BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Medicare Payments For Durable Medical Equipment Are Higher Than Necessary

In October 1977, the Congress passed a law aimed at reducing the cost to the Medicare program and its beneficiaries for prolonged rentals of durable medical equipment, such as wheelchairs and walkers, when the purchase of such items would be more economical. Although final regulations were issued in July 1980, the Department of Health and Human Services and its paying agents (carriers) have not applied them, and excessive rental payments have continued.

At the carriers GAO reviewed for 1979, excess rental payments totaled about $2 million or about 21 percent of total payments for durable medical equipment. About one-third of these excess payments could have been avoided if the 1977 law had been followed. For several reasons discussed in this report, GAO could not conclude that the other excess rental costs could have been avoided.

Although there is controversy over part of the regulations dealing with lease-purchase arrangements, GAO sees no justification for the failure to apply other parts of the regulations, such as the requirement to purchase low-cost items like walkers, canes, and commodes.

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

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

This report discusses the probable fiscal impact of the failure of the Department of Health and Human Services to implement an October 1977 law aimed at reducing the cost to the Medicare program and its beneficiaries for the prolonged rentals of durable medical equipment.

We are sending copies of the report to the Director, Office of Management and Budget, and the Secretary of Health and Human Services.

Charles A. Bowsher

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

MEDICARE PAYMENTS FOR DURABLE MEDICAL EQUIPMENT ARE HIGHER THAN NECESSARY

D I G E S T

Although 5 years have passed, the Department of Health and Human Services (HHS) has yet to fully carry out the intent of legislation to reduce the cost of renting durable medical equipment under Medicare.

Durable medical equipment--hospital beds, wheelchairs, commodes, oxygen equipment, etc.--is paid for under Medicare whenever it is medically necessary and used in a beneficiary's home. The Medicare payments for durable medical equipment for calendar year 1979 were estimated at $125 million. The program reimburses beneficiaries 80 percent of the reasonable charges for either renting or purchasing medical equipment. (See p. 2.)

This review was undertaken to determine the extent, if any, that unnecessary costs had been incurred as a result of HHS' failure to implement a 1977 law providing for Medicare reimbursement based on the purchase of such items--if more economical than rental. In recent years, GAO received congressional inquiries citing the alleged waste of Medicare funds by paying for long-term rentals of durable medical equipment where purchase would have been less costly. The uneconomical long-term rental of equipment was supposed to have been alleviated by passage of section 16 of Public Law 95-142 in October 1977. Although final regulations implementing section 16 of Public Law 95-142 were issued in July 1980, they had not taken effect as of May 1982. (See p. 4.)

At the time of GAO's review, HHS instructions to implement the regulations would have required Medicare carriers to determine, for items with a purchase allowance of more than $60, 1/ whether

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1/In commenting on a draft of this report, HHS stated it had revised its instructions to implement the regulations, and the revised instructions are expected to be issued by June 30, 1982. The revised instructions propose to increase the $60 to $120. (See p. 21.)

purchase would cost less or be more practical than rental and, if so, reimburse on a purchase basis. Purchase reimbursement would be made by either using a lease-purchase arrangement, if more economical than lump-sum payment, or making a lump-sum payment. Carriers were to make rent/purchase decisions based on the medical necessity forms the physician prepares and which usually accompany a beneficiary's initial claim. Items with a purchase allowance of $60 or less always were to be purchased. (See p. 7.)

Although GAO acknowledges that the part of the regulation dealing with lease-purchase arrangements has been controversial, it can see no justification for the failure to apply other parts of the regulation, such as the requirement to purchase low-cost items like walkers, canes, and commodes. (See p. 7.)

SAMPLES DEMONSTRATE THE EFFECT OF DELAY IN IMPLEMENTING REGULATIONS

GAO analyzed 10 statistical samples totaling 988 beneficiaries renting and/or purchasing durable medical equipment during 1979 at six Medicare carriers throughout the country. These six carriers processed about 15 percent of the Medicare claims processed in fiscal year 1979 by all carriers. Six samples were of 587 beneficiaries who purchased oxygen and either rented or purchased oxygen delivery equipment, and four samples were of 401 beneficiaries at four of the six carriers who rented or purchased other equipment items. Based on these samples, GAO estimates that about $2 million in excess rental payments occurred during 1979 at these carriers.

The $2 million in excess rental payments averaged about 21 percent of total payments for durable medical equipment by these carriers. Of this amount, GAO estimates that at least $738,000, or 37 percent, could have been avoided if section 16 of Public Law 95-142 had been implemented for 1979. The lost savings consist of two categories:

--An estimated $275,000 would have been saved if all items costing $60 or less were purchased on a lump-sum basis as contemplated in the regulations.

--An estimated $463,000 would have been saved if items costing $60 or more were purchased when an analysis of the medical necessity forms showed that the expected length of need for these items exceeded their breakeven points (e.g., where the cumulative monthly rentals equaled or exceeded the purchase price).

GAO could not conclude that the other $1,262,000 of the $2 million in excess rental payments could have been avoided because (1) in many cases the determinations to rent or buy could not be made because of missing medical necessity forms, (2) an analysis of a few forms at one carrier was not done, and (3) in many cases, the rent decisions were correct based on the expected periods of need shown on the forms, but the actual periods of use exceeded those anticipated and excess rentals occurred. (See pp. 7 to 21.)

Savings similar to the $738,000 would have been achieved if all items costing $100 or less were purchased on a lump-sum basis and no effort had been made to make a rent or purchase decision for each item on the basis of the medical necessity forms. (See p. 19.)

APPLICATION OF LEASE-PURCHASE CONTROVERSIAL

The widespread use of lease-purchase arrangements is questionable. It is doubtful that there will be any circumstances in which a lease-purchase arrangement where title passes to the beneficiary will be more economical than lump-sum purchase. A lease-purchase arrangement appears to be applicable to high-cost items where the risk to the program of outright purchase is not justified, but rental of the equipment may possibly extend for a long period of time. Carriers and medical equipment supplier officials questioned how practical and widespread lease-purchase arrangements would be. Many of the suppliers GAO contacted made it clear that they would not participate in lease-purchase arrangements under any circumstances and those that would participate stated it would be substantially more costly than lump-sum purchase or the typical rental of from 3 to 5 months. Beneficiaries are also expected to become involved in dealing with lease-purchase arrangements as well as making arrangements for deferred payments to suppliers when there is

financial hardship due to large coinsurance requirements. GAO believes that beneficiaries' illnesses and general immobility will make extensive involvement unlikely. (See pp. 22 to 28.)

RECOMMENDATIONS TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

GAO recommends that the Secretary direct the Administrator of the Health Care Financing Administration to:

--Immediately notify the Medicare carriers to (1) stop rental reimbursement for new rentals of items costing $60 or less and (2) where possible for more costly items, make analyses of medical necessity forms to determine whether reimbursement on a rental or lump-sum purchase basis would be more economical and pay on the most economical basis.

--Increase the $60 limit used for requiring purchase to $100 and periodically adjust for inflation.

--Require carriers to improve their monitoring and retention of medical necessity forms. Carriers must have the forms completely filled out by physicians in order to make effective rent or purchase decisions. (See p. 20.)

--Provide beneficiaries with written material explaining the regulations on lease-purchase arrangements. (See p. 26.)

GAO also recommends that the Secretary modify the regulations to recognize that lease-purchase arrangements usually will be more costly than lump-sum purchases and thus would have limited applicability to certain high-cost items where the expected period of need is uncertain and/or where the beneficiaries cannot afford the coinsurance associated with lump-sum purchases.

AGENCY COMMENTS AND GAO EVALUATION

HHS concurred fully with GAO's concerns. It stated that the operating instructions for the Medicare carriers would be issued by June 30, 1982, which would give effect to the first three recommendations, including raising the

automatic purchase limit to $120. (See p. 21.) HHS also said that consistent with the fourth recommendation, the Health Care Financing Administration was drafting informational material to be made available to beneficiaries.

With respect to the lease-purchase issue, HHS stated that it did not plan to revise the regulations at this time. It stated that the instructions to the Medicare carriers would provide that carriers (1) cannot require lease-purchase arrangements, (2) should process claims involving lease-purchase plans offered by suppliers that meet the regulatory requirements, and (3) encourage suppliers to develop acceptable lease-purchase plans.

GAO believes that, as a practical matter, the impasse with the industry over the lease-purchase issue can only be resolved through fostering a more competitive environment by providing suppliers with tangible incentives to offer a lease-purchase plan. (See p. 27.)

Contents

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

CHAPTER 1

INTRODUCTION

In the past few years, we received several congressional inquiries citing examples of the alleged waste of Medicare funds by paying for long-term rentals of durable medical equipment when purchase would have been less costly. The uneconomical long-term rentals of equipment was supposed to have been alleviated by the passage of section 16 of Public Law 95-142. This legislation required the reimbursement for equipment on a purchase basis when more economical or practical than rental. The law was effective for any items of equipment rented or purchased on or after October 1, 1977. As of May 1982, however, the Department of Health and Human Services (HHS) 1/ had not yet implemented the law, primarily because of controversy concerning the methods of reimbursement under lease-purchase arrangements. 2/

Because of congressional inquiries about long-term rentals of durable medical equipment, we reviewed Medicare's reimbursement for durable medical equipment. Our overall objective was to determine the extent that Medicare was making rental payments for equipment rented on or after October 1, 1977, which exceeded the purchase amounts for these items because section 16 of Public Law 95-142 had not been implemented.

MEDICARE BACKGROUND

The Medicare program was established with the enactment of title XVIII of the Social Security Act (42 U.S.C. 1395) on July 30, 1965. Medicare, which became effective July 1, 1966, is a Government program which pays much of the health care costs for eligible persons 65 or older and certain disabled persons. The program is administered by HHS' Health Care Financing Administration (HCFA).

1/Formerly the Department of Health, Education, and Welfare.

2/Under a lease-purchase arrangement, the beneficiary, in effect, buys the equipment on an installment basis until (a) it is no longer needed and the item is returned to the supplier or (b) it is eventually paid for, in which case title passes to the beneficiary. One proposed arrangement provided for a 12-month period with equal monthly lease payments at 10 percent of the purchase price culminating in the purchase with no additional payment; however, a penalty payment of 1 month's lease charge would be made if the beneficiary wished to break the lease before the completion of the purchase transaction.

Medicare consists of two parts. Part A--Hospital Insurance for the Aged and Disabled--covers inpatient hospital care, home health care and, after a hospital stay, inpatient care in a skilled nursing facility. Part A is principally financed by taxes on earnings paid by employers, employees, and self-employed persons. During fiscal year 1981 an average of 28 million people were enrolled for Part A benefits. Benefit payments for fiscal year 1981 amounted to $28.9 billion.

Part B--Supplementary Medical Insurance for the Aged and Disabled--covers (1) physician services, (2) outpatient hospital care, (3) home health care, and (4) other medical and health services. This insurance generally covers 80 percent of the reasonable charges or costs for these services and/or supplies subject to an annual $75 deductible. 1/ Enrollment in Part B is voluntary. Part B is financed by beneficiaries' monthly premium payments and appropriations from general revenues. During fiscal year 1981 an average of 27.7 million people were enrolled for Part B benefits. Benefit payments in fiscal year 1981 for Part B amounted to $12.3 billion.

HCFA administers Part B benefits furnished by noninstitutional providers, such as doctors, laboratories, and suppliers, with the assistance of 40 carriers under prime contracts with the Government. Carriers' payments of claims are usually on the basis of reasonable charges. Twenty-six of the carriers are Blue Shield plans, 12 are commercial insurance companies, 1 is principally a data processing firm, and 1 is a State agency. Durable medical equipment and oxygen involve primarily Part B claims and are paid by the carriers. HCFA estimates that payments for durable medical equipment and oxygen exceed $125 million per year. We estimate about $30 million of this is for oxygen, which of course is only purchased, not rented.

DURABLE MEDICAL EQUIPMENT

HCFA instructions define durable medical equipment as equipment which

--can withstand repeated use,

--is primarily and customarily medical in nature, and

--is generally not useful to a person who does not have an illness or injury.

1/The annual deductible was increased from $60 effective January 1, 1982, by section 2134 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35), approved August 13, 1981.

Under HHS regulations, to be covered by Medicare, the equipment must be used in the patient's home and be considered medically necessary and reasonable for the treatment of the patient's illness or injury. Such items as hospital beds, wheelchairs, respirators, medical regulators, crutches, commodes, and traction equipment are considered to be durable medical equipment.

Legislative background on coverage of durable medical equipment under Part B of Medicare

Under the Social Security Amendments of 1965 (79 Stat. 286), which established Medicare, Part B covered only the rental of durable medical equipment. The Social Security Amendments of 1967 (81 Stat. 821), approved January 1968, provided for reimbursement for either purchase or rental of durable medical equipment. If a beneficiary elected to purchase equipment after December 31, 1967, reimbursement, subject to the deductible and coinsurance provisions, could be made under Part B of Medicare

--on a lump-sum basis for equipment costing $50 or less or

--in periodic installments (1) equal to the rental payments for equipment costing over $50 as long as the item is needed or (2) up to Medicare's share of the purchase price.

To control and contain costs for durable medical equipment, the Social Security Amendments of 1972 (Public Law 92-603) modified the payment provisions for specific equipment items. For medical services, supplies, and equipment (and equipment servicing) that in the judgment of the Secretary of HHS do not vary significantly in quality from one supplier to another, reimbursement may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality.

Section 245 of the 1972 amendments also authorized HHS to experiment with reimbursement approaches to avoid unreasonable expenses to the program resulting from prolonged rentals of durable medical equipment and to implement without further legislation any purchase approach found to be workable, desirable, and economical. 1/

1/An experiment, with an effective starting date of October 15, 1976, was done under the authority of section 245 by a contract with Exotech Research and Analysis Incorporated. A two-volume report on the results of the experiment entitled "Reimbursement for Durable Medical Equipment" was published by HCFA in March 1980 (HCFA Pub. No. 03018).

Section 16 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142) enacted on October 25, 1977, revised these reimbursement provisions. The legislation was intended to protect the Medicare program and beneficiaries against excessive expenditures caused by prolonged rentals of equipment. The legislation required the Secretary of HHS to determine on the basis of medical information whether the expected duration of need warrants a presumption that purchase would be less costly or more practical than rental and, if so, reimburse on the basis of lump-sum or lease-purchase arrangement. The Secretary may, despite this determination, authorize rental of equipment if the required purchase would impose an undue financial hardship on the beneficiary.

The Secretary was also directed to take steps to encourage suppliers, through whatever administrative arrangements were feasible and economical, to make equipment available to beneficiaries on a lease-purchase basis. Section 16 also retained the provision which authorized the Secretary to waive the 20-percent coinsurance requirement with respect to the purchase of used equipment whenever the purchase price is at least 25 percent less than the reasonable charge for comparable new equipment. Section 16 applied to equipment purchased or rented on or after October 1, 1977. To implement the change in the law, HHS issued proposed regulations in December 1978 and final regulations on July 1, 1980, which were supposed to become effective December 29, 1980. However, as of May 1982, the regulations had not been applied.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our overall objective was to identify the extent that Medicare was making rental payments for durable medical equipment items, including oxygen equipment, rented on or after October 1, 1977, which exceeded the purchase price for these items because HHS had not implemented section 16 of Public Law 95-142. Under this overall objective we:

- --Determined the extent of excess rental payments made during calendar year 1979 for samples of equipment items rented on or after October 1, 1977, and estimated the amounts of excess rentals that could have been avoided if certain features of the proposed or final regulations had been put into effect.

- --Analyzed HHS' final regulations to implement section 16 of Public Law 95-142 to identify (1) any additional savings which could occur if the regulations were modified and (2) those features of the regulations which did not appear workable and may have been obstacles to implementation.

To determine the extent of excess rental payments, we developed and analyzed 10 statistical samples at six carriers throughout the country. Of the 10 samples, 6 related to beneficiaries who during calendar year 1979 purchased oxygen and either rented or purchased oxygen delivery equipment, and 4 samples were of beneficiaries who during calendar year 1979 rented or purchased other equipment items. The location, scope, time frame, and sample methodology are detailed in appendix II. The sample results cannot be projected nationwide; however, they were developed by visiting carriers from various sections of the country. The six carriers selected for the oxygen samples processed about 19.1 million Part B claims during fiscal year 1979. This represented about 15 percent of the total claims processed nationwide. Of these six carriers, four were selected for the other medical equipment samples, and they processed about 6.3 million Part B claims during fiscal year 1979, or about 5 percent of the total claims processed nationwide.

To estimate the extent that the excess rental payments could have been avoided, we applied two criteria. The first criteria assumed certain low-cost items, such as canes and walkers, should always be purchased. Under the proposed December 1978 regulation, it was contemplated that carriers would determine whether the administrative costs of renting inexpensive items made purchase more practical or less expensive. The July 1980 final regulations expanded on this concept by indicating lists of durable medical equipment that should be purchased or rented routinely would probably be provided to carriers.

Section 5101 of the Carriers Manual, which contains the guidance for carrying out the regulations, further defines this concept. This section sets forth the criteria for payment of durable medical equipment under the rules set out in section 16 of Public Law 95-142 and covered by the July 1980 regulations. Section 5101.1 requires that inexpensive items (defined as under $60) should always be purchased. Accordingly, we calculated the excess rentals for items in our samples where the purchase allowance was $60 or less. The second criteria, pertaining to items costing more than $60, involved determining the breakeven point of an item in terms of the number of months the Medicare rental allowance would equal the purchase allowance and comparing this with the expected duration of need as shown on the medical necessity forms filed by the beneficiaries' physician. We did not attempt to attribute any savings lost through the failure to use lease-purchase arrangements because we found no such arrangements existed at the time of our fieldwork.

Our analysis of the final HHS regulations and related guidelines focused on a review of provisions for using lease-purchase arrangements and an assessment of the probable impact of the requirement that all items with a purchase allowance of $60 or less

should be purchased. We talked with HCFA, carrier, and supplier officials. We also discussed with HCFA officials the process they used to develop the regulations and the implementing guidelines. We contacted one national trade and two national supplier associations to obtain their views on the feasibility and fairness of the new regulations. Members of these associations gave us written comments on various provisions in the new regulations, such as requiring that specific equipment items always be purchased, the introduction of lease-purchase arrangements, and the increased emphasis on the use of carriers' medical necessity forms to make rent/purchase decisions.

When suppliers do not take assignment, beneficiaries must pay the difference from what the supplier charges and the carrier allows. To assess the impact of the new regulations on beneficiaries, we contacted 77 who were randomly selected from our statistical samples to determine (1) how extensively they were involved in obtaining their equipment and (2) why they made particular choices, such as rental versus purchase, or selected specific suppliers.

Our review was performed in accordance with the Comptroller General's current standards for audits of governmental organizations, programs, activities, and functions.

CHAPTER 2

LACK OF IMPLEMENTATION OF LAW HAS RESULTED IN INCREASED COSTS FOR DURABLE MEDICAL EQUIPMENT

HCFA's failure to implement a law which changed the reimbursement policy for durable medical equipment has resulted in excessive costs to the Medicare program. Section 16 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments was enacted on October 25, 1977, primarily to protect the Medicare program and beneficiaries against excessive expenditures resulting from prolonged rentals of durable medical equipment. Although this provision was effective for any equipment rented on or after October 1, 1977, HCFA did not publish proposed regulations in the Federal Register until December 1978 and final regulations until July 1980.

Further, the regulations noted that HCFA planned to issue administrative guidelines to assist the carriers in implementing these regulations. The regulations were to be implemented by December 29, 1980; as of May 1982, the regulations and related guidelines had not been applied by the carriers.

A HCFA official told us that the delay was due to the time it took to determine how HCFA would deal with certain provisions in the new regulations. For example, HCFA had no experience with developing and implementing lease-purchase agreements. HCFA also had to decide whether the type of equipment or a dollar limit should be established as a basis for the carrier to determine what items should always be purchased.

As discussed in chapter 3, we acknowledge that the application of the lease-purchasing provision has been controversial; however, we can see no valid justification for failing to apply other parts of the regulations, such as the requirement to purchase low-cost items like walkers, canes, and commodes. 1/

Our samples of 988 beneficiaries using oxygen and other medical equipment during calendar year 1979 showed that excess rental payments of about $66,000 were made to or on behalf of sampled beneficiaries during 1979. Projecting the sample results to our universe of 44,027 beneficiaries results in estimated excess rental

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1/In commenting on this report (see app. IV), HHS said that we had not adequately addressed the congressional and industry interest in delaying or revoking the law and regulations. Although we have seen some congressional correspondence on the subject, such as a letter dated July 31, 1981, signed by 35 members of the House of Representatives, the thrust of the concerns seemed to focus on the lease-purchase provisions in the regulations.

payments of about $2 million, or about 21 percent of the total payments made at the selected carriers. 1/ We estimate that about $738,000 of these payments could have been avoided if the law had been implemented. This lost savings is composed of two categories. First, we estimate that $275,000 would have been saved if all items costing $60 or less were purchased on a lump-sum basis. Second, we estimate that $463,000 would have been saved if items costing $60 or more were purchased when an analysis of the medical necessity forms showed that the expected length of need for these items exceeded their breakeven points.

We could not conclude that the other $1,262,000 could have been avoided because (1) for 50 items in our sample the medical necessity forms could not be located, thus a rent or buy determination could not be made, (2) we did not examine the forms for 21 sampled items at Blue Shield of California because at the time of our visit the carrier's employees were on strike, and (3) for 102 sampled items the rental decision was correct based on the anticipated periods of need--however, the actual periods of use exceeded the breakeven points and excess rental payments were made.

EXCESS PROGRAM COSTS INCURRED DUE TO HCFA'S DELAY

The intent of Public Law 95-142 was that HCFA, through its carriers, would determine for beneficiaries whether their durable medical equipment would be reimbursed on a rental or purchase basis. This determination would be based on how long the equipment was needed and what would be the least costly method to acquire it--rent or purchase. Before October 1977, the reimbursement basis, either rental or purchase, was based on the method the beneficiary chose to obtain the equipment. Because HCFA has not yet implemented the 1977 law, beneficiaries in effect still have the option and still continue to rent when it would be more economical to buy. Consequently, the Medicare program continues to make rental payments for equipment which exceeds the purchase allowances for these items.

To gain insight into the cost impact of HCFA's not implementing section 16 of Public Law 95-142, we statistically selected 10 samples 2/ of Medicare beneficiaries who had either rented or purchased equipment during 1979 at six carriers. Six samples included

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1/Only equipment rented on or after October 1, 1977, was considered in this analysis. For items rented by the universes of beneficiaries, both before and after October 1, 1977, the excess rental payments in 1979 were about $3.3 million or about $1.3 million higher. (See app. III.)

2/See app. II for locations and sample methodology.

587 beneficiaries who purchased oxygen and either rented or purchased the oxygen delivery equipment, and four samples included 401 beneficiaries who rented or purchased other equipment. Because the change in the law was effective October 1, 1977, we made separate analyses of rentals on each sample which began both before and after the date of the change. 1/ The results of our samples and case studies from the samples for rentals beginning after October 1, 1977, are discussed below.

Oxygen equipment sample results

Beneficiaries can either rent or purchase the equipment that delivers oxygen. Because most beneficiaries, once started, usually remain on oxygen for the rest of their lives, continuous rental of the equipment can result in significant beneficiary and program costs. The 587 beneficiaries in our six samples rented or bought 996 equipment items 2/ during calendar year 1979. Of these, 343 items for which rental began after October 1, 1977, were associated with excess rentals. Of the 343 items, 129 cost $60 or less and 214 had reached the breakeven point during or before 1979. We estimate that at least 247 of the 343 items probably would not have had excess rental payments if the law had been implemented.

We calculated that about $46,000 in excess rental payments were made during 1979 on behalf of our sampled beneficiaries. This projects out to about $1,360,000 in excess rental payments for our universe of beneficiaries at the six carriers. The results are shown in the following table.

1/For results of analyses of items rented before and after October 1, 1977. (See app. III.)

2/Nine hundred thirty-two items were rented and 64 items were bought. Of the 932 rental items, 215 were rented before and 717 after October 1, 1977.

Estimated Excess Rental Payments Made
During 1979 for Oxygen-Related Equipment

Carrier	Total payments made during 1979		Amount of excess rentals		
	Sample	Projection	Sample	Projection	Percent of total payments
New Hampshire/Vermont Blue Cross/Blue Shield	$ 56,754	$ 529,519	$ 9,667	$ 167,876	31.7
Connecticut General	124,578	745,556	12,760	225,951	30.3
Prudential Insurance Company of America (Georgia)	55,262	743,170	12,225	198,976	26.8
Blue Shield of Kansas City	38,680	273,334	4,607	46,953	17.2
General American - St. Louis	39,232	1,162,148	3,609	115,204	9.9
Blue Shield of California (Northern California)	40,827	3,004,881	2,921	605,370	20.2
Total	$355,333	$6,458,608	$45,789	a/$1,360,330	b/21.1

a/This projection is subject to a sampling error of plus or minus $681,700.

b/This projection is subject to a sampling error of plus or minus 11 percent.

We estimate that at least $514,000 or about 38 percent of the projected excess rental payments of $1,360,000 could have been saved if the guidelines designed to implement the October 1977 law had been in effect. This estimate consists of two categories. First, we estimate that $140,000 1/ could have been saved if all items costing $60 or less were purchased outright. Second, we estimate that $374,000 could have been saved if items costing $60 or more were purchased when an analysis of the medical necessity forms indicated that the expected length of need for these items exceeded their breakeven points (see pp. 14 to 16). The $374,000 estimate is probably understated because we could not do our analysis of the expected duration of need at Blue Shield of California

1/This estimate is a gross amount. It has not been offset by the amount where Medicare might have "lost" as a result of the lump-sum purchase. That is, where monthly rental payments stopped before reaching the breakeven point. However, in our samples, the maximum potential loss was only about 7 percent of the savings. The net loss is not known because many items were still being rented at the end of the period analyzed. Further, this potential loss was more than offset by the excess rentals during 1978 applicable to those items initially rented before 1979.

(see p. 14). Also, as discussed on page 8, we could not conclude that the excess rentals for the remaining sample items would have been avoided, because of missing medical necessity forms and because the actual rental periods exceeded the anticipated periods of need which indicated that rental was appropriate.

Oxygen equipment case studies

Although the above projections were limited to calendar year 1979 because our universe only included those beneficiaries using oxygen equipment during that period, the following case studies demonstrate the broader cost impact to the Medicare program caused by excess rentals from October 1, 1977, to December 31, 1979.

--A beneficiary rented an $89 oxygen regulator for 27 months. Total payments for the period were $680.59. If purchased, the program would have paid $71.20, or $609.39 less than the incurred costs. The breakeven point for this item was reached in 3 months.

--A beneficiary rented a $450 intermittent positive breathing machine for 20 months. Total payments for the period were $972. If purchased, the program would have paid $360 or $612 less than the incurred costs. The breakeven point for this item was reached in 8 months.

--A beneficiary rented a $21.50 humidifier for 24 months. Total payments for the period were $186. If purchased, the program would have paid $17.20 or $168.80 less than the incurred costs. The breakeven point for this item was reached in 2 months.

In each case, the time needed indicated on the medical necessity form when compared to the breakeven point indicated that purchase was more economical.

Other durable medical equipment sample results

The rental periods for durable medical equipment items other than oxygen delivery equipment vary considerably from 1 month up to several years. The variety of the equipment used and the length of its need fluctuate considerably more than oxygen and its delivery equipment. However, due to many low-cost items with short breakeven points and long rentals, there are still many instances where Medicare rental payments exceed Medicare's share of the cost at which the equipment could have been purchased. The 401 beneficiaries in our four samples rented or bought 657 items 1/ during

1/Five hundred and five items were rented and 152 items were purchased. Of the 505 rental items, 64 were rented before and 441 after October 1, 1977.

calendar year 1979. Of these, 184 items for which rental began after October 1, 1977, were associated with excess rentals. Of the 184 items, 63 cost $60 or less and 121 had reached the break-even point during or before 1979 (see p. 14). We estimate that 107 of the 184 items may not have incurred excess rental payments if the law and related regulations had been implemented.

We determined that about $20,000 in excess rental payments were made during 1979 to our sampled beneficiaries. This projects to about $632,000 in excess rental payments for our universe of beneficiaries at the four carriers. The results are shown in the following table.

Estimated Excess Rental Payments Made During 1979

Carrier	Total payments made during 1979		Amount of excess rental payments		
	Sample	Projection	Sample	Projection	Percent of total payments
New Hampshire/Vermont Blue Cross/Blue Shield	$10,906	$ 241,278	$ 1,458	$ 32,218	13.4
Prudential Insurance Company of America (Georgia)	20,349	1,573,560	3,316	256,459	16.3
Blue Shield of Kansas City	31,395	786,206	9,817	245,818	31.3
General American - St. Louis	15,862	291,486	5,312	97,622	33.5
Total	$78,512	$2,892,530	$19,903	a/$632,117	b/21.9

a/This is subject to a sampling error of plus or minus $376,800.

b/This is subject to a sampling error of plus or minus 13 percent.

We estimate that at least $224,000 or 35 percent of the projected excess rental payments of $632,117 could have been avoided if the law had been implemented. This estimate consists of two categories. First, we estimate that $135,000 1/ could have been saved if all items costing $60 or less were purchased. Second, we estimate that $89,000 could have been saved if items costing $60 or more were purchased when the expected length of need for these items exceeded their breakeven point (see pp. 14 to 16). For the reasons previously mentioned, we could not conclude that the excess rentals could have been avoided for the other $408,000.

Other durable medical equipment case studies

Although the above projections were limited to calendar year 1979 because our universe only included those beneficiaries using other medical equipment during that period, the following case studies demonstrate the cost impact to the Medicare program caused by excess rentals from October 1, 1977, to December 31, 1979.

--A beneficiary rented a $63 commode for 27 months. Total payments for the period were $230.09. If purchased, the program would have paid $50.40 or $179.69 less than the incurred costs. The breakeven point for this item was 5 months.

--A beneficiary rented a $38.50 invalid walker for 27 months. Total payments for the period were $171.00. If purchased, Medicare would have paid $30.80 or $140.20 less than the incurred costs. The breakeven point for this item was 5 months.

--A beneficiary rented $85 bed siderails for 26 months. Total rental payments were $279.91. If the siderails had been purchased, the program would have paid $68 or $211.91 less than the incurred costs. The breakeven point for the siderails was 6 months.

In each case, the time indicated on the medical necessity form when compared to the breakeven point indicated that purchase was more economical.

1/This estimate is a gross amount. It has not been offset by an estimate of the amounts where Medicare might have "lost" as a result of the lump-sum purchase. However, in our samples, the maximum potential loss was only about 17 percent of the savings. The net loss is not known because many items were still being rented at the end of the period reviewed. Further, this potential loss was more than offset by the excess rentals during 1978 applicable to those items rented before 1979.

BREAKEVEN ANALYSIS

We performed a breakeven analysis for all 527 items rented on or after October 1, 1977, where excess rental payments were identified. The analysis determined the number of monthly rental payments needed to equal the purchase allowance for the item. The purchase allowance was the amount that Medicare would have allowed toward the purchase of the item at the time the rental began. For 264 items costing more than $60, we also compared the computed breakeven point to the time indicated on the medical necessity form to determine if rental was the correct decision. 1/

The average breakeven point was about 4-1/2 months for oxygen equipment and about 7 months for other medical equipment. As shown by the following table the breakeven point lengthened as the purchase allowance increased.

Breakeven Point for Items
Where Excess Rental Payments Were Identified

Purchase allowance	Oxygen-related equipment		Other durable medical equipment		Combined	
	No. of items	Breakeven point (months)	No. of items	Breakeven point (months)	No. of items	Breakeven point (months)
$1 to $60	129	3.6	63	4.3	192	3.8
$61 to $100	128	4.1	50	6.7	178	4.8
$101 to $200	28	5.9	13	7.9	41	6.5
Over $200	58	7.2	58	9.5	116	8.4
Overall	343	4.6	184	6.8	527	5.4

Comparison of breakeven points to period of need indicated on medical necessity forms

We compared the time of need indicated on the original medical necessity forms to the breakeven point for 264 of the 335 items costing more than $60 rented on or after October 1, 1977, in our samples where excess rental payments were identified. 1/

1/Blue Shield of California which had 21 excess rental items costing more than $60 was not included because the carrier was subject to an employee strike during our review. Also, we could not make the comparison for 50 items at the other carriers because the medical necessity form could not be found.

The comparison was done to determine whether carriers could base rent/purchase decisions on the expected duration of need indicated on the initial medical necessity form when this is compared to the breakeven point. 1/ A specific length of time needed was indicated on the medical necessity form for only 18 of the items reviewed. On the other forms, length of need was indicated as "permanent or life" or "indefinite." For the forms which indicated the need as "permanent or life" we considered the length of need as 12 months since regulations require the doctors' recertification of need for these items after 12 months. For "indefinite" we considered the need as 6 months since regulations require a recertification of these items every 6 months.

Summary of Medical Necessity Forms
Reviewed Where Rental Exceeded Purchase Price

Stated duration of need	Oxygen-related equipment		Other durable medical equipment		Total	
	No. of forms	Percent	No. of forms	Percent	No. of forms	Percent
Duration of need:						
Life (12 months)	69	43.7	30	28.3	99	37.5
Indefinite (6 months)	73	46.2	74	69.8	147	55.7
Number of specific months	16	10.1	2	1.9	18	6.8
Total	158	100.0	106	100.0	264	100.0

For the 264 items analyzed, the rent decision was not correct in 162 instances or 61 percent. For the other 102 items, the rent decision was correct based on the anticipated period of need as indicated by the medical necessity forms; however, the actual period of use exceeded the breakeven point and these items were

1/The suppliers responding were virtually unanimous (51 out of 58) in their opinion this could not be done.

associated with excess rental payments. 1/ The excess rental payments for 162 items were about $23,100 which, when projected over the universe of beneficiaries, results in excess rental payments of $463,000 during calendar year 1979, $374,000 for oxygen-related equipment and $89,000 for other medical equipment. We believe these payments would not have been made if the law had been implemented.

We recognize that a decision based only on an analysis of medical information together with the breakeven point will not always result in cost savings because of unforeseen events; nevertheless, we found that a more appropriate rent/purchase decision could have been made for 61 percent of the items costing more than $60.

HCFA'S PURCHASE LIMIT MAY NOT BE HIGH ENOUGH

HHS' final regulations noted that implementing guidelines would be issued which may include lists of durable medical equipment that should be routinely purchased. A HCFA official told us that it became too complicated to determine which items should be included on a list. So, instead of listing specific items, HCFA established that any items costing $60 or less would always be purchased. A HCFA official said that this limit was a compromise, the initial proposal had been $50. We believe program savings will significantly increase if a limit higher than $60 is used.

Few items affected by limit

In our samples, few rented items had a purchase allowance of $60 or less. These items consisted of canes, walkers, commodes, flowmeters for oxygen regulators, humidifiers, and oxygen stands with a purchase allowance up to $60. Also, the number of items 2/ in our samples for which excess rental payments were identified increased substantially when a purchase allowance of $100 is applied versus $60. This point is demonstrated by the following table:

1/The difference between the 102 items and the 173 items shown on the table in app. I consisted of 50 items for which no medical necessity forms could be located and 21 items of Blue Shield of California where the medical necessity forms were not reviewed.

2/Analysis done for only those items for which rental began after October 1, 1977.

Number of Items in Samples

	$1 to $60			$61 to $100			$1 to $100		
	Total	With excess rentals	Percent	Total	With excess rentals	Percent	Total	With excess rentals	Percent
Oxygen equipment	160	129	81	189	128	68	349	257	74
Other durable medical equipment	96	63	66	116	50	43	212	113	53
	256	192	75	305	178	58	561	370	66

The 561 items with a $100 or less purchase allowance represent about 48 percent of the total 1,158 items rented after October 1, 1977. The 370 items with excess rentals having a purchase allowance of $100 or less represented about 70 percent of the total items with excess rental payments. The 370 items were rented for an average of 8 months beyond their breakeven points of about 4 months; thus, on the average Medicare paid for these items about three times.

The 178 items with a purchase allowance between $61 and $100 had a breakeven point of about 5 months, only about 1 month longer on the average than the breakeven point (4 months) for the 192 items with a purchase allowance of $60 or less. The items falling in the $61 to $100 range consisted mainly of oxygen regulators and siderails for hospital beds.

Increased program savings with $100 limit

The Medicare program could realize increased savings if the requirement to reimburse on a purchase basis is raised to $100. For 1979, about 13 percent of the excess costs would have been avoided if beneficiaries in our samples had been reimbursed on a purchase basis for all items costing $60 or less. 1/ The percentage increased to about 38 percent if the limit was $100. This

1/This consists of $140,000 for the oxygen equipment samples and $135,000 for the other equipment samples or $275,000 as compared with the total projected excess rental payment of $2 million.

is attributed primarily to oxygen regulators which had a Medicare allowance of about $60. This increase to $100 would have a minor impact on beneficiaries. For the difference of $40, for example, a beneficiary would be additionally liable for 20 percent coinsurance or $8.

Further, the risks to the program seem to be minimal because the breakeven point for these items is about 5 months. Because there will always be at least a 1-month rental and a 20-percent coinsurance factor, the maximum risk to the program on a $100 item is $64, less whatever administrative costs are saved by processing one claim instead of many.

For all the rented items in our samples with a purchase allowance of $100 or less, the maximum potential loss was about 20 percent of the gross savings. The net loss is not known because many items were being rented at the end of the period reviewed. Further, in the aggregate this potential loss was more than offset by the excess rentals during 1978 applicable to those items rented before 1979.

Suppliers' views on whether certain items should be rented or purchased

We contacted three medical equipment supplier associations to obtain their views on whether certain items should be purchased or rented. The associations asked various members to provide their views to us, of which 58 responded.

Over half the suppliers (31) indicated that some items should be always purchased. Fifteen suppliers stated that all items costing less than a stated amount should be purchased. The suppliers suggested various dollar values ranging from $25 to $100. Among the most frequently mentioned items that should always be purchased were canes, walkers, and commodes because of their low purchase prices and lack of service requirements. 1/

Some suppliers (15) indicated that certain items should not always be purchased. These suppliers believe a rent/purchase decision should be made for each item. Factors to be considered are length of need, cost of item, amount of service an item needs, and the patient's situation. Many suppliers (23) indicated that items needing regular servicing such as intermittent positive breathing

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1/This seems consistent with the suppliers' views for some time. According to the Exotech report discussed on page 3, at a November 1977 convention of the National Affiliation of Durable Medical Equipment Companies, the suppliers generally endorsed the proposition that inexpensive equipment (costing less than $50 to $75) should always be sold, rather than rented.

machines and oxygen concentrators should always be rented. A few suppliers stated that the long-term rentals of the low-cost items were justified because they made up for the losses on the delivery and installation on short-term rentals and thus was a factor that enabled them to stay in business.

MEDICAL NECESSITY FORM PROCEDURE NEEDS IMPROVEMENT

When the new regulations are finally applied, the carriers will determine whether reimbursement for a particular equipment item will be on a rental or purchase basis. For items valued over a specific amount, this will be done primarily by reviewing the medical necessity forms prepared by the physicians. These forms, which usually accompany a beneficiary's initial claim, are supposed to include diagnosis of the illness, the medical equipment required, and the length of expected need for the equipment. Carriers now use the forms as a basis for denying or paying claims. Carriers generally require that the medical necessity forms be updated by the physicians and reviewed at least once a year depending upon the length of need indicated on the initial form.

Some improvements are needed in the accumulation and use of medical necessity forms. Based on our samples, for example, the carriers could not locate 16 percent of the initial medical necessity forms we asked to review. Although the forms do indicate length of need, a decision to rent or purchase cannot be based solely on this. The carrier must also determine what the breakeven point is for a particular equipment item.

CONCLUSIONS

At the carriers reviewed, the excess rental payments averaged about 21 percent of the total payments for all equipment (oxygen and other equipment). Of this amount, we estimate that at least 37 percent of the excess payment could have been avoided if the 1977 law had been implemented for 1979. This estimated savings consisted of (1) the reimbursement on a purchase basis of items with a Medicare purchase allowance of $60 or less and (2) the reimbursement on a purchase basis of those items where the indicated duration of need showed that rental was not justified when compared with the breakeven points. Similar results would have been achieved if the purchase limit had been increased to $100 and no effort had been made to make a rent or purchase decision for each item on the basis of the medical necessity forms.

As shown by the table in appendix I, there were 1,158 equipment items in our samples which were rented during 1979 and where the rentals began on or after October 1, 1977. Of these, about 55 percent were not associated with excess rental payments through December 31, 1979--although many were still being rented.

On an item basis--rather than a projectable dollar basis--we believe that for about two-thirds of the excess rental items, the added costs could have been avoided if section 16 of Public Law 95-142 had been implemented.

The principal reason why the proportion of avoidable excess costs is much higher on an item basis (67 percent) as compared to a projectable dollar basis (37 percent) is the high percentage of the items valued at less than $60 that should have been purchased. The average savings per item for 1979 costing $60 or less was low as compared with the average savings of higher cost items based on 1979 projectable dollars. This is because once a costly item reaches the breakeven point, the excess rental in terms of absolute dollars rapidly escalates. For example, during the period of our review, a $400 hospital bed had a monthly rental allowance of $45. If it was rented for an entire year the total charges would be $540--or $140 more than the bed cost.

Under the new regulations, many changes have been set forth; however, the changes may not fully achieve HCFA's objective of controlling costs. The regulations will give carriers the decision to determine whether durable medical equipment will be reimbursed on a rental or purchase basis. The carriers will base this decision on the medical necessity forms attached to the initial prescription. In our opinion, some improvements are needed in the retention and use of these forms.

The requirement that all items costing under $60 be purchased would exclude a number of relatively low-cost items commonly used for extended periods, specifically, oxygen regulators and certain types of commodes. We believe that raising the limit to $100 would not only include more items, but also have a larger impact on reducing program costs and have only a minimal cost effect on beneficiaries.

RECOMMENDATIONS

We recommend that the Secretary of HHS direct the Administrator of HCFA to:

- --Immediately notify the Medicare carriers to (1) stop reimbursements for new rentals of items costing $60 or less and (2) where possible make analyses of medical necessity forms to determine whether reimbursement on a rental or lump-sum purchase basis would be more economical, and pay benefits on the most economical basis.

- --Increase the $60 limit used for requiring purchase to $100 and periodically adjust for inflation.

--Require carriers to improve their monitoring and retention of the medical necessity forms. Carriers must have the forms completely filled out by physicians in order to make effective rent or purchase decisions.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report (see app. IV), HHS said it concurred fully with our concerns. It stated that operating instructions for the Medicare carriers are expected to be issued by June 30, 1982, which would give effect to the foregoing recommendations. In fact, HHS' proposed operating instructions provide for increasing the $60 limit for requiring purchase to $120, instead of $100 as we proposed. Considering the effects of inflation since the 1979 base year for our review, we believe HHS' proposal is appropriate. Further, we believe the instructions should largely resolve the problem of excess rentals in terms of the number of items (but not necessarily in terms of dollars) and, at the same time, simplify program administration and minimize carrier claims processing costs.

CHAPTER 3

APPLICATION OF LEASE-PURCHASE ARRANGEMENTS IS CONTROVERSIAL

HHS' new medical equipment regulations require the use of lease-purchase agreements as one of the principal methods of paying for the purchase of durable medical equipment. Under the regulations, lease-purchase agreements are to be used when more economical than lump-sum reimbursement. We believe it is doubtful that there would be any circumstances where title passes to the beneficiary when a lease-purchase arrangement will be more economical than an outright lump-sum purchase. A lease-purchase arrangement appears to be applicable to high-cost items where the risk to the program, and perhaps the beneficiary, of outright purchase is not justified, but where rental payments could extend over several years.

Further, as discussed in the previous chapter, increasing the lump-sum minimum purchase requirement to allow for items of $100 or less could solve much of the problem in terms of the number of items--but not necessarily the dollars--associated with excess rentals. Accordingly, the consideration of the application of the lease-purchase concept should be focused on such items as hospital beds, wheelchairs, and the more expensive oxygen therapy equipment.

Carrier and supplier officials questioned how practical and widespread lease-purchase arrangements would be. Under the new regulations, carriers will decide whether the equipment will be reimbursed under a rental or purchase basis. However, the new regulations contemplate that beneficiaries will be involved with suppliers concerning lease-purchase arrangements or making arrangements for deferred payments of coinsurance amounts when there is a financial hardship. Even under the current system where beneficiaries make their own rent/purchase decision, we found that many, due to illness, did not actively participate in the process. We believe it is unrealistic to expect a great deal of beneficiary involvement.

LEASE-PURCHASE ARRANGEMENTS NOT WIDELY AVAILABLE

The use of lease-purchase arrangements between carriers and medical suppliers is provided for under the new regulations. According to the regulations, if the carrier determines that purchase is more practical or less costly than total rental charges for the expected period of need, the carrier shall pay for durable medical equipment under a lease-purchase agreement if reasonably available to the beneficiary. The regulations also provide for the lump-sum purchase of equipment if "a more equitable and economical lease-purchase agreement * * * is not available."

Based on discussions with HCFA, carrier, and supplier officials, it is highly questionable whether lease-purchase arrangements (where title passes to the beneficiary) that are more economical than lump-sum purchases would be available.

HCFA's comments in the regulations published in the Federal Register acknowledged its lack of experience in working with lease-purchase arrangements by noting that:

--Lease-purchase contracts are not common currently between suppliers of medical equipment and patients.

--There is no established body of knowledge in this area; the regulation does not set definitive rules for lease-purchase contracts.

--HCFA will evaluate any available lease-purchase plans and will work with suppliers and consumer groups to develop acceptable standard lease-purchase arrangements.

A HCFA official told suppliers that HCFA was looking to suppliers for assistance in developing standard lease-purchase arrangements.

HCFA assumes that lease-purchase arrangements would be less costly than outright purchase. A HCFA official said that the lease-purchase system envisioned in the law was that rental payments would be made until they equaled the purchase price. At that time, the beneficiary would assume ownership. According to the suppliers, however, as a practical matter under lease-purchase agreements, the monthly lease-purchase rate would be usually higher than a rental rate so that total payments would be more than the purchase price. According to one supplier, a common lease-purchase arrangement would require 20 percent down, 20 to 30 percent annual interest, penalty charges for late payments, a maintenance fee, and a final buy-out payment. 1/ At the time of our review, HCFA had not developed a lease-purchase format acceptable to the industry for suppliers to use.

Carriers' views

Several carrier officials contacted during our review questioned the practicality of lease-purchase primarily because HCFA had not established any specific criteria and the suppliers lacked experience. One carrier official considered that lease-purchase would be attractive to the beneficiary but an administrative hindrance to the carrier. Another considered that the lease-purchase

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1/At least one major mail-order chain advertised that it would apply the full first month's rent of an item to the purchase price. Also about 17 percent of suppliers responding said they followed a similar policy.

alternative may be impractical and that very few suppliers would get involved. The March 1980 study of the durable medical equipment program by Exotech Research and Analysis Incorporated, under a HCFA contract, concluded that few suppliers have been willing to get involved with lease-purchase. (See p. 3.)

Suppliers' views on lease-purchase

We contacted three medical equipment supplier associations to obtain their views on lease-purchase. The associations had various members give us their opinion on lease-purchase. Most of the 58 suppliers that responded stated that they did not consider the lease-purchase alternative to be practical from several standpoints.

Many suppliers stated they are unable to finance the ownership of medical equipment, especially when lease payments would be made on a monthly basis. As some suppliers noted, they are not a bank or a finance company but are primarily a service industry. They need their money on a timely basis.

Moreover, suppliers that do not have title to their own medical equipment because of their financing arrangements with the manufacturer may be unable to make lease-purchase contracts. Also, because most suppliers have never been involved with lease-purchase, their accounting systems are not designed to handle and control such arrangements. According to suppliers, those systems would require revision. This is especially true for small suppliers who considered it would be too expensive and cumbersome for them to establish a lease-purchase program. The few suppliers that indicated a willingness to consider such an arrangement pointed out that it would be much more costly than the outright purchase of equipment or the typical 3- to 5-month rental of such items.

List of suppliers providing lease-purchase

To encourage the availability of lease-purchase agreements, carriers will establish and maintain a system for informing beneficiaries of suppliers willing to enter into lease-purchase agreements. Both carriers and suppliers had problems with this approach.

Officials from five of the seven carriers who responded to our questions were against publishing such lists. They speculated that problems, such as restraint of free trade or conflict of interests, could arise from this practice. An official from another carrier considered the process might be appropriate as long as the list of suppliers would be provided to physicians who could direct beneficiaries in obtaining their medical equipment. An official from the remaining carrier considered there was no problem with developing the list, especially considering the small number of suppliers who would offer lease-purchase.

With few exceptions, the 58 suppliers who responded were against the publication of carriers' lists for various reasons. Some suppliers considered that this would provide the carriers with too much control over the equipment suppliers, and unfairly discriminate against suppliers who do not consider offering a lease-purchase plan as a sound business decision. Other suppliers were concerned whether the carriers would keep the lists current. Finally, some suppliers questioned whether it was equitable to publish lists of those who offer lease-purchase arrangements and not other lists, such as of doctors who take assignment. 1/ Others stated that with the publication of such lists, they would initiate litigation.

EXTENT OF BENEFICIARY INVOLVEMENT REQUIRED BY NEW REGULATIONS NOT REALISTIC

The effective implementation of the new regulations depends to some extent on beneficiaries becoming actively involved with suppliers and carriers. The regulations take the rent/purchase option away from beneficiaries and give it to the carriers. However, beneficiaries are expected to become "prudent buyers" and thus become more involved with suppliers and carriers regarding lease-purchase arrangements or making arrangements for deferred payments when there is financial hardship. Such financial hardship could result when relatively expensive items, such as hospital beds, are reimbursed by Medicare on a lump-sum purchase basis, and the beneficiary would be responsible for paying the 20-percent coinsurance amount. Based on our discussions with beneficiaries, their anticipated participation with the new regulations may not be realistic.

During our review, beneficiaries had the option of renting or purchasing their medical equipment, but those we contacted did not always make the choice on their own. We randomly selected 77 beneficiaries from five States to determine how actively they participated in the process for obtaining medical equipment. The following table shows the extent to which beneficiaries we contacted participated in the decision.

1/A legislative proposal has been made to do exactly this. (S. 1566 introduced July 31, 1981.) When a doctor accepts assignment of a Medicare claim, he or she agrees to accept Medicare's reasonable charge as the total charge.

Who Made the Decision on How To Acquire Equipment

Category	Number	Percent
Beneficiary	19	24.7
Physician	25	32.4
Hospital	14	18.2
Family member	5	6.5
Supplier	8	10.4
Other	6	7.8
Total	77	100.0

As noted above, beneficiaries generally did not make the decision as to how their medical equipment would be acquired. Therefore, it is unlikely that beneficiaries who may not be healthy or mobile will handle any arrangements required by the new regulations without assistance from a physician, relative, or other party. HCFA is aware that beneficiaries can experience problems in obtaining medical equipment. HCFA's Office of Beneficiary Services is planning to prepare written material for beneficiaries explaining the new regulations.

CONCLUSIONS

The widespread use of lease-purchase is questionable. It is doubtful that there will be any circumstances where a lease-purchase arrangement, where title eventually passes to the beneficiary, will be more economical than lump-sum purchase. Such an arrangement appears to be applicable to high-cost items in which the risk to the program of outright purchase is not justified, but where the period of the rental of the equipment is uncertain although it could extend for a long period of time. Both carrier and supplier personnel question how practical and widespread lease-purchase arrangements would be.

Many suppliers told us that they would not participate in lease-purchase arrangements under any circumstances and those that would stated it would be substantially more costly than lump-sum purchase or the typical rental.

Beneficiaries are also expected to become involved in dealing with lease-purchase arrangements as well as making arrangements for payments when there is financial hardship. We believe that extensive beneficiary involvement is unlikely.

RECOMMENDATIONS

We recommend that the Secretary of HHS modify the regulations to recognize that lease-purchase arrangements will generally be more costly than lump-sum purchase and thus would have limited

applicability to certain high-cost items where the expected period of need is uncertain and/or where beneficiaries cannot afford the coinsurance associated with lump-sum purchases. We further recommend that the Secretary direct the Administrator of HCFA to provide beneficiaries with written material explaining the regulations on lease-purchase arrangements.

AGENCY COMMENTS AND OUR EVALUATION

HHS stated that HCFA was drafting informational material to be made available to beneficiaries, which will explain the rules regarding Medicare reimbursement for the purchase or rental of durable medical equipment. The HCFA material will advise beneficiaries to ask suppliers about any cost-beneficial lease-purchase plans they may be offering to their customers.

With respect to the broader issue concerning the lease-purchase provision in the regulations, HHS said it did not plan to revise the regulations at this time. HHS said that the manual instructions for the regulations would provide that the carriers (1) cannot require lease-purchase arrangements, (2) should process claims involving lease-purchase plans offered by suppliers that meet the regulatory requirements, and (3) encourage suppliers to develop acceptable lease-purchase plans.

As previously discussed, the basic problem with the regulations as presently written is that it is highly questionable whether any suppliers will voluntarily develop lease-purchase arrangements (where title passes to the beneficiary) that are more economical than lump-sum purchase or the typical short-term rental. In our view, the impasse with the industry over the lease-purchase issue can only be resolved through fostering a more competitive environment by providing suppliers with tangible incentives to offer a lease-purchase plan, irrespective of whether such a plan is more economical than lump-sum purchase or not.

This could be accomplished by requesting proposals in a given area covering selected high-use, high-cost items which would invite the suppliers to offer their most economical lease-purchase proposal, including arrangements for servicing and maintaining the items. The supplier or suppliers, if any, responding with the most attractive offers would enter into an agreement with the area carrier which would establish the standard criteria for determining the upper level of reasonable charges for the covered items. Beneficiaries and their physicians would be informed of the agreement, but could choose any supplier they wanted. However, accumulated rental charges which exceed the total cost under the available lease-purchase plan of the successful offeror or offerors would not be paid by Medicare. Thus, beneficiaries, whose periods of need for the selected high-cost items are uncertain, would have a strong incentive to select the successful supplier or suppliers to avoid exposure to unnecessary financial risk.

We do not know whether this approach would work because of the lack of direct beneficiary involvement in acquiring equipment and the lack of suppliers' interest in lease-purchase arrangements under any circumstances. Nevertheless, in view of the widespread interest in the public and private sectors of using competition as a means for holding down rising health care costs, such an approach, even on a demonstration basis, could provide useful information to test the hypothesis of the competition theory as it relates to this aspect of the Medicare program.

SUMMARY OF EQUIPMENT ITEMS RENTED AFTER OCTOBER 1, 1977, INCLUDED IN SAMPLES

	Oxygen-related equipment		Other medical equipment		Total	
	No. of items	Percent	No. of items	Percent	No. of items	Percent
Total rented items in samples	717	100	441	100	1,158	100
Less items not associated with excess rental	374	52	257	58	631	54
Items associated with excess rentals	343	48	184	42	527	46
Items where excess rentals could have been avoided:						
Items with purchase allowance of less than $60	129	38	63	34	192	36
Items where purchase indicated by duration of need	118	34	44	24	162	31
Subtotal	247	72	107	58	354	67
Items with excess rentals which probably could not have been avoided even if section 16 of Public Law 95-142 were implemented	96	28	77	42	a/173	33
Total items associated with excess rental	343	100	124	100	527	100

a/Includes 50 items where the medical necessity form could not be located and 21 items costing more than $60 at Blue Shield of California where the medical necessity forms were not analyzed.

STATISTICAL METHODOLOGY

The estimates in this report were developed from 10 probability (i.e., statistical) samples taken at six carriers from records of payments to or on behalf of beneficiaries during calendar year 1979. Six separate samples totaling 587 beneficiaries who received payments for oxygen and its related delivery equipment were drawn at six carriers. Four separate samples totaling 401 beneficiaries who received payment for other medical equipment were drawn at four carriers.

The sampling methodology involved three steps. First, because carriers do not separately accumulate data on either other medical equipment or oxygen equipment, we had to develop a universe for each of the 10 samples. The universe we selected was the number of beneficiaries that either rented or purchased oxygen equipment and beneficiaries that either rented or purchased other medical equipment during a specific period of time--calendar year 1979 for four samples and September 1979 for the other six samples. This step was accomplished by separately identifying all vendors (by provider number) that could bill for the two types of equipment.

We then asked the carriers to accumulate separately two lists--beneficiaries associated with paid oxygen equipment claims and beneficiaries associated with paid other medical equipment claims. Because some beneficiaries used more than one vendor, the lists were compared to eliminate duplications.

The second step involved taking random samples of beneficiaries from the "purified" universe of beneficiaries. This was accomplished by using simple random sampling to select the sample beneficiaries at each carrier, except at Kansas City Blue Shield. At that carrier, a random selection procedure was used, in which each beneficiary's probability of selection was proportionate to the number of items for which he or she was reimbursed. At two carriers--New Hampshire/Vermont, and Blue Shield of California--the sample beneficiaries were selected from the payment data for calendar year 1979. At three carriers--Connecticut General, Prudential, and Kansas City Blue Shield--the sample was selected from beneficiaries who had claims paid during September 1979. At the last carrier, General American, the oxygen sample beneficiaries were selected from the payment data for calendar year 1979, while the other equipment beneficiaries were selected from beneficiaries who had claims paid during September 1979. The effect was that for the samples of beneficiaries who had claims paid during September 1979, there were fewer beneficiaries to select from (1 month instead of 1 year), thus slightly understating estimated excess rental payments for those carriers and for all six aggregated. Carrier officials have assured us that the beneficiaries whose claims were paid in September would not differ from beneficiaries whose claims were paid during other months of the year in terms of type of illness, or equipment utilized.

The following table identifies by carrier for each sample the beneficiary universe and number of beneficiaries sampled.

Carrier	Oxygen-related equipment No. of beneficiaries Universe	Oxygen-related equipment No. of beneficiaries Sample	Other durable medical equipment No. of beneficiaries Universe	Other durable medical equipment No. of beneficiaries Sample
New Hampshire/Vermont Blue Cross/Blue Shield	1,424	82	2,276	103
Connecticut General Life Insurance Co.	1,660	100	(a)	(a)
Prudential Insurance Co. of America (Georgia)	1,709	105	7,734	100
Blue Shield of Kansas City	1,084	101	2,504	100
General American Insurance Co. of St. Louis	2,903	98	1,801	98
Blue Shield of California (Northern California)	20,932	101	(a)	(a)
Total	29,712	587	14,315	401

a/Not applicable.

The third and final step involved obtaining calendar year 1979 payment data for each sampled beneficiary. This was accomplished by asking the carriers to produce a payment history for each sampled beneficiary for claims incurred during calendar year 1979. Payments made for either oxygen equipment or other medical equipment were abstracted from these data.

Savings were calculated on an annual basis. Sampling errors of the estimates are shown in appendix III. All sampling errors are stated at the 95-percent confidence level. This means the chances are 19 out of 20 that the estimates obtained from the sample would differ by less than the tabulated sampling error from the results of a review of payments to all beneficiaries.

ESTIMATED COMBINED TOTALS, RATIOS, AND RELATED SAMPLING ERRORS

Item	Estimate for calendar year 1979	Sampling error [±]
Oxygen-related equipment:		
Entire period (note a):		
Amount of excess rental payments	$2,357,900	$880,480
Excess rental payments as a percent of total payments for durable medical equipment	0.3651	0.1363
Period after 10/1/77 (note b):		
Amount of excess rental payments	$1,360,330	$681,700
Excess rental payments as a percent of total payments for durable medical equipment	0.2106	0.1055
Other durable medical equipment:		
Entire period (note a):		
Amount of excess rental payments	$974,100	$443,500
Excess rental payments as a percent of total payments for durable medical equipment	0.3368	0.1533
Period after 10/1/77 (note b):		
Amount of excess rental payments	$632,117	$376,800
Excess rental payments as a percent of total payments for durable medical equipment	0.2185	0.1303

a/Includes equipment items for which rental began both before and after October 1, 1977.

b/Includes only those equipment items for which rental began on or after October 1, 1977.

APPENDIX IV

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 10 1982

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 of a proposed report "Medicare Payments for Durable Medical Equipment Are Higher Than Necessary." 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,

for Richard P. Kusserow
Inspector General

Enclosure

Comments of The Department of Health And Human Services on The General Accounting Office Draft Report, "Medicare Payments For Durable Medical Equipment Are Higher Than Necessary"

GAO Recommendations

That the Secretary of HHS direct the Administrator of HCFA to:

-- Immediately notify the Medicare carriers to (1) stop reimbursements for new rentals of items costing $60 or less, and (2) where possible make analyses of medical necessity forms to determine whether reimbursement on a rental or lump sum purchase basis would be more economical, and pay benefits on the most economical basis.

-- Increase the $60 limit used for requiring purchase to $100 and periodically adjust for inflation.

-- Require carriers to improve their monitoring and retention of the medical necessity forms. Carriers must have the forms completely filled out by physicians in order to make effective rent or purchase decisions.

-- Modify the regulations to recognize that lease - purchase arrangements will generally be more costly than lump-sum purchase and thus would have limited applicability to certain high cost items where the expected period of need is uncertain.

-- Provide beneficiaries with written material explaining the regulations on lease-purchase arrangements.

Department Comment

We concur fully with GAO's concerns. We have addressed in detail each of the issues GAO has raised in operating instructions that have been prepared for the Medicare carriers to implement the amendment. These instructions are consonant with the thrust of the GAO report. They are presently in the clearance process and it is expected that they will be issued this quarter. We do not however, plan to revise the lease-purchase provision in the regulations at this time. The manual instructions we are issuing to the Medicare carriers to implement the regulation will provide that carriers: (1) can not require lease-purchase arrangements; (2) should process claims involving lease-purchase plans that are offered by suppliers and that satisfy the regulatory requirements; and (3) encourage suppliers to develop acceptable lease-purchase plans. In this connection, HCFA is drafting informational materials to be made available to beneficiaries; these materials will explain the new rules regarding Medicare reimbursement for the purchase or rental of durable medical equipment. We will advise beneficiaries to ask suppliers about any cost beneficial lease-purchase plans they may be offering to their customers.

APPENDIX IV

By way of additional comment, we note, in the introductory portion of Chapter 1, it is stated that, because of congressional inquiries about long-term rentals of durable medical equipment, GAO reviewed Medicare reimbursement for durable medical equipment. While GAO acknowledges that the subject is controversial, the draft does not adequately address the interest of certain members of Congress and industry interest in delaying or revoking this provision. The Department needed to assess and respond to these concerns as well.

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