with Federal requirements and the State's approved plan.

Two groups of people can be covered under Medicaid. The first group, known as the categorically needy, is persons entitled to public assistance under the Social Security Act, such as Supplemental Security Income for the aged, Blind, and Disabled, and Aid to Families with Dependent Children. In addition, States can cover other persons whose incomes and other resources exceed State requirements to qualify for public assistance but are not sufficient to pay for necessary medical care. These are called the medically needy.

An estimated $14.7 billion was spent during fiscal year 1976 to provide medical care to people receiving benefits under Medicaid. Of this amount, the Federal

Government paid about $8.2 billion and State and local governments paid the rest.

Under the Medicaid program, reimbursement procedures for eyeglasses and other supplies and services are set forth in the individual State plans. Payments for such items cannot exceed the prevailing usual and customary charges in the locality. In some States, these charges are also subject to maximum fee schedules established by the States or localities. Participating vendors agree that the amount paid by Medicaid will be accepted as payment in full.

VARIATIONS IN MEDICAID COVERAGE FOR EQUIPMENT, SUPPLIES, AND SERVICES

Although the Social Security Act requires that State Medicaid programs provide certain basic services to all eligibles, Medicaid coverage for miscellaneous supplies and services is not uniform. For example, while eyeglasses and hearing aids must be provided to children, they do not have to be provided to other Medicaid recipients if a State elects not to do so.

Forty-two States and jurisdictions provide durable medical equipment, such as wheelchairs, crutches, and canes to Medicaid recipients; but 15 of them do not provide durable medical equipment to the medically needy, only to the categorically needy. Ten States and Puerto Rico do not provide durable medical equipment under their Medicaid programs.

To illustrate the difference in State coverages, California and Washington provide eyeglasses, hearing aids, and durable medical equipment to both the categorically and medically needy, while Oregon provides such items only to the categorically needy. Idaho provides eyeglasses and hearing aids only to eligible children.

MEDICAID COVERAGE FOR CLINICAL LABORATORY SERVICES

Laboratory and X-ray services are required to be provided under State Medicaid plans to eligible recipients. A clinical laboratory examines material (specimens) derived from the human body to help the physician diagnose and treat a patient's ailment. Laboratory specimens are

generally drawn by the attending physician or an assistant. They are then either picked up by laboratory representatives or mailed. In some cases, patients are referred directly to the laboratory; in other instances, laboratory personnel visit the patient's home. Most diagnostic tests can be completed and reported to the attending physician within 24 to 48 hours after receiving the specimen.

Laboratories can be found in doctors' offices, hospitals, public health agencies, industrial plants, or pharmaceutical firms. In many cases, these laboratories are privately owned companies, commonly referred to as independent clinical laboratories, which are the facilities discussed in this report.

The independent clinical laboratory is not attached to a physician's office, a hospital, or any other health facility. It may operate under the direction of a physician, medical scientist, or specialists, and its primary purpose is to provide diagnostic laboratory services.

SCOPE OF REVIEW

Our review included two separate work phases. One focused on the Medicaid purchasing policies and practices for medical appliances, giving particular attention to the interests expressed by the Chairman, House Select Committee on Aging, in his February 23, 1977, letter to us, regarding the ramifications of contract purchasing of medical supply items under Medicaid. The other dealt with the establishment of fees for clinical laboratory services and the feasibility of obtaining better prices. Accordingly, we examined Federal and State laws and regulations, and other documents related to Medicaid procurement of medical supplies and services.

To evaluate Medicaid policies and practices for purchasing eyeglasses, oxygen, and durable medical equipment, we visited the States of California, Idaho, Oregon, and Washington. We interviewed individuals responsible for carrying out program requirements at the State and local levels. We also contacted the major Medicaid suppliers of eyeglasses, durable medical equipment, and oxygen to determine their pricing policies.

In addition, we obtained information on the Veteran Administration's (VA) policies and procedures for

purchasing durable medical equipment and for operating its equipment pools.

We reviewed laboratory fees in New York, New Jersey, and Massachusetts. We examined Federal and State laws and regulations and other documents related to independent laboratory fees. We also met with HCFA representatives at both the headquarters and regional level (Regions I and II); interviewed individuals responsible for managing the program at the State and local levels; and spoke with independent laboratory officials, as well as administrators of private medical insurance plans.

CHAPTER 2

OPPORTUNITIES FOR SAVINGS THROUGH CONTRACT PURCHASES OF MEDICAID SUPPLIES AND EQUIPMENT

The Medicaid program could realize considerable savings if the States used competitively bid or negotiated contracts to purchase medical supplies or services for Medicaid recipients. States using direct contract methods obtain supplies at lower prices than those States applying the criteria of usual and customary, and prevailing charges as permitted by HEW regulations. In addition, Federal contracts for wheelchairs have resulted in more favorable prices than those paid by State Medicaid programs.

In this chapter we discuss possible savings in the cost of eyeglasses, oxygen, and wheelchairs, based on different prices being paid by States in the same regions. The prices in a particular State can be affected by various factors, such as labor rates, purchase volumes, and manufacturers. Consequently, our estimated savings are not intended as a measurement of what the precise savings would be through contract purchasing methods. Rather, we are demonstrating that significant price differences exist and that they are related to the method of procurement, rather than to the quality of the supplies and services received.

POTENTIAL SAVINGS THROUGH CONTRACT PURCHASING OF EYEGLASSES

The State of Washington obtains eyeglass lenses and frames for its Medicaid program through a formal competitively bid contract at prices below those being paid in California and Oregon. For example, Washington paid from $6.35 to $7.10 for a pair of single-vision lenses during 1976, compared to $10.90 which California paid during the same period. (The average cost for a pair of single-vision lenses was not available in Oregon.) Similarly, Washington paid $2.60 to $5.05 for frames, compared to $8.41 in Oregon and $7.91 in California during 1976. Providers in Oregon and California are paid their usual and customary charge up to a maximum price established by the State.

In 1976 California paid about $7.2 million for Medicaid eyeglasses; however, based on Washington's competitively bid contract for eyeglasses, the cost would have been only

$3.9 million. Likewise, Oregon paid $77,600 for eyeglass frames, whereas under Washington contract prices, the cost would have been only about $41,400. Furthermore, the Washington contract included specifications for the lenses and frames to help insure the quality of the eyeglasses provided.

Washington's procurement practices

In July 1975, Washington invited bids from optical suppliers to provide eyeglass lenses and frames for its Medicaid and Vocational Rehabilitation programs. As of October 1, 1975, Bausch and Lomb, the successful bidder, began supplying eyeglass lenses and frames for these programs.

Frames were selected from current styles of eyeglasses. Under the contract, Bausch and Lomb frames, as well as frames manufactured by two other companies, were provided. Lenses were to be made in the United States and were required to meet the first-quality requirements of the American National Standards for impact-resistant dress lenses or protective lenses.

The contract provides for single-vision, bifocal, and trifocal corrected-curve white plastic or impact-resistant glass dress eyewear mounted in approved frames. Twelve dress frame styles are available, including three each for men, women, boys, and girls. In addition, occupational protective lenses and frames are available for men and women. The contract also requires that a suitable case be included.

From October 1975 through June 1976, the contractor provided two single-vision lenses for $6.35, two bifocal lenses for $14.35, and frames at prices ranging from $2.60 to $5.05. From July 1976 through June 1977, the contract cost of two single-vision lenses rose to $7.10. The contractor furnished the eyeglasses to optometrists or opticians participating in the Medicaid program.

From October 1975 through September 1976, Washington spent $362,292 for eyeglasses under this contract. As compared to the State's prior method of purchasing eyeglasses at suppliers' usual and customary charges, which were subject to maximum prices established by the State, the State estimates that annual savings were about $96,000.

California's procurement practices

Reimbursements for eyeglasses and other eye appliances are based on the State's maximum fee schedules or the provider's usual and customary charge, whichever is lower.

The maximum fee schedules' rates are based on a 1975 study of material and service cost data provided by opticians and optometrists. The 50th percentile, or median, of the reported usual and customary charges was used to establish the payment level for lenses. The State determined that this would cover material and overhead costs reported by most optometrists and would provide an adequate profit.

The maximum payment level for a single vision glass lens ranged from $12.30 to $37.75, depending on the type and strength of the lens. These prices include both services and materials. For example, the $12.30 lens price includes $5.41 for material and the remainder for services.

The maximum fee for plastic frames was set at $14. The State believed that an adequate number of durable and serviceable frames were available for $14, which included $8 for the material price of the frames.

For 1976, a comparison of the average material prices paid by California with the average prices paid by Washington follows.

	Average material price	
	California	Washington
Two single-vision lenses	$10.90	$ 6.35
Two bifocal lenses	20.32	14.35
Frames	7.91	3.96

During 1976, California paid about $7,246,000 for the material cost of eyeglass lenses and frames under its Medicaid program (excluding the service fee, which is paid as part of the eyeglass cost). However, based on Washington's competitively bid contract prices, the cost would have been only $3,875,000.

Oregon's procurement practices

Oregon reviewed the published prices of large optical firms to establish the maximum allowable fees for eyeglass

frames and lenses for its Medicaid program. The maximum fees were based on the highest published prices plus an allowance for postage. Suppliers were limited to the lesser of their usual and customary charges or the maximum fees as payment in full for goods provided.

The maximum fees for one single-vision lens ranged from $4.90 and $11.45, depending on the type and strength of the lens. The maximum fee for frames was $8.50. According to the State's optometric consultant, this maximum fee limits the number of frame styles available to about 10, most of which are plastic.

In 1976 the average cost for frames was $8.41 in Oregon, compared to $3.96 in Washington. The average cost for single-vision and bifocal lenses was not available in Oregon. During 1976, Oregon paid about $77,600 for eyeglass frames under the Medicaid program; however, based on Washington's competitively bid contract price, the cost would have been only about $41,400.

Idaho's procurement practices

Idaho limits payments for eyeglasses to $20 for frames, $22 for a pair of single-vision lenses, and $25 for a pair of bifocal lenses, or the supplier's usual and customary charge, whichever is lower. Accordingly, the maximum price for single-vision eyeglass lenses and frames is $42, compared with about $10.31 in Washington. A State official advised us that maximums were established before 1974 based on a survey of the Medicaid prices being paid in nearby States.

During 1976, Idaho paid $76,712 for new eyeglasses. We were not able to determine an average amount paid for new lenses and frames because such purchases are not separately identified in Idaho's financial reports.

POTENTIAL SAVINGS THROUGH CONTRACT PURCHASING OF OXYGEN

Washington obtains oxygen for Medicaid recipients in their homes and in nursing homes through a competitively bid contract, at prices below those being paid in California and Oregon. Providers in Oregon are paid the usual and customary charge. California pays the usual and customary charge up to a preestablished maximum fee.

Washington's procurement practices

Washington uses competitively awarded contracts to purchase oxygen for Medicaid recipients in their homes and in nursing homes. Through August 1976, oxygen was provided by two contractors; however, the contract was readvertised, and effective September 1, 1976, an exclusive statewide contract was awarded to one contractor. The State estimated that the new contract would save about $1,000 per month over the previous contract prices.

The cost of oxygen under the new contract ranges from $3.10 to $4.30 per 100 cubic feet, depending on the location. The contractor does not charge extra for deliveries during regular working hours and within specific routes. However, a charge of $15 is made for emergency trips, and deliveries 5 miles outside the normal routes are billed at 75 cents per mile. The contractor also charges a cylinder rental of 10 cents per day if the cylinder is kept longer than 30 days. During April 1977, the average cost of 100 cubic feet of oxygen delivered to Medicaid recipients in their homes, including cylinder rental, was $3.70 under the September 1976 contract. The total cost of oxygen delivered to Medicaid recipients in nursing homes was not readily available. However, a State official responsible for auditing oxygen claims advised us that the average cost of oxygen for Medicaid recipients in nursing homes was lower, since the State does not usually pay cylinder rental or delivery charges for these patients.

California's procurement practices

Reimbursements for oxygen are based on a March 1974 State study of manufacturers' catalogs or suggested retail prices and charge data received from about 100 dealers. During the rate study, meetings were held with representatives of the dealers and manufacturers to discuss the proposed rates.

In October 1976, the maximum payment levels for oxygen, including delivery, ranged from $5.22 to $8.20 per 100 cubic feet, depending upon the volume of oxygen purchased. Cylinder rental is limited to a maximum of $2.40 per month.

During October 1976, California paid about $66,150 for over 1 million cubic feet of oxygen, including cylinder

rental and delivery, under its Medicaid program. However, based on the average cost of $3.70 per 100 cubic feet under the Washington contract (including cylinder rental), California would have paid only $42,064.

Oregon's procurement practices

An Oregon Medicaid official told us that Oregon pays the amount charged by the vendor for oxygen, including cylinder rental. Oregon has not established maximum prices for oxygen.

The cost and volume of oxygen purchased during 1976 in Oregon were not reported separately in the State's financial reports. Our analysis of 11 local offices' miscellaneous medical service authorization forms and invoices showed that these offices purchased 256,844 cubic feet of oxygen at an average cost of $6.15 per 100 cubic feet, which includes cylinder rental and delivery costs. These 11 offices accounted for 51 percent of the State's total miscellaneous medical expenditures, including oxygen, during 1976. These offices paid about $15,800 for oxygen under the Medicaid program. However, based on Washington's contract prices, the cost would have been only about $9,500 at an average cost of $3.70 per 100 cubic feet.

Idaho's procurement practices

The acting chief of Idaho's Bureau of Medical Assistance told us that Idaho pays the vendors' usual and customary charge for oxygen. The State's cost reports do not report oxygen volumes or costs separately for the Medicaid program. State officials estimated that only three Medicaid recipients received oxygen in their homes during 1976.

POTENTIAL SAVINGS IN PURCHASING WHEELCHAIRS

Both Washington and the Veterans Administration, by using more efficient procurement practices, were able to obtain wheelchairs at prices well below those paid by California. Washington purchased wheelchairs for Medicaid beneficiaries at prices which averaged about 14 percent lower than the manufacturers' suggested list prices during

October 1976. 1/ VA hospitals in Los Angeles, San Francisco, and Seattle purchased wheelchairs through negotiated or competitive purchasing agreements at prices that ranged between 7 and 29 percent lower than the manufacturers' suggested list prices, exclusive of delivery charges. However, California purchased Medicaid wheelchairs at prices that averaged only 3.1 percent below list prices during October 1976 because most wheelchairs were purchased at manufacturers' suggested prices. For example, for a specific model wheelchair with a manufacturer's suggested list price of $331, California paid $331, Washington paid $281.35, and VA had a local contract in Washington with a price of $264.80. If California purchased wheelchairs at reductions to list prices similar to those obtained by Washington or VA, the State could have saved between about $118,000 and $299,000 in 1976. (These savings allow for possible sampling errors in our estimates.) Durable medical equipment, including wheelchairs, was not purchased under the Idaho Medicaid program.

Washington's procurement practices

Washington requires that all Medicaid durable medical equipment purchases over $50 be approved by the State. The State office performing this function checks the State's durable medical equipment pool to determine if a suitable, used wheelchair (or other piece of durable medical equipment) is available. If not, the office approves the purchase of a wheelchair. According to State officials, most purchases are made from several large suppliers in the State who have offered reductions to list prices as high as 20 percent. During 1976, Washington approved the purchase of 644 wheelchairs which we estimate cost about $169,000, or $262 each.

Oregon's procurement practices

Local welfare offices approve the purchase of wheelchairs for Medicaid beneficiaries in Oregon. Charitable resources in the community are asked to provide needed items to Medicaid recipients without charge before the use of Medicaid funds for their purchase is approved. Used wheelchairs are sometimes purchased. During 1976, we estimate that

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1/We selected October 1976 for our test month for reviewing wheelchair purchases in Washington and California.

Oregon purchased approximately 25 wheelchairs costing about $12,500, or about $500 each, with Medicaid funds.

California's procurement practices

California purchases Medicaid wheelchairs based on the lesser of the amount billed by the dealer or (1) the State's maximum allowance schedule or (2) if not on this schedule, the manufacturer's suggested list price. Based on our review of vendors' billings for wheelchairs in October 1976, we estimate that during 1976 California purchased about 2,510 wheelchairs costing about $1.3 million, or $518 each. Since most of these wheelchairs were purchased at manufacturers' suggested list prices, the reductions averaged only 3.1 percent. Sixteen of the 17 dealers interviewed stated that because supplying durable medical equipment was such a highly service-oriented business, they generally did not offer discounts from the manufacturers' suggested list prices to the State or anybody else.

VA's procurement practices

VA purchases durable medical equipment through negotiated contracts with manufacturers nationwide. For example, VA can purchase two types of wheelchairs under its nationwide contract at $140.70 and $196.70, which represent a 30-percent reduction from the manufacturer's suggested list prices of $201 and $281, respectively. These contracts provide for delivery to local VA hospitals ordering the wheelchairs.

VA also purchases durable medical equipment through competitively bid areawide contracts with local dealers for delivery to nonhospitalized veterans. For example, in 1976, two of these contracts in California provided for the purchase of wheelchairs at prices which included reductions of 7 to 29 percent of the manufacturer's list price. An additional delivery charge, which averaged $23 per wheelchair during January and February 1977, was made for deliveries outside a 20-mile free delivery zone.

CHAPTER 3

MEDICAID PAYING HIGHER CLINICAL LABORATORY FEES THAN OTHER PURCHASERS

In three Northeastern States, Medicaid was paying higher prices for clinical laboratory services than other purchasers even though the program was a large consumer of such services. Other purchasers are taking advantage of volume and professional discounts, lower fee schedules, and direct contracting to obtain better prices.

In 1975 New York City attempted to contract on a competitive basis for Medicaid laboratory services, which would have reduced annual costs by about $5 million; however, the contracts were never executed because a Federal court issued a preliminary injunction enjoining the particular arrangement indicating that it might be inconsistent with the provision of the Medicaid law which gives recipients the freedom of choice to select a provider of service.

BASIS USED TO ESTABLISH CLINICAL LABORATORY FEES

In most States, Medicaid payments for clinical laboratory services are made on the basis of established fee schedules. In New Jersey, New York, and Massachusetts, the fees were generally based on what private individuals had to pay in the open market. None of the fee schedules were established by criteria which considered the

--nature and frequency of services,

--estimated cost of services, and

--dollar volume of services or prices available to other volume purchasers.

The only exception was New York City, which under the New York State Medicaid Plan, can establish its own fee schedule. City officials concerned about reports of industry kickbacks, the impact of technological advances on production costs, and lower prices available elsewhere, developed a fee schedule with fees for some tests ranging 50 to 60 percent less than the comparable State fee schedule. In establishing the new fees, city officials obtained cost

estimates developed by the city's Bureau of Laboratories, reviewed prices paid for laboratory services under other city programs, and discussed prices with operators of large automated laboratories.

As a result of this price analysis, certain common tests, such as the SMA-12 (a battery of tests) and CBC (complete blood count), which were listed on the State schedule at $12.50 and $5.00, were lowered to $5.00 and $2.50, respectively. The use of different fee schedules within the State presents a paradox: some laboratories that do Medicaid business with both New York City and other welfare districts charge the latter higher State fees for the same services.

VIABLE OPTIONS TO BETTER PRICING USED BY OTHER PURCHASERS

Fee schedules for clinical laboratory services established by New York, New Jersey, 1/ and Massachusetts, which were in effect during the latter part of 1976, have not reflected the best available prices. Generally, these States are paying "list prices" for clinical laboratory services. Other buying options, however, such as volume and professional discounts, offer the likelihood of lower prices. Probably the best option for better prices is direct competitive contracting with clinical laboratories by State and local governments. In New York City alone, direct contracting could reduce laboratory spending by about $5 million each year. The authority to do so at the present time, however, is unclear.

Volume discounts

Volume discounts are prevalent in the clinical laboratory industry, but the Medicaid program is not taking advantage of them. For example, when Federal agencies, with few exceptions, purchase clinical laboratory services, discounts ranging from 10 to 25 percent may be obtained through use of the General Services Administration (GSA) Federal supply schedule price lists. The following compares fees set by the three States included in our review with prices available from three laboratories in New Jersey and Pennsylvania having GSA contracts.

1/In August 1976 New Jersey had reduced its fee schedule 40 percent across the board.

	State Medicaid fees			GSA fee schedule		
	New York	New Jersey	Massa-chusetts	Lab A	Lab B	Lab C
SMA-12	$12.50	$ 7.50	$10.00	$4.40	$5.25	$5.24
CBC (with differential)	5.00	3.00	6.00	3.08	2.96	3.04
T-4 (thyroid) (note a)	10.00	6.00	10.00	5.28	4.50	6.16
Cholesterol	4.00	3.00	5.00	1.98	2.44	2.20

a/Tests for thyroid malfunction.

The above discounted prices are based on agencies having monthly purchases exceeding stipulated amounts, ranging from $1,850 to $10,000. In addition, GSA discounts are predicated on reimbursement within 30 days. Many laboratory operators in New York City indicated that although volume discounts are available, the Medicaid program would not be eligible because the city did not reimburse the laboratory operators on a timely basis. Although this may be true of New York City, we were informed that New Jersey and Massachusetts were paying Medicaid claims promptly.

The States included in our review were major purchasers of laboratory services. In fact during 1975, New York City alone paid one laboratory $747,000 for clinical laboratory services--almost as much as the entire annual Medicaid laboratory expenditure in Massachusetts. We found that 69 laboratories in the three States visited were each paid over $50,000 for Medicaid laboratory services during 1975. Expenditures of this magnitude, coupled with prompt payment, should warrant volume discounting.

Professional discounts

In addition to volume discounts, certain laboratories maintain two price schedules: one for patients and a lower priced one for medical professionals. Four examples of prices available from two laboratories which have multiple fee schedules and which are located in New Jersey and used extensively by New York follow.

Test	New York State Medicaid Fee	Fees charged			
		Lab A		Lab B	
		Patient	Physician	Patient	Physician
SMA-12	$12.50	$10.00	$7.00	$11.30	$5.20
CBC (with differential)	5.00	5.45	3.95	4.00	3.85
T-4 (thyroid)	10.00	7.50	6.00	10.00	6.25
Cholesterol	4.00	4.25	3.25	3.60	2.50

As indicated above, the fees charged to physicians are significantly lower than the State Medicaid schedule. Further, the prices charged to private patients, with two exceptions, were lower than those established by Medicaid.

Direct contracting

At least two other federally funded programs in New York City were involved in large-scale contracts for laboratory services. The laboratory prices under these programs are substantially less than the State Medicaid fees.

New York City contracted with a provider to give preemployment medical examinations to both public assistance recipients and job training applicants. About 60,000 such individuals were to be examined during the 13-month period ending June 30, 1977. Included in the medical examination is a package of laboratory tests, which includes a complete blood count, SMA-12, basic urine analysis, serology, and drug screen. The laboratory work was subcontracted to an independent clinical laboratory at $6.25 for the package. For these same tests, the three States' Medicaid agencies which we visited paid from $14.70 to $25.50.

Under the city's Family Planning program, all necessary laboratory work is generally forwarded to one independent clinical laboratory. According to a Family Planning representative, the program averages about 3,000 tests monthly. Program authorities arranged for prices that are usually less than State Medicaid fees, as shown in the following table.

Test	New York City family planning prices	State Medicaid fees		
		New York	New Jersey	Massachusetts
Pap test	$2.75	$ 6.30	$3.00	$ 6.00
SMA-12	3.75	12.50	7.50	10.00
Glucose	1.75	2.50	3.00	5.00
CBC (with differential)	3.50	5.00	3.00	6.00

Laboratory representatives stated that they offered better prices under contract because of anticipated guaranteed volume. Lower fees were also made available because specimens are picked up at a limited number of locations. In addition, they said that billing procedures were much simpler than those used by the Medicaid program.

NEW YORK CITY'S PROPOSED COMPETITIVE CONTRACT

New York City officials, interested in better cost control and dissatisfied with the quality of work done by laboratories under the Medicaid program, attempted to formally and competitively contract for laboratory services. However, a coalition of clinical laboratories sought a Federal court injunction to prevent contract implementation. The outcome revealed that under the Federal Medicaid law, the city's authority to enter into these particular contracts was unclear.

The city advertised for multiple procurements in April 1975. Potential bidders were invited to submit bids on any or all of New York City's five boroughs. Successful bidders, however, could be awarded exclusive contracts covering no more than two boroughs. A sequential system of bid openings was designed based on the decreasing order of each borough's Medicaid population. As bidders were awarded particular boroughs, they became ineligible for further awards, even though they may have been low bidder. This procedure was followed to maximize laboratory participation in the award process. Because of its low Medicaid population, the borough of Staten Island was awarded last and to the lowest bidder, regardless of prior awards.

The bidders were required to submit two price quotations, a maximum aggregate fee and a unit price for each

test. The maximum aggregate fee represented the fixed ceiling price, for which the contractor agreed to provide all clinical laboratory services requested within the designated borough during the stipulated time period. This amount was to be the basis for the contract award.

HEW filed a friend of the court brief contending that the proposed contract was contrary to Federal law because it violated a Medicaid recipient's right to choose a laboratory. At the same time, HEW recommended that the city contract for such services on an experimental basis for a limited time.

In August 1975, the Court concluded that, in effect, the city's authority to enter into its proposed exclusive-contract plan to provide laboratory services to Medicaid recipients might be contrary to Federal law but recognized that some benefits may be derived from contracting for laboratory services. He permitted the city to pursue a contract on an experimental basis. As of April 1978, a contract had not been awarded; however, according to HCFA, it has placed centralized purchasing of laboratory services on its research priority list for fiscal year 1978.

As discussed in more detail in the next chapter, as of June 1978, the Congress was considering legislation to authorize competitive procurement of laboratory services and to deal with the issue of Medicaid paying a laboratory more than other purchasers.

CHAPTER 4

HEW AND CONGRESSIONAL ACTIONS TO ENCOURAGE SAVINGS IN PURCHASING MEDICAID SUPPLIES AND LABORATORY SERVICES

In the past, HEW and many States have concentrated their efforts on attempting to control Medicaid costs for those services having the highest proportion of total expenditures, such as hospital and nursing home care. However, HEW has recently taken action to propose changes in the regulations regarding the purchase of medical supplies and laboratory services to encourage savings by the States.

In 1975 HEW filed a friend of the court brief expressing the view that a proposed New York City contract for Medicaid laboratory services would deny Medicaid recipients their freedom of choice to select their providers. In contrast, in May 1977, during testimony before the Senate Subcommittee on Monopoly and Anticompetitive Practices of the Select Committee on Small Business, HEW said that a State's right to purchase eyeglasses in volume from manufacturers was not in conflict with a Medicaid recipient's right to free choice of providers.

Furthermore, proposed legislation (S.705), which was passed by the Senate in July 1977, would amend title XIX of the Social Security Act to permit competitive bidding for laboratory services under Medicaid on a 1-year experimental basis. This same legislation would revise the definition of reasonable charges for laboratory services.

In March 1978 the Committee on Interstate and Foreign Commerce, House of Representatives, reported a similar bill (H.R. 10909) which would allow States to purchase laboratory services for a 3-year period under arrangements which would not be subject to the general freedom-of-choice provision of the Medicaid law, provided that HEW approved the plan.

PROPOSED CHANGES TO REGULATIONS ON PAYMENTS FOR NONINSTITUTIONAL SERVICES

Medicaid regulations (42 CFR 450.30(b)(4)), formerly (45 CFR 250.30(b)(4)), in effect as of April 1978, provide that payment for noninstitutional services (other than individual practitioner services) may be made up to a ceiling,

which is established on the basis of the locality's prevailing charges for comparable services under comparable circumstances. Payments under Medicare and by other third-party insurers are among the criteria to be considered in determining the reasonableness of prevailing charges.

The 1972 amendments to the Social Security Act provided that reasonable charges for medical supplies, equipment, and services under Medicare which, in HEW's judgment, do not differ significantly in quality from one supplier to another, would be limited to the lowest charge consistently and widely available within a geographic area. Any limitations under Medicare would also be applicable to Medicaid. The Senate Committee report on this legislation mentioned routine laboratory work as a service that should meet this criteria. 1/ In January 1977, HEW published proposed regulations to revise the Medicaid reasonable charge requirements and to give effect to the foregoing reasonable charge criteria. The regulations had not been finalized as of April 1978.

The proposed regulations would revise the upper limits for noninstitutional services covered by Medicaid (other than individual practitioner services) to meet the reasonable charge recognized under Medicare. This notice of proposed rulemaking noted that HEW had reason to believe that an upper limit for payment of medical services, supplies, and equipment, which is based on a locality's prevailing charges for comparable services, was not sufficient to assure that payment for such services would not exceed reasonable charges consistent with efficiency, economy, and quality of care. The notice specifically pointed to investigations of the clinical laboratory industry in several States as the basis for HEW's belief.

The January 1977 notice referred to the September 20, 1976, proposed changes in Medicare regulations, which provided for the application of the lowest charge level criteria to 12 commonly performed laboratory services and to 2 items of durable medical equipment (standard wheelchairs and hospital beds). As more supplies, services, and equipment become part of the lowest charge level provision for Medicare, notice with respect to such coverage will be published in the Federal Register and State Medicaid agencies will also be informed.

1/S. Rept. 92-1230.

Although these proposed regulations pertaining to laboratory tests under Medicare would also provide comparable charge limits on tests provided under Medicaid, some tests, such as sickle cell preparations and pregnancy tests, are commonly performed for Medicaid recipients, but rarely for older people enrolled in Medicare. Thus, in developing additional services for the application of Medicare's lowest charge criteria, HEW should consider those laboratory tests commonly provided under Medicaid. In addition, in establishing fees under Medicaid, States--as a minimum--should be required to find out what other volume purchasers (such as the Federal Government, physicians, and local programs) are paying for the same services and then use this information in establishing their fee limitations.

In April 1978, officials of HCFA's Medicaid Division of Policy and Standards informed us that HCFA had prepared a notice of intent to issue a proposed rulemaking, asking for ways to reduce the cost of purchasing Medicaid hearing aids and eyeglasses. The proposed notice stated that since the volume-purchasing arrangements and maximum allowable cost 1/ approaches appear to offer the best alternative methods of reimbursement, comments on these approaches would be closely examined to determine the feasibility of requiring them under Medicaid. The proposed notice of intent has not been published.

HEW STUDY TO REDUCE EXPENDITURES FOR SUPPLIES AND SERVICES

To help develop more effective and efficient policies for payment of Medicaid services (other than hospital, physician, or nursing home care), HEW awarded a contract on September 29, 1976, to the National Institute for Advanced Studies for the evaluation of selected Medicaid services reimbursement practices and policies--hearing aids, eyeglasses, clinical laboratory services, and Health Maintenance Organization services.

1/Under the Medicaid Maximum Allowable Cost drug program, the Department sets specific upper limits for payment for certain prescribed multiple-source drugs; for all other drugs, the upper limit for payment is based on the lower amount of either (1) the acquisition cost of the drug as estimated by the State, or (2) the provider's usual and customary charge to the public.

In May 1977, the Institute issued a report, "Alternative Reimbursement Approaches for Eyeglasses and Implications for Medicaid Policy," which pointed out the benefits of Washington's eyeglass contract in terms of saving money and guaranteeing quality. The Institute also issued a report on alternative reimbursement approaches for hearing aids in May 1977. This report recommended limiting payments for hearing aids obtained from a dealer to (1) the manufacturers' suggested wholesale prices and (2) a predetermined hearing aid dealer fee which would be based on the actual expenses incurred by the dealer in supplying the hearing aid to a Medicaid recipient.

In July 1977, the Institute issued a report on alternative reimbursement approaches for laboratory services which recommended that the States and HEW take several actions. Included in these recommendations were that HEW sponsor:

--A study to develop a relative cost base for laboratory procedures which States would use in establishing maximum fee schedules and which HEW would use to establish national upper limits for fees.

--A demonstration project to test the feasibility and effectiveness of laboratory service contracts for specific areas.

HCFA's Medicaid Bureau officials support these recommendations.

HEW LEGAL POSITION ON CONTRACTING

The Social Security Act (42 U.S.C. Section 1396a(a)(23)) provides

> "* * * that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required * * * who undertakes to provide him such services * * *."

Both the House and Senate reports accompanying H.R. 12080 (the Social Security Amendments of 1967, Public Law 90-248 which added this section) stated that this provision was included to provide Medicaid recipients with

freedom in choosing their medical institution or medical practitioner.

Our reviews have indicated that past efforts by certain States to minimize Medicaid costs through direct contracting have raised the question of whether such practices are in conflict with the freedom-of-choice provision. For example, as discussed on page 19, HEW had filed a friend of the court brief in the New York City laboratory case. In its brief, HEW stated that:

> "* * * in light of the clear wording of Section 1396a (a)(23) itself and HEW's consistent construction that the provision encompasses freedom of choice as to all providers of services, including laboratories, the Secretary submits that the New York proposal, which would effectively end a recipient's freedom of choice in obtaining laboratory services, is contrary to federal law."

The HEW brief also stated that the New York City laboratory project might be acceptable as either an experimental, pilot, or demonstration project for a limited duration, or as a nonexclusive contract with a particular laboratory which would permit Medicaid recipients to choose a different qualified laboratory, if that laboratory would perform the medical services at the same fee.

The HEW brief also noted that:

> "As a practical matter most Medicaid patients do not make a meaningful choice as to which laboratory is to perform their laboratory tests but as a normal practice simply accept the referral of their doctor."

As another example, on May 12, 1972, we issued a report regarding durable medical equipment 1/, in which we discussed Washington's practice of purchasing and pooling equipment under its Medicaid program. In a letter dated January 26,

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1/"Need for Legislation to Authorize More Economical Ways of Providing Durable Medical Equipment under Medicare," (B-164031(4), May 12, 1972.)

1972, attached to the report, HEW's General Counsel stated that HEW believed Washington's practice was contrary to Federal law and regulations. Accordingly, we concluded that:

> "The practices of certain States, under title XIX of the Social Security Act, of maintaining pools of durable medical equipment that are required to be used by program recipients on a loan basis as long as they need it appears to us to be an economical method of obtaining the optimum use of available resources. Therefore, the Congress may wish to clarify its intent as to whether such an arrangement is inconsistent with the freedom-of-choice provision of the statute."

Despite the adverse opinion by HEW, Washington has continued its pooling of durable medical equipment. However, HEW does not believe that Washington's arrangements for acquiring eyeglasses is inconsistent with the freedom-of-choice provision of the Medicaid law. To illustrate, in hearings before the Senate Subcommittee on Monopoly and Anticompetitive Practices, the Director of the HCFA Medicaid Bureau's Division of Policy and Standards stated:

> "We see no conflict between a Medicaid recipient's right to free choice of providers and a State's right to purchase eyeglasses in volume from manufacturers.
>
> "With volume purchasing, Medicaid recipients are still free to choose an opthalmic dispenser (ophthalmologist, optometrist, optician), and they still may choose from a selection of glasses and frames. Freedom of choice is exercised with the primary provider, not the secondary one."

In commenting on our report, HEW (see app. I) said that in August 1977 its office of General Counsel concluded that freedom of choice is a concept that exists for the benefit of the recipients--it does not exist for the benefit of providers or suppliers. Therefore, HEW distinguished between (1) situations where States require Medicaid providers to obtain their supplies from designated suppliers which had already agreed with the State to furnish such supplies for a specified price to providers on behalf of Medicaid recipients and which are consistent with the law and (2) those situations where a State enters into exclusive arrangements to provide goods and services directly to Medicaid recipients which are not. Thus, under this interpretation, Washington's contract for providing eyeglasses

and frames would not violate the freedom-of-choice requirement whereas Washington's contract for providing oxygen would.

PROPOSED LEGISLATION REGARDING LABORATORY SERVICES

On July 28, 1977, the Clinical Laboratory Improvement Act of 1977 (S. 705) passed the Senate and included an amendment to title XIX of the Social Security Act to permit competitive bidding for laboratory services on an experimental basis for 1 year, after which the States entering into such experimental arrangements would be required to report the results to HEW. The Committee report accompanying the bill (S. Rept. 95-360) stated that after HEW has evaluated the experiments, the Committee expects a report on competitive bidding to be presented to the Congress, including recommendations on whether legislative action should be taken to allow such arrangements to continue.

In addition, Senate bill 705 would amend the reasonable charge provision of the Medicaid law. The amendment provides that payments under Medicaid for laboratory services cannot exceed the lowest amount charged (which is determined without regard to administrative costs that are related solely to the method of reimbursement of services) for comparable services by the provider of such services to any person or entity.

On March 24, 1978, the House Committee on Interstate and Foreign Commerce reported on a similar bill (House bill 10909 formerly House bill 6221) 1/ which contained a provision which would allow States (or parts thereof) to purchase laboratory services for a 3-year period under arrangements, including competitive bidding, which would not be subject to the general freedom-of-choice provision of the Medicaid law provided that HEW approved the plan.

HEW would determine that services would be purchased only from laboratories that met standards and that prices would not exceed the lowest amount charged to others for similar tests. Additionally, HEW must be satisfied that, under the arrangement, adequate laboratory services

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1/H. Rept. 95-1004, Part I.

would be available to the physician and other providers treating Medicaid patients. The Committee report expressed concern that the proposed legislation not be implemented so as to create a monopolistic situation in any large health delivery area, and stated that the Committee had instructed HEW to report to the Congress on the results of the new arrangement so that it could be determined whether the changes could be made permanent.

In addition, House bill 10909 contains a provision similar to Senate bill 705 with respect to Medicaid payments not exceeding the lowest rates charged to others by a laboratory.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The State of Washington's practice of competitively awarding contracts for the purchase of eyeglasses and oxygen has resulted in worthwhile savings to the State and the Federal Government. Also, Washington, by using more efficient procurement practices, has been able to obtain wheelchairs at considerable reductions from manufacturers' suggested list prices. Other States could obtain comparable savings in purchasing eyeglasses, oxygen, and wheelchairs by using similar techniques.

As of April 1978, HEW had prepared a notice of intent to issue proposed rulemaking which might require States to purchase Medicaid eyeglasses and hearing aids, either through volume-purchasing arrangements or maximum allowable cost approaches. We believe that HEW's actions to propose changes to the regulations are a step in the right direction, particularly with regard to requiring such actions by the States.

The issue of whether direct contracting by States, to minimize Medicaid costs, is consistent with the freedom-of-choice provision of the Social Security Act is still unclear. However, HEW has concluded that a State's right to purchase eyeglasses in volume from manufacturers to be furnished to qualified providers on behalf of recipients is not in conflict with a Medicaid recipient's right to free choice of providers. Therefore, the basic question is whether such items as oxygen and wheelchairs could be furnished directly to recipients through agreements with suppliers based on competitive bids or competitive negotiations.

We believe that eyeglasses, oxygen, and many items of durable medical equipment can be purchased through competitively awarded contracts without conflicting with the freedom-of-choice provision of the Social Security Act. However, as mentioned above, the issue is not entirely clear, since Medicaid beneficiaries may not have a "free choice" in the selection of suppliers or providers although items to be furnished may be identical regardless of the provider. Accordingly, the Congress should clarify its intent in this regard.

In accordance with a provision of the 1972 Amendments of the Social Security Act, HEW has also issued proposed regulations limiting the reimbursable charges for certain

laboratory services under Medicare to the lowest charge levels consistently and widely available within a geographic area. These limits would also be applicable to Medicaid. We believe the Medicare regulations should be expanded to include commonly provided Medicaid tests for pregnancy and sickle cell anemia which are not included in the Medicare listings. Also, States should be required to find out what other volume purchasers are paying when establishing maximum fees for laboratory services.

While we believe that the lowest available charge criteria should help reduce the prices paid under Medicaid, it does not assure that the lowest possible prices are being paid. In our opinion, agreements with laboratories through competitive bids or competitive negotiation would provide greater assurance; however, according to a Federal court, the procurement of clinical laboratory services on an exclusive-contract basis, as was proposed by New York City, may be in conflict with the freedom-of-choice provision of title XIX of the Social Security Act. The Senate has passed legislation to authorize competitive procurement on an experimental basis, which was pending in the House of Representatives as of June 1978. In addition, the bill would limit payments under Medicaid for laboratory services to the lowest amount charged by a laboratory to any person or entity for comparable services.

RECOMMENDATIONS TO THE SECRETARY OF HEW

To better assure that States purchase Medicaid supplies and services at the lowest possible price, we recommend that the Secretary of HEW direct the Administrator, HCFA, to:

- --Publish regulations which encourage States to purchase eyeglasses, oxygen, wheelchairs, and such common items of durable medical equipment through agreements with suppliers (by means of competitive bids or competitive negotiation) to the extent permitted by existing law.

- --Expand Medicare's proposed lowest charge regulations to include laboratory tests which are the most commonly ordered under Medicaid.

- --Require the States to find out what other volume purchasers of laboratory services, such as the Federal Government and local agencies, are paying when developing their fee schedules.

RECOMMENDATIONS TO THE CONGRESS

In June 1978 the Congress was considering legislation (S. 705 and H.R. 10909) which included amendments to the Medicaid law which would (1) authorize competitive procurement of laboratory services on an experimental basis and (2) limit Medicaid payments to a laboratory to the lowest charge to other purchasers for comparable services. In our opinion, these provisions would remedy the conditions discussed in chapter 3 of this report and should be enacted.

In addition, to facilitate the competitive procurement of Medicaid supplies by eliminating any possibility of questions being raised under the freedom-of-choice provision of title XIX of the Social Security Act, the Congress should amend section 1902(a)(23) of the act to specifically exclude eyeglasses, hearing aids, oxygen, and such common items of durable medical equipment as the Secretary of HEW may prescribe.

HEW COMMENTS

In commenting on our report in a letter dated May 12, 1978, (see app. I), HEW agreed with the need to better assure that States purchase quality Medicaid supplies and services at the lowest possible prices. HEW pointed out that in testimony before the Senate Subcommittee on Monopoly and Anticompetitive Practices in May 1977, it favored using alternative reimbursement methods for eyeglasses and hearing aids and also indicated that a volume purchase arrangement, direct from the manufacturer, for these items would be less costly and would simplify administration. As discussed on page 24, HEW distinguishes between centralized competitive purchases of supplies to be furnished to qualified providers and centralized competitive purchases of supplies to be furnished directly to recipients. HEW believes the former situation is consistent with the freedom-of-choice provision while the latter is not.

HEW supports the provisions in H.R. 10909 which gives States authority to try competitive bidding for laboratory services on an experimental basis. Although the Secretary has authority under section 1115 of the Social Security Act to waive freedom of choice for demonstration purposes, HEW said this specific statutory authority will be helpful in giving States greater flexibility to experiment in competitive bidding. In addition, HEW has placed centralized purchasing of laboratory services on its research priority list for fiscal year 1978.

HEW agreed that competitive bidding and centralized purchasing of medical supplies and services should be encouraged whenever appropriate. HEW also agreed that States should look at what other large purchasers of laboratory services are paying before setting their Medicaid fee schedules and plans to issue guidelines to that effect. HEW also pointed out that the enactment of the pending legislation discussed above would have the effect of requiring States to obtain favorable prices.

With respect to our recommendation to expand Medicare's proposed lowest charge regulations to include common Medicaid tests, HEW agreed, in principle, but said that such Medicaid-only tests should be included in Medicaid regulations. While we believe that HEW's response meets the thrust of our recommendations, we believe that our proposal conforms more with the authorizing legislation and HEW's January 1977 and September 1976 proposed regulations. The basic statutory authority for establishing the lowest charge levels is contained in section 1842(b)(3) of the Medicare Act and the comparable Medicaid provision limiting payment (section 1903(i)(1)) refers to an amount which exceeds the charge which would be determined to be reasonable under section 1942(b)(3). Thus, under the legislative scheme of things, Medicaid's lowest charge limits were expected to follow the Medicare determinations.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

May 12, 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Savings Available by Contracting for Medicaid Supplies and Laboratory Services". The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

COMMENTS

Comments of the Department of Health, Education, and Welfare on the General Accounting Office's Report to the Congress entitled, "Savings Available by Contracting for Medicaid Supplies and Laboratory Services"

General Comments

We agree with the need to better assure that States purchase quality Medicaid supplies and services at the lowest possible prices.

In testimony before the Senate Subcommittee on Monopoly and Anticompetitive Practices in May 1977, HEW favored using alternative methods of reimbursing for eyeglasses and hearing aids and pointed out that a volume purchase arrangement, direct from the manufacturer, for these items would be less costly and would simplify administration.

In this connection, we do not believe that the "freedom of choice" issue is still as "unclear" as the GAO report indicates. HEW's Office of General Counsel (OGC), Human Resources Division, stated in its opinion of August 4, 1977, that States have great latitude under both the Medicaid statute and regulations to make centralized purchases of goods and services, as long as the State does not foreclose any choices which a recipient now has. While States may not restrict Medicaid recipients from exercising their right to choose among qualified providers, a Medicaid recipient is not free to determine the provider's choice of suppliers. This interpretation is consistent with both the decision in the Bay Ridge case involving New York's attempt to contract for Medicaid laboratory services, and with the Medicaid Bureau's position that a State's right to purchase eyeglasses and other medical items in volume from manufacturers is not in conflict with a Medicaid recipient's right to free choice of providers. The OGC opinion explains that a State may not execute a contract with a single provider (e.g., laboratory, pharmacist, optometrist) in a given geographic area, but a State is free to require that all optometrists or pharmacists (for example) who want to participate in the Medicaid program must obtain their lenses, frames, or drugs from designated suppliers which have agreed with the State to furnish the supplies for a specified price.

General Comments (Cont.)

We support the provision in H.R. 10909, the House version of the Clinical Laboratory Improvement Act (CLIA) of 1978, which would give authority to States to try competitive bidding for laboratory services on an experimental basis. Although the Secretary has authority under Section 1115 of the Social Security Act to waive freedom of choice for demonstration purposes, this specific statutory authority will be helpful in giving States greater flexibility to experiment in competitive bidding.

HCFA has placed centralized purchasing of laboratory services on its research priority list for Fiscal Year 1978. Last year, New York State submitted a proposal for doing such a demonstration project in Suffolk County, but the proposal was turned down because the firm designated to do the study was judged insufficiently qualified.

GAO Recommendation

We recommend that the Secretary of HEW:

- - direct the Administrator, HCFA, to publish regulations which encourage States to purchase eyeglasses, oxygen, and wheelchairs through agreements with suppliers -- through competitive bid or competitive negotiation.

Department Comment

We concur.

We agree that competitive bidding and centralized purchasing of medical supplies and services should be encouraged wherever appropriate. We have already begun this process by preparing a Notice of Intent to Issue Proposed Rule Making (NOI) which asks for public comments on the idea of requiring centralized purchasing or maximum allowable cost reimbursement for eyeglasses and hearing aids under Medicaid. This NOI will be published in the Federal Register soon. The NOI is based in large part on the findings and recommendations contained in two reports on alternative reimbursement approaches for eyeglasses and hearing aids, prepared for us under contract by the National Institute for Advanced Studies.

In addition, we are planning to prepare another NOI discussing Medicaid reimbursement for medical supplies and durable medical equipment, again asking for comments on competitive bidding and other reimbursement alternatives.

Page 3 - Comments

GAO Recommendation

We recommend that the Secretary of HEW:

- - direct the Administrator, HCFA, to expand the Medicare proposed lowest charge regulations to include laboratory tests which are commonly ordered under Medicaid.

Department Comment

We do not concur.

We agree that common Medicaid-only laboratory tests e.g. pregnancy and sickle cell anemia tests should be included in the lowest charge regulations. However, we believe the best place to include them is in the Medicaid lowest charge regulations, because the Medicare carriers will not have the reasonable charge data to make the lowest charge determinations for these Medicaid-only tests. The State Medicaid agencies are in the best position to do this. Medicaid Bureau issued a proposed lowest charge regulation in January 1977. Consideration is being given to include in the development of the final regulations the common Medicaid-only laboratory tests.

GAO Recommendation

We recommend that the Secretary of HEW:

- - direct the Administrator, HCFA, to require the States to find out what other volume purchasers of laboratory services -- such as the Federal Government and local agencies -- are paying when developing their fee schedules.

Department Comment

We concur.

We agree that States should look at what other large purchasers of laboratory services are paying before setting their Medicaid fee schedules, so States can get the best prices available in the marketplace. The current Medicaid regulation governing reimbursement for non-institutional services (42 CFR 450.30(b)(4)) already directs States, in reviewing prevailing charges for reasonableness, to consider Medicare and other third party payments "for comparable services under comparable circumstances".

APPENDIX I

Department Comment (Cont.)

In addition, States are to consider "other criteria ... appropriate to the specific provider service". The Medicaid Bureau plans to issue guidelines on reimbursement for laboratory services which will include encouraging States to take a closer look at other volume purchaser rates when setting their Medicaid fee schedules.

We support the provision of CLIA 1978 (H.R. 6221) which would amend title XIX to require that Medicaid payments for clinical laboratory services cannot exceed the lowest amount charged to any customer, regardless of administrative costs. This will have the effect of requiring States to take advantage of their ability to negotiate with clincal laboratories to obtain prices for services similar to those now paid by the laboratories' physician customers.

PRINCIPAL HEW OFFICIALS RESPONSIBLE FOR ADMINISTERING ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Joseph A. Califano, Jr.	Jan. 1977	Present
David Mathews	Aug. 1975	Jan. 1977
Caspar W. Weinberger	Feb. 1973	Aug. 1975
ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION:		
Robert Derzon	Apr. 1977	Present
Don I. Wortman (acting)	Mar. 1977	Apr. 1977
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Don I. Wortman (acting)	Jan. 1977	Mar. 1977
Robert Fulton	June 1976	Jan. 1977
Don I. Wortman (acting)	Jan. 1976	June 1976
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975

(106119)