BY THE COMPTROLLER GENERAL

Report To The Chairman Committee On Finance United States Senate

OF THE UNITED STATES

Procedures For Avoiding Excessive Rental Payments For Durable Medical Equipment Under Medicare Should Be Modified

The extent and amount of excess costs resulting from long-term rentals of durable medical equipment have been the subject of two previous studies--one by GAO and another by a Department of Health and Human Services grantee--that reached opposite findings and conclusions. These differences stemmed from the fact that the data on the length of equipment rentals in the two previous studies differed significantly.

GAO reexamined the issue and found that overall, Medicare still pays substantially more to rent some items than it would pay to purchase them. These excess rentals represented about 54 percent of the amounts allowed for lower cost items ($120 or less) and about 34 percent for higher cost items.

GAO is recommending a modification to Medicare's present method of reimbursing for lower cost items that would avoid a greater portion of excess costs and is offering for the Congress' consideration an option for reducing excess costs on higher priced items.

GAO/HRD-85-35
JULY 30, 1985

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

B-219003

The Honorable Bob Packwood
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

In accordance with the previous Chairman's request, we have evaluated the probable effects of implementing certain Department of Health and Human Services (HHS) procedures for avoiding excess rental payments for durable medical equipment under Medicare. We focused on the question of whether implementing such procedures would save Medicare money, as our previous study suggested, or cost the program more, as another study had indicated. This report also discusses a number of other issues raised in the request, such as the appropriateness of lease/purchase arrangements as a cost-saving mechanism under Medicare.

Comments from HHS and two supplier organizations were considered in finalizing the report. The report contains a recommendation to the Secretary of HHS and matters for consideration by the Committee.

As arranged with your office, we are making a general distribution of this report upon its issuance.

Sincerely yours,

Charles A. Bowsher

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CHAIRMAN
COMMITTEE ON FINANCE
UNITED STATES SENATE

PROCEDURES FOR AVOIDING EXCESS RENTAL PAYMENTS FOR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE SHOULD BE MODIFIED

D I G E S T

Medical equipment for use in a beneficiary's home is generally covered by Medicare if medically necessary and prescribed by a physician. This equipment consists of such items as wheelchairs, hospital beds, and commodes. GAO estimates, based on the most current data available, that Medicare expenditures for medical equipment were about $310 million in 1983.

Instructions prepared in July 1982 by the Department of Health and Human Services (HHS) stated that Medicare would pay for all low-priced medical equipment (items costing $120 or less) on a purchase basis and high-priced equipment on a purchase basis if the expected duration of need indicated purchase was less costly than rental.

However, these instructions were not finalized until December 1984 since their effect on program payments was uncertain because of two conflicting reports on the likely outcome of implementation. A July 1982 GAO report--Medicare Payments for Durable Medical Equipment Are Higher Than Necessary (HRD-82-61)--indicated that the instructions would save Medicare money, while an April 1983 study by Williams College under an HHS grant predicted that implementing the instructions would result in higher Medicare payments. (See pp. 1 to 3.)

The Chairman, Senate Finance Committee, asked GAO to evaluate whether savings would result from implementing the instructions. In addition, GAO was asked to address why the GAO and Williams College studies resulted in different findings and conclusions. (See p. 3.)

HOW THE STUDIES' RESULTS DIFFERED

The principal differences in results between GAO's 1982 study and Williams College's study were:

--GAO estimated that excess rental payments were about 35 percent of equipment rental and purchase expenditures in 1979. Williams estimated the excess at about 14 percent of rental payments, but if it had included expenditures for purchases, the estimate would have been about two percentage points lower. As defined by both studies, excess rental payments represent the difference between total Medicare rental payments for an equipment item and Medicare reimbursement for the item if it had been purchased.

--GAO concluded that savings would result from implementing HHS' instructions for reimbursing low-cost items on a purchase basis because about two-thirds of the rented items in its study costing $100 or less would have been cheaper to buy. Williams concluded that implementation would increase the cost by about 15 percent.

--GAO concluded that with improvements in completing and maintaining the documentation from the beneficiaries' physicians, adequate information would be available to estimate the duration of need and to make appropriate rent/purchase decisions on the high-cost items. Williams disagreed because the probable "errors" in making such decisions would offset maximum potential savings. (See pp. 17 and 18.)

WHY THE STUDIES DIFFERED

The primary reason why the studies' conclusions differed related to episode lengths. An episode is a beneficiary renting a single piece of equipment over a period of time.

GAO's 1979 sample data showed substantially fewer short-term rentals than Williams' 1976-77 data (22 percent versus 64 percent for episodes lasting 1 or 2 months) and substantially more long-term rentals (33 percent versus 8 percent for episodes lasting more than 12 months). The greater the number of short-term rentals, the greater the likelihood of Medicare losing money by requiring purchase, because the purchase price is more apt to exceed the rental costs. The reverse is true for long-term rentals.

Therefore, the substantially different reported episode lengths resulted in the different conclusions reached by GAO and Williams College. (See p. 18 to 22.)

GAO'S PRESENT POSITION

To determine whether GAO's or Williams College's data more accurately reflected the distribution of rental lengths, GAO analyzed 1981-83 data at the two locations from each study that most heavily influenced the studies' results. That is, from the seven locations covered by the Williams' study, GAO selected Idaho and southern California because these locations reportedly had the highest percentages of short-term rentals. And, from the six locations covered by GAO's study, GAO selected Georgia and a location covering parts of Kansas and Missouri for re-review because these locations had the lowest percentages of short-term rentals.

GAO's current findings about the extent of excessive equipment rentals still differ from the Williams study. Based on the 1981-83 rental episode data for the four locations, GAO identified excessive rentals of about 39 percent of allowed charges as compared with the 14 percent reported by Williams in April 1983. (See pp. 24 and 25.)

Findings on low-cost items

GAO's current data indicate that under present instructions, if all low-cost items in the four locations reviewed, were reimbursed on a purchase basis, the allowed charges for these items would have been reduced by about 21 percent as compared with the 15-percent increase in costs reported earlier by Williams.

The distribution of rental episode lengths at five other locations included in the Williams' study and at three other locations included in the earlier GAO study showed similar or fewer short-term rentals and similar or more long-term rentals than were identified at the four locations in the current GAO study. (See pp. 20 and 23.) Therefore, GAO's conclusions concerning the effect of the HHS instructions on low-cost items considered data from 12 locations.

GAO also found that HHS could increase the savings from 21 to 30 percent and achieve greater uniformity of savings at three of the four locations in its current review by allowing beneficiaries one month's rent (to see if they will need the item longer) before limiting reimbursement to a purchase basis. The cost of the additional month's rent would be more than offset by the "savings" achieved by allowing a month's rent for beneficiaries who needed an item for only one month instead of encouraging them to buy it. (See ch. 3.)

Findings on high-cost items

While GAO's data showed that excess rentals were 34 percent of total allowed charges for high-cost equipment, GAO found that sufficient data are not available to reliably predict when purchasing an item would be less costly than renting it. Also, excess rentals occurred in only 18 percent of the total rentals. In its 1982 report, GAO concluded that cost-effective rent-purchase decisions can be made if physicians were required to provide more complete data on patient medical needs on the medical necessity forms they complete. Although GAO noted some improvements in the availability of those data, overall GAO found that the data continued to be unreliable for predicting the anticipated period of need.

Therefore, because of the risk of increased costs if the carriers' purchase decisions prove to be incorrect, GAO now generally agrees with Williams' earlier conclusions regarding the probability that savings from implementing HHS' existing instructions for high-cost items would be uncertain.

Alternative reimbursement approach for high-cost items

Nevertheless, because the excess rental allowances for the high-cost items were about 34 percent of total allowed charges, GAO believes the problem needs attention. Therefore, GAO simulated the potential savings from implementing several alternative solutions that do not require the use of medical necessity forms to reduce the excess charges, including one proposed by a durable medical equipment trade association.

The most promising approach simulated involved "capping" the amount of equipment rental payments. At least two state Medicaid programs covering the health care costs of the poor essentially provide limits, or "caps," on the amount of equipment rental payments based on the percentage of the purchase allowance of an item. GAO simulated this approach with limits of 125, 150, 175, and 200 percent of the purchase price. This simulation showed that even at a 200-percent limit, about one-third of the excess rental allowances could have been avoided.

GAO believes that the principal disadvantage of the "cap" approach is that to protect beneficiaries, durable medical equipment suppliers would have to agree to accept whatever percentage is adopted as they are required to do under Medicaid. Presently, Medicare does not require that suppliers accept Medicare payment rates, so without an amendment to the law, suppliers could simply charge beneficiaries for any difference between Medicare's "cap" and the total rental charges for as long as the item is needed. (See ch. 4.)

RECOMMENDATION TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

GAO recommends that HHS modify the December 1984 instructions dealing with the reimbursement of low-cost items on a purchase basis to authorize a 1-month waiting period and to implement the modified instructions. With respect to the high-cost items, because of the uncertainty as to whether implementing the December 1984 instructions would result in avoiding excess rental allowances, GAO is making no recommendations as to their implementation. (See pp. 40 and 62.)

MATTERS FOR CONSIDERATION BY THE SENATE COMMITTEE ON FINANCE

Because of the potential savings involved, GAO believes the Committee should consider whether a legislative change is warranted that limits rental allowances for high-cost durable medical equipment items to a specific percentage in excess of the purchase allowance and also requires suppliers to accept whatever percentage is adopted. (See p. 62.)

AGENCY, SUPPLIER, AND WILLIAMS' COMMENTS

GAO obtained written comments on a draft of the report from HHS and two supplier organizations. These comments are included in appendixes III to V. GAO also requested written comments from the two principal authors of the Williams College study, but received none. (See p. 26.)

HHS did not agree with GAO's recommendation that it modify the December 1984 instructions dealing with the reimbursement for low-cost items to authorize a 1-month waiting period. Apparently, HHS assumes that beneficiaries who need low-cost items are in a position at the onset of their need to make prudent decisions on whether to purchase or rent. However, to the extent that beneficiaries who decide to rent find that they need the item for a prolonged period, they will incur unreimbursed charges because Medicare rental payments would generally stop after 3 to 6 months. GAO believes that, if the beneficiaries are allowed a 1-month waiting period, they will generally be in a better position to make the rent/buy decision because they will have more information on the length of time the equipment will be needed. This, in turn, will decrease the beneficiaries' risk of incurring unreimbursed charges. Moreover, GAO's simulations of actual rental data show that providing incentives for 1-month rentals would increase program savings. (See p. 40.)

The supplier association comments focused on their support for implementing the HHS December 1984 instruction for low cost items and their strong opposition to implementing the instruction for high-cost items which required that rent purchase decisions be made on a case-by-case basis. Both associations supported the "cap" approach proposed by GAO and a similar one proposed by the industry as being better than the HHS approach. HHS also expressed support for the GAO proposed approach because it would be administratively simpler than the HHS approach and would be likely to produce the most certain program savings. (See pp. 62 and 71.)

Contents

ILLUSTRATIONS

ABBREVIATIONS

DME	durable medical equipment
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
NAMES	National Association of Medical Equipment Suppliers

CHAPTER 1

INTRODUCTION

Under Medicare, durable medical equipment (DME) for use in a beneficiary's home is generally covered under the Supplementary Medical Insurance or Part B portion of the program if medically necessary and prescribed by a physician. DME consists of such well-known items as wheelchairs, hospital beds, and commodes. It also includes less familiar items, such as concentrators, which take oxygen out of air and electronically concentrate it, and regulators, which regulate the flow of oxygen gas from tanks. We estimate that Medicare expenditures for DME were about $310 million in 1983, excluding oxygen gas and liquid oxygen. DME can be purchased or rented; however, for the four locations we reviewed (which may not be representative nationally), about 86 percent of the expenditures were for equipment rentals and about 14 percent of the rentals lasted longer than a year.

Uneconomical long-term equipment rentals were supposed to have been alleviated by section 16 of Public Law 95-142. This legislation generally required reimbursement for equipment on a purchase basis when more economical or practical than rental. The law was effective for equipment rented or purchased on or after October 1, 1977. Regulations were issued in July 1980 to become effective in December 1980.

In July 1982, the Health Care Financing Administration (HCFA), which administers Medicare, issued instructions to its claim processing contractors (called carriers) on how to implement the 1977 law and related regulations. The new instructions were to be implemented as soon as HCFA issued other instructions to its carriers on the review process for equipment claims. In December 1984, HCFA issued these other instructions as well as a revised version of the July 1982 operating instructions, which were implemented in February 1985. The December 1984 instructions were essentially the same as the July 1982 version, but HCFA had waited to implement them partly because of uncertainty as to whether their implementation nationwide would save the program money.

Under the regulations and instructions, carriers will have broad authority to reimburse for DME on the basis of rental or purchase, whichever is the most economical and effective method of acquiring it. The HCFA instructions generally

--require reimbursement on a purchase basis for inexpensive items costing $120 or less,

--require reimbursement on a rental or purchase basis depending on which arrangement would be least costly for items costing more than $120,

--allow reimbursement on a lease/purchase basis[1] when advantageous to the program and the beneficiary and when less costly than lump-sum purchase, and

--allow 100-percent reimbursement of the allowed charges for used equipment only when suppliers provide the same warranty for used as for new equipment.

The instructions allow for interim rental payments for up to 6 months on items costing over $120 before a rent/purchase decision must be made. The interim rental payments would be in addition to any purchase payment. Also, the regulations and instructions consider the possible financial hardship to a beneficiary for large coinsurance amounts on lump-sum purchases by allowing carriers to pay up to 3 months' rentals while the beneficiary makes purchase arrangements.

The problem of excessive rental payments--which the HCFA regulations are intended to minimize--was the subject of previous GAO and HCFA-financed studies. In July 1982 we issued a report entitled Medicare Payments for Durable Medical Equipment Are Higher Than Necessary (HRD-82-61). In this report we estimated, based on 10 statistically random samples involving 1,595 episodes at six carriers, that excess rental payments for items rented after October 1, 1977, totaled about $2 million, or about 21 percent of their total 1979 equipment payments. We estimated that about one-third of these excess payments could have been avoided if the 1977 law had been implemented in 1977. The report recommended that HCFA require reimbursement on a purchase basis for items costing $100 or less and the purchase of items costing more than $100 when more economical than rental based on the anticipated period of need.

In April 1983, under a HCFA grant, Williams College issued a study entitled Determinants of Current and Future Expenditures on Durable Medical Equipment by Medicare and its Program Beneficiaries. The study was based on an analysis of 21,658 rental "episodes" that occurred in seven states in calendar years 1976 and 1977. An episode was defined as a beneficiary renting a

---

[1]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.

single item for 1 or more months. The study simulated the costs of HCFA's new regulations and concluded that the regulations should not be implemented because, under assumptions Williams said were reasonable, their implementation would increase program costs.

WHAT WE WERE ASKED TO DO

The Chairman of the Senate Committee on Finance requested us to evaluate the responsiveness of HCFA's July instructions to the concerns expressed in HRD-82-61 and to determine if HCFA's reimbursement modifications adequately address equipment supplier associations' concerns regarding the rent/purchase issue. These matters, as well as the probable results of implementing the instructions, are discussed in chapters 3 and 4.

The staffs of other committees also contacted us and expressed interest in these issues and in particular why the GAO and Williams College studies resulted in different findings, conclusions, and recommendations. The reasons for these differences are discussed in chapter 2. In addition, the Finance Committee Chairman asked us to

- --assess the appropriateness of lease/purchase as a cost-saving mechanism,
- --determine the equity of requiring new equipment warranties on used equipment, and
- --evaluate the adequacy of Medicare reimbursement for equipment.

These three issues are discussed in chapter 5.

MEDICARE BACKGROUND

The Medicare program was authorized 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, pays much of the health care costs for eligible persons 65 or older and certain disabled persons. The program is administered by HCFA, which is in the Department of Health and Human Services (HHS).

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 1983 over 29 million

people were eligible for Part A benefits, and benefit payments amounted to $38.7 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. Enrollment in Part B is voluntary. Part B is financed by beneficiaries' monthly premium payments and appropriations from general revenues. During fiscal year 1983 an average of 28.7 million people were enrolled in Part B, and benefit payments amounted to about $17.2 billion, of which about 23 percent was financed by enrollees' premiums and about 77 percent by appropriations.

HCFA administers Part B benefits furnished by non-institutional providers, such as doctors, laboratories, and suppliers, with the assistance of 40 carriers under contract with the government. Carriers' payments of claims are usually on the basis of reasonable charges. Twenty-seven of the carriers are Blue Shield plans, 12 are commercial insurance companies, and 1 is a state agency. DME and oxygen involve primarily Part B claims and are paid by the carriers. We estimate that Medicare payments for DME were about $310 million in 1983. We estimate there were additional payments of about $85 million for oxygen gas and liquid oxygen, which of course is only purchased, not rented.

DURABLE MEDICAL EQUIPMENT

HCFA instructions define DME as equipment that

--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.

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, oxygen regulators, crutches, commodes, and traction equipment are considered to be DME.

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 rentals. The Social Security Amendments of 1967 (81 Stat. 821), approved January 1968, provided for reimbursement for either DME purchase or rental. 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 either

--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 the costs of DME, 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 HHS' judgment did 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. Medicare pays for two DME items (standard wheelchairs and standard hospital beds) under the lowest charge level rule.

Concerning the rent/purchase issue, section 245 of the 1972 Social Security Amendments authorized HHS to experiment with reimbursement approaches and to implement without further legislation any purchase approach found to be workable, desirable, and economical.[2] Also, the amendment permitted the waiver of the 20-percent coinsurance requirement on the purchase of used equipment where the purchase price was at least 25 percent less than the reasonable charge for new equipment.

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

---

[2]This legislation was based in part on a GAO report to the Congress entitled Need for Legislation to Authorize More Economical Ways of Providing Durable Medical Equipment Under Medicare (B-164031(4), May 12, 1972).

against excessive expenditures caused by prolonged equipment rentals. The legislation required 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, to reimburse on the basis of a lump-sum purchase or a lease/purchase arrangement. HHS could, despite such a determination, authorize equipment rentals if requiring purchase would impose an undue financial hardship on the beneficiary.

HHS was also directed 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 that authorized the Secretary to waive the 20-percent coinsurance requirement regarding 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, the regulations had not been applied until December 1984 because of uncertainty as to whether they would result in program savings.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our major review objective was to determine if HCFA's regulations and related July 1982 carrier instructions will decrease DME costs, as suggested in HRD-82-61, or increase costs, as the Williams College study predicts. Specific assignment objectives were to

- --determine the relative accuracy of the data in the GAO and the Williams College studies by identifying the relative lengths of DME rentals using the Williams' methodology;

- --evaluate the feasibility and effects of alternative reimbursement methods, such as the New York Blue Cross/Blue Shield and National Association of Medical Equipment Suppliers (NAMES) proposals, as well as other reimbursement approaches, such as capping total rental payments and allowing DME rentals for up to a 6-month period before requiring a purchase decision; and

- --evaluate the reasonableness of HCFA's proposed reimbursement requirements and their responsiveness to HRD-82-61 and supplier association concerns.

Our analysis was conducted using computer tapes of allowed DME claims for the service areas of the four carriers shown below.

Carrier	Service area
Blue Shield of Kansas City	Portions of Missouri and Kansas
Prudential Insurance Company of America	Georgia
Transamerica Occidental Life Insurance Company	Southern California
The Equitable Life Assurance Society of the United States	Idaho

The combination of carriers and service areas selected provides a mix of data used by GAO and Williams College in previous studies of DME rentals. One of the reasons for the differences in conclusions reached by our 1982 study and the Williams study was the different distribution of rental episode lengths. The 1976-77 data used by Williams College showed significantly more (64 percent versus 22 percent) short-term (1 or 2 month) rental episodes and significantly fewer (8 percent versus 33 percent) long-term (over 1 year) episodes than the data used in our 1982 study. Accordingly, one of our objectives was to apply Williams' basic methodology at the same carriers using more current data. Two carriers were selected from the Williams study, and two carriers were selected from our previous study to determine which data were more accurate. The rationale for selecting the four carriers follows.

We selected two of the seven locations and the related carriers (Occidental for southern California and Equitable for Idaho) included in the Williams study because they accounted for about 45 percent of the study's 21,658 episodes and because the data for these two locations showed significantly more short-term rentals and fewer long-term rentals than the data for the other five (see ch. 2). Williams officials had suggested we include Occidental in our analysis because data from that carrier made up about 40 percent of their data base. In addition, it was not feasible to include the carrier and location in the Williams' study that accounted for the second highest percentage of episodes--about 27 percent. This location had been consolidated with the location of another carrier after 1977, and more current comparable data for that location were not readily available.

We selected two of the six locations and related carriers (Kansas City Blue Shield for portions of Missouri and Kansas and Prudential for Georgia) included in HRD-82-61 because they accounted for about 49 percent of our prior study's 1,595 sample episodes. We also selected these locations because we wanted to determine whether one of the sampling techniques used in HRD-82-61 yielded a typical episode length, particularly for short-term rentals. For that report, six statistical samples were selected from beneficiaries renting or purchasing DME during a 1-month period, and four statistical samples were selected from beneficiaries renting or purchasing DME for a 1-year period.

These samples consisted of 1,437 items that were reconstructed from the working papers of our prior review into 1,595 rental episodes for comparison with one another and with Williams' data. The sample episodes from the 1-month period showed fewer short-term rentals (about 18 percent) than the sample episodes from the 1-year period (about 34 percent). Four of the six samples selected from the 1-month period were from Kansas City Blue Shield (two samples) and Prudential in Georgia (two samples) and included both oxygen- and non-oxygen-related items. These were the only locations from our prior study with samples from a 1-month period that included both types of equipment. These four samples consisted of 785 episodes. By using computer tapes, Williams' rental episode methodology can establish the length of all DME rentals starting during a specified time period and thus produce a much larger data base than either of our prior sampling techniques. Therefore, we applied the rental episode methodology to more current data at the two carriers for comparison with the data from our prior study.

The information used in our episode analysis for Kansas City Blue Shield was based on a computer tape of DME claims obtained from the HHS Regional Audit Office of the Inspector General in Kansas City, Missouri. The Regional Audit Office also provided schedules and other materials developed in its computer-assisted analysis of DME claims. The information used in our episode analysis for Equitable in Idaho, Occidental in southern California, and Prudential in Georgia is based on computer tapes of DME claims obtained from the carriers. The tapes from Occidental and Prudential covered DME transactions that the carriers had extracted from total Medicare payment transactions. The tape obtained from Equitable included all Medicare transactions. On all tapes we excluded oxygen gas, liquid oxygen, and certain expendable supplies that can only be purchased.

Our analysis did not include a reliability assessment of the computer systems used to generate the data provided by the carriers, but did include several edits to determine if the

tapes provided included data for the periods requested and represented only valid DME procedure codes.

The periods covered by the tapes and the amounts of allowed charges, which totaled about $76.6 million for rentals and purchases, are summarized in the following table. The classes or types of items are listed in appendixes I and II.

Summary of Allowed Charges for DME Items
Rented and Purchased at the Four Carriers Reviewed

Location	Period	Oxygen-related DME			Non-oxygen-related DME			Grand total
		Rented	Purchased	Total	Rented	Purchased	Total	
		(000 omitted)						
Idaho	10/ 1/80 to 1/12/83	$ 637	$ 51	$ 688	$ 81	$ 248	$ 329	$ 1,017
Georgia	10/ 1/80 to 6/30/83	8,441	139	8,580	9,938	2,078	12,016	20,596
Southern California	10/ 1/80 to 12/31/82	15,342	923	16,265	21,435	5,320	26,755	43,020
Portions of Kansas/ Missouri	10/ 1/80 to 1/31/83	5,083	56	5,139	4,865	1,976	6,841	11,980
Total		$29,503	$1,169	$30,672	$36,319	$9,622	$45,941	$76,613

We developed a computer program that identified DME rental episodes with initial dates of service in either the third, fourth, or fifth month of tape history (December 1980, January 1981, or February 1981). We began with the third month in the tape history to ensure that we identified only new rental episodes. The program then searched the remaining months in the tapes to calculate how long an episode lasted.[3] Our analysis assumed that a 2-month period without a rental charge constituted a break in the rental of the item and the end of the rental episode.

[3]Williams officials agreed that this methodology was appropriate to test the validity of its study data and our data in HRD-82-61.

The maximum number of months that rental episodes could be tracked is summarized below by location. Because the tapes identified an item of equipment for each beneficiary by procedure code, we could not be certain that a beneficiary was renting the same piece of equipment during an entire episode. For example, a piece of equipment could have been replaced because the original item needed to be repaired.

	Maximum number of months a rental episode could be tracked
Idaho (Equitable)	23 to 25
Georgia (Prudential)	29 to 31
Southern California (Occidental)	23 to 25
Kansas/Missouri (Kansas City Blue Shield)	24 to 26

The amount of allowed rental charges and the number of rental episodes included in our analyses are summarized in the following table.

Prevailing charge for purchase	Idaho		Georgia		Southern California		Portions of Kansas and Missouri		Total	
	Number of episodes	Allowed charges	Number of episodes	Allowed charges	Number of episodes	Allowed charges	Number of episodes	Allowed charges	Number of episodes	Allowed charges
$120 or less	173	$ 7,835	2,136	$ 168,534	11,185	$ 790,758	2,135	$ 384,128	15,629	$1,351,255
More than $120	183	76,769	3,153	1,232,620	7,255	1,873,633	1,225	680,054	11,816	3,863,076
Undetermined[a]	6	406	26	4,406	809	229,035	119	32,069	960	265,916
Total	362	$85,010	5,315	$1,405,560	19,249	$2,893,426	3,479	$1,096,251	28,405	$5,480,247

[a]Rental episodes for which a prevailing purchase allowance could not be determined.

Our approach in addressing the remaining issues in the Chairman's request was as follows.

To address the supplier associations' concerns regarding the rent/purchase issue and to evaluate the adequacy of Medicare reimbursement for DME, we met several times with representatives of two of the organizations to obtain specific information. In addition we agreed to simulate the probable effects of an alternative reimbursement method proposed by one organization with our rental episode data. One specific concern--that the Medicare allowances for DME purchased items were too low--was not fully addressed, however, because we were not given verifiable data on how much the suppliers actually paid for such items.

To assess the appropriateness of lease/purchase as a cost-saving mechanism, we inquired about the existence of such an arrangement for DME items under Medicare and identified none; however, to the extent that the alternative proposals contained features of a lease/purchase arrangement, the probable effects were simulated. In addition, we reviewed the individual state charts contained in the Commerce Clearing House Medicare and Medicaid Guide to determine whether any states had adopted a lease/purchase type of arrangement for DME under their Medicaid programs.[4] If it appeared that they had, we contacted the states and obtained their reimbursement regulations and other descriptive information concerning the reimbursement methodology used.

To assess the equity of requiring new equipment warranties on used equipment, we examined selected manufacturers' warranties and discussed the issue with supplier and carrier representatives.

We performed our review in accordance with generally accepted government auditing standards.

---

[4]Medicaid is a federal grant program that assists the states in paying for medical services provided to eligible low-income persons and families. The states initiate, design, and operate their programs within broad federal requirements.

Although our audit work and analysis focused on the July 1982 instructions, we reviewed the December 1984 version, which was essentially the same, and reexamined our findings in light of any language changes in the current version.

In commenting on a draft of this report, NAMES took exception to certain features of our methodology, particularly regarding our approach to computing excess rental costs. However, because NAMES' comments included a number of criticisms that we do not agree with or involve proposed adjustments to our computations based on inadequate or unavailable data, such comments are not summarized in the body of this report, but are analyzed in detail in appendix IV.

CHAPTER 2

FINDINGS AND CONCLUSIONS OF PREVIOUS DME STUDIES DIFFER

According to HCFA officials, one reason why the July 1982 HCFA instructions had not been implemented in 1982 was because of the uncertainty about whether they would save Medicare money or cost it more. Contributing to this uncertainty was that the findings and conclusions of the July 1982 GAO and the April 1983 Williams College studies concerning the probable effects of implementing the instructions differed in three important respects.

--The first difference involved the extent of excess rentals. We estimated that excess rental payments[1] were about 35 percent of DME expenditures, but Williams College estimated the excess at only about 14 percent of rental payments.

--The second difference pertained to the cost effectiveness of reimbursing low-cost items, such as regulators, walkers, and commodes, on a purchase basis. We had concluded that savings would result from implementing such a policy because two-thirds of the items included in our sample, rented after October 1, 1977, and costing $100 or less to buy, resulted in excess rentals. Williams College concluded that implementing such a policy would increase the costs of such items by about 15 percent.

--The third difference pertained to the feasibility of reimbursing for the higher cost items, such as wheelchairs, on a rent or purchase basis depending on the anticipated period of need. We assumed that with

---

[1]As generally defined in both studies, excess rental payments represent the difference between total Medicare rental payments for a DME item and Medicare reimbursement for the item if it had been purchased.

Neither study reflected the "interest costs" associated with the earlier cash outlay if an item is purchased instead of rented or the "interest benefits" associated with avoidance of rentals in excess of the purchase allowance. However, our analysis of selected items of DME with a purchase allowance of under $120 showed that the net interest cost associated with outright purchase were nominal (from 1 to 3 percent of the purchase allowance).

improvements in completing and maintaining physicians' medical necessity forms, which are required to justify the acquisition of DME items, adequate information would be available for carriers to make appropriate rent/purchase decisions. The Williams study disagreed based on the assumption that "incorrect" purchase decisions and the carrier costs of administering the provision would offset any potential savings.

Our current review showed the following: (1) Excessive rental allowances were about 39 percent of allowed rental charges for all items (54 percent for low-cost and 34 percent for high-cost). (2) Depending on the location, if all items were purchased, the HCFA instructions pertaining to low-cost items would have avoided from 9 to 86 percent of the excessive rental payments for such items at three of the four locations studied; but if the instructions were modified to permit some rentals, from 38 to 83 percent of the excess rentals would have been avoided. (3) Because improvements in completing and maintaining the medical necessity forms had not occurred, using the information from the form in making rent/purchase decisions may not be feasible. Additional information on the two studies and the reasons for the different findings and conclusions follow.

OUR STUDY AND THE HCFA-FINANCED STUDY ARRIVED AT DIFFERENT CONCLUSIONS

The problem of excessive DME rental payments--which the HCFA July 1982 instructions are intended to minimize--has been the subject of previous HCFA-financed and GAO studies. In our July 1982 report, we estimated, based on 10 random statistical samples at six carriers,[2] that for items rented after October 1977, the excess rental payments were about $2 million, or 21 percent of these carriers' total 1979 DME payments for

---

[2]The carriers and locations were (1) New Hampshire Vermont Blue Cross/Blue Shield (New Hampshire), (2) Connecticut General Life Insurance Company (Connecticut), (3) Prudential Insurance Company of America (Georgia), (4) Kansas City Blue Shield (parts of Kansas and Missouri), (5) General American Insurance Company of St. Louis (the rest of Missouri), and (6) Blue Shield of California (northern California). The carriers were selected to cover various sections of the country, but as noted in the report, the sample results could not be projected nationwide.

oxygen- and/or non-oxygen-related equipment.[3] We also estimated that about one-third of these excess payments could have been avoided if the 1977 law had been implemented requiring Medicare reimbursement based on the purchase of DME items when more economical than rental. In HRD-82-61 we recommended that HCFA require carriers to reimburse on a purchase basis for items costing $100 or less and for the more expensive items if the anticipated period of need indicated that purchase would be more economical.

In April 1983, Williams College, under a HCFA grant, issued a report entitled Determinants of Current and Future Expenditures on Durable Medical Equipment by Medicare and its Program Beneficiaries. The study included simulations of alternative DME reimbursement policies. The simulations were based on an analysis of a sample of 21,658 DME rental episodes that occurred at seven locations involving four Medicare carriers during an

---

[3]Because section 16 of Public Law 95-142 was effective October 1, 1977, excess rental payments for rental episodes starting before that date were not included in this estimate.

The sampling errors at the 95-percent confidence level were plus or minus 11 percent for oxygen-related equipment and plus or minus 13 percent for the non-oxygen items. For rental episodes beginning both before and after October 1, 1977, the comparable amount was about $3.3 million, or about 35 percent of the carriers' 1979 total DME payments for oxygen- and/or non-oxygen-related equipment. The sampling errors were plus or minus 14 percent and 15 percent, respectively.

18-month period from February 1, 1976, through July 1977.[4] The report concluded that HCFA's new instructions should not be implemented because, under the assumptions used by Williams, the new requirements would result in increased program costs.

Differences between Williams College and prior GAO findings

The major differences between our prior findings based on the 1979 sample data and Williams findings based on 1976-77 data involved (1) the percentages of DME expenditures that were estimated as excessive, (2) the potential savings that would result from reimbursing low-cost items on a purchase basis, and (3) the feasibility of carriers making rent/purchase decisions for high-cost items based on the estimated duration of need. We estimated that about 35 percent of calendar year 1979 DME expenditures (including those for purchases) for the locations studied represented excessive rental payments; the most comparable Williams' estimate was 14 percent of rental payments. We estimated that about one-third of the 1979 excess rental payments

---

[4]The carriers and locations were as follows: (1) Equitable (Idaho), (2) Occidental (southern California), (3) The Travelers (parts of Minnesota and Virginia and all of Mississippi), and (4) Group Health, Inc. (Dade and Monroe Counties in Florida and Queens County in New York).

The selection of carriers for the Williams study was dictated by the use of payment history tapes from a previous HCFA-financed DME study authorized by section 245 of the Social Security Amendments of 1972. Under this previous study entitled Reimbursement for Durable Medical Equipment, dated March 1980, by Exotech Research and Analysis Incorporated, 19 carriers serving all or parts of 37 states were invited to participate, of which only 5 involving 11 states agreed to do so. For various reasons, Williams discarded the data for one carrier and four of the locations, which resulted in the use of data for four carriers and seven locations. As noted in the Exotech study, these constraints based on the voluntary participation of carriers precluded a statistical sampling approach for selecting carriers. In effect, this limitation in the selection of carriers was carried forward to the Williams College study, which used the Exotech tapes in developing its rental episodes. Despite this limitation, Williams had concluded that its data were representative of the country as a whole although, as shown by the table on page 21, its own data suggested that there could be significant variations in the lengths of DME rentals by location.

for items rented after October 1977 could have been avoided if items costing $100 or less were reimbursed on a purchase basis; Williams concluded that HCFA's instructions with respect to low-cost items would increase Medicare costs for these items by about 15 percent based on the assumption that all such items would be reimbursed on a purchase basis.[5]

We concluded that with the recommended physician and carrier improvements in completing and maintaining medical necessity forms,[6] adequate information would be available to make rent/purchase decisions for the higher cost items. Williams disagreed and concluded that a carrier error rate as low as 20 percent in making rent/purchase decisions would cut more than half of the maximum potential savings without regard to other variables, such as carrier administrative costs for implementing the instructions, which would further reduce the potential savings.

Differences in episode lengths

A major reason for the different findings and conclusions involved the distribution of DME rental episode lengths. We identified a higher percentage of rentals lasting longer than 12 months and a smaller percentage lasting 1 and 2 months than did Williams. The following comparison of the rental episode lengths in the two studies shows that about 64 percent of the Williams study's episodes were for 1 and 2 months and only about

---

[5]Although not included in the report, the most comparable GAO estimate based on the 1979 samples was about a 42-percent decrease in Medicare costs for such items.

[6]To be covered by Medicare, DME should be prescribed by a physician. Accompanying the prescription are medical necessity forms that justify the need for the item and are supposed to include information on the expected duration of need.

8 percent were over a year. Our sample data from the six carriers included in the 1982 report showed 22 percent were for 1 and 2 months and 33 percent lasted more than a year.[7]

Length of rental episode (months)	Williams (7 locations)		GAO 1979 sample data (10 samples)	
	Number	Percent	Number	Percent
1 and 2	13,796	63.7	351	22.0
3 to 6	4,338	20.0	373	23.4
7 to 12	1,878	8.7	344	21.6
Over 12	1,646	7.6	527	33.0
Total	21,658	100.0	1,595	100.0

To some extent, the difference in rental episode lengths may have been caused by different sampling techniques. We selected our samples of beneficiaries renting or purchasing DME items from both 1-year and 1-month periods as opposed to the William episode methodology. Based on data reconstructed from the working papers of our prior review, the samples for the different periods showed different distributions of short-term (1- and 2-month) rentals. Samples from 1-month periods may have understated the incidence of short-term rentals and accordingly overstated the potential savings from purchasing low-cost items because the offsetting "losses" would be understated. This would occur because if items rented for only 1 or 2 months had been reimbursed on a purchase basis, the program would have paid more to purchase than to rent. The distribution of rentals based on the different sampling periods is shown on the following table.

---

[7]We arranged the distribution of episode lengths by intervals of 1 and 2 months, 3 to 6 months, 7 to 12 months, and over 12 months to limit the amount of data presented and to facilitate comparisons. Episodes of 1 and 2 months would almost always result in program losses if reimbursed on a purchase basis; episodes from 3 to 6 months would usually not result in much savings but any losses would also be minimal so they would tend to be neutral with regard to the rent/purchase issue. Except for certain items where the frequency of episodes was relatively low, episodes of from 7 to 12 months represent potential savings if reimbursed on a purchase basis, and for episodes of over 12 months, rental allowances were probably two or more times the purchase allowances.

Length of rental episodes (months)	Rental episodes based on: September 1979 samples (6 samples) Number	Percent	CY 1979 samples (4 samples) Number	Percent
1 and 2	209	17.8	142	33.5
3 to 6	281	24.1	92	21.7
7 to 12	273	23.3	71	16.7
Over 12	408	34.8	119	28.1
Total	1,171	100.0	424	100.0

The probable effect of this sampling technique is shown in the following table, which compares DME rental episode lengths in Georgia and parts of Missouri and Kansas in our 1-month samples in 1979 and in our current review, which included all rental episodes in these locations that began in December 1980 and January and February 1981.

Length of rental episodes (months)	Rental episodes based on: GAO September 1979 samples (4 samples) Number	Percent	GAO (1981-83) Rental episode data Number	Percent
1 and 2	123	15.7	3,712	42.2
3 to 6	203	25.9	2,043	23.2
7 to 12	206	26.2	1,205	13.7
Over 12	253	32.2	1,834	20.9
Total	785	100.0	8,794	100.0

Differences in carriers and locations

Another possible reason for our prior data and findings differing from the Williams' data and findings is that none of the carriers and/or locations were the same. Although we cannot quantify the impact of this difference, our analyses of Williams' rental episode data by location shows that there were significant differences in the distribution of DME episode lengths for Idaho and southern California, which represented 45 percent of the total 21,658 episodes, and the other five locations included in that study. These differences are shown in the following table.

Length of rental episodes (months)	Minnesota		Mississippi		Virginia		Florida		New York		Subtotal		Idaho and southern California		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1 and 2	713	60.0	893	40.4	628	48.7	3,026	51.0	661	51.8	5,921	49.8	7,875	80.7	13,796	63.7
3 to 6	255	21.4	587	26.6	309	23.9	1,419	23.9	325	25.4	2,895	24.3	1,443	14.8	4,338	20.0
7 to 12	107	9.0	378	17.1	227	17.6	684	11.6	162	12.7	1,558	13.1	320	3.3	1,878	8.7
Over 12	114	9.6	352	15.9	127	9.8	799	13.5	129	10.1	1,521	12.8	125	1.2	1,646	7.6
Total	1,189	100.0	2,210	100.0	1,291	100.0	5,928	100.0	1,277	100.0	11,895	100.0	9,763	100.0	21,658	100.0

As shown in the above table, the data from Idaho and southern California tended to increase the percentage of short-term rentals and lower the percentage of long-term rentals in the overall Williams data base.

DIFFERENCES BETWEEN WILLIAMS' AND CURRENT GAO RENTAL EPISODE DATA

A comparison of Williams' 1976-77 rental episode distribution for Idaho and southern California with our 1981-83 episode data for the same locations using essentially the same methodology is summarized in the following table.

Length of rental episode (months)	Idaho				Southern California			
	Williams 1976-77		GAO 1981-83		Williams 1976-77		GAO 1981-83	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1 and 2	2,156	85.7	220	60.8	5,719	78.9	10,570	54.9
3 to 6	241	9.6	66	18.2	1,202	16.6	4,481	23.3
7 to 12	77	3.0	32	8.8	243	3.4	1,985	10.3
Over 12	42	1.7	44	12.2	83	1.1	2,213	11.5
Total	2,516	100.0	362	100.0	7,247	100.0	19,249	100.0

As the table shows, we identified comparatively fewer short-term (1- and 2-month) and more long-term (over a year) episodes than the Williams study in Idaho and southern California. Further, we believe that the data for Idaho (which is the fourth smallest carrier in the country in terms of the number of claims processed) were given too much weight in the Williams study.

For example, the seven carrier locations in the Williams study processed about 12,349,000 Medicare claims during the period October 1977 through September 1978. The carrier in Idaho processed about 307,000, or 2.5 percent of them. In contrast, of the 21,658 DME rental episodes in the Williams study, the Idaho carrier represented 2,516, or 11.6 percent of them. More important, however, Williams identified 2,516 episodes starting during the 6-month period from February through July 1976, whereas we identified only 362 for the 3-month period from December 1980 through February 1981. Because of the age of the Williams' data, we could not determine the reasons for this difference in the number of rental episodes.

In contrast to the differences in the rental episode distributions for Idaho and southern California, the Williams 1976-77 data for the remaining five locations and the GAO

1981-83 data for the four locations included in this review are remarkably similar. This comparison is shown on the following table.

Length of rental episodes (in months)	Williams 1976-77 (5 locations) Number	Percent	GAO 1981-83 (4 locations) Number	Percent
1 and 2	5,921	49.8	14,502	51.1
3 to 6	2,895	24.3	6,590	23.2
7 to 12	1,558	13.1	3,222	11.3
Over 12	1,521	12.8	4,091	14.4
Total	11,895	100.0	28,405	100.0

Accordingly, although we did not review the assumptions on which the Williams simulations were based, we believe that if the study had presented its analysis by location instead of in the aggregate, the findings, particularly regarding the extent of excess rentals and the cost-effectiveness of reimbursing for low-cost items on a purchase basis, would have differed by location.

Differences in methodology in determining rental episodes

There were two differences between the Williams and the current GAO methodology for determining the length of rental episodes. One of the differences partially explains the differences in the findings.

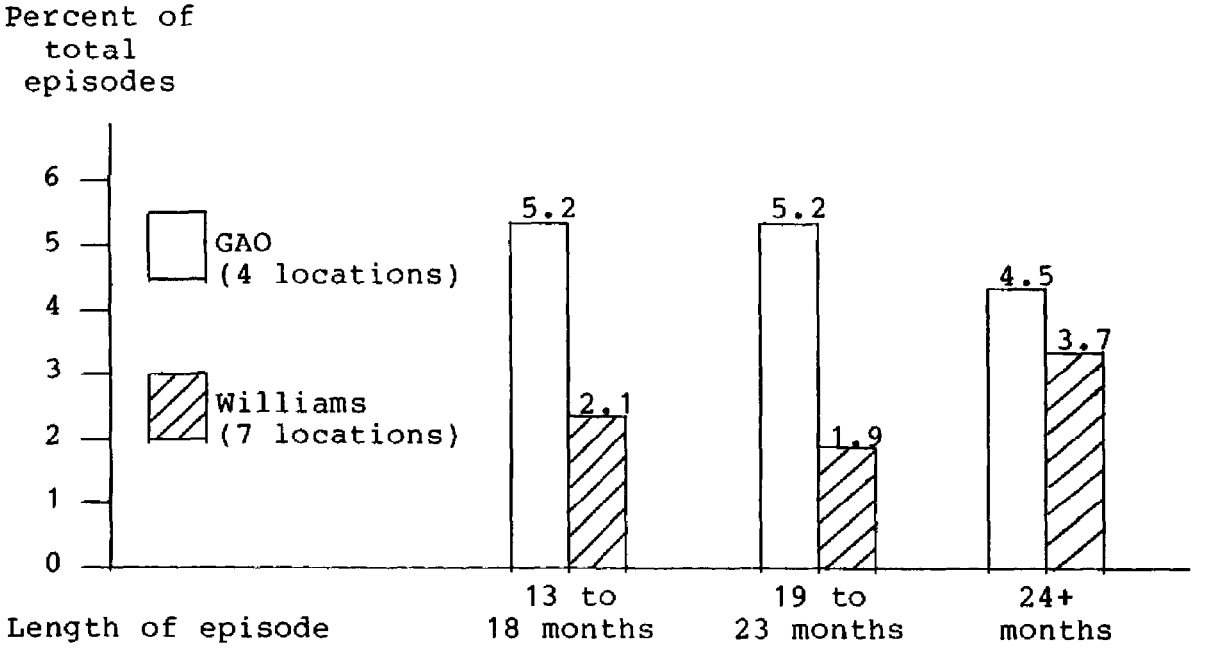
For assigned[8] claims (which by product type ranged from 61 to 92 percent in the Williams episode data), Williams used a 1-month break in service as terminating a rental episode. For nonassigned claims, it used a 2-month break in service to terminate a rental episode. We assumed that a 2-month period without a rental charge constituted a break in the rental of the item and the end of the episode. We used a 2-month break because if a beneficiary was hospitalized during a month, the rented DME

---

[8]On an assigned claim, the carrier pays the supplier 80 percent of the allowed charge, and the supplier agrees to accept Medicare's allowed charge as the full charge. For a nonassigned claim, the carrier pays the beneficiary 80 percent of the allowed charge, the supplier does not have to accept the Medicare allowed charge, and the beneficiary may be liable for the difference.

items would not be needed and thus might not be covered by Medicare. For Idaho and southern California, the use of a 1-month break in service in determining a rental episode would increase our 1- and 2-month rentals by about 2.4 percentage points in Idaho and by about 6 percentage points in southern California. It would also decrease our episodes lasting over 12 months by about 4 percentage points in Idaho and 4.5 percentage points in California.

Second, Williams did not have reliable information about episodes continuing after July 1977. Williams used actual data to track rental episodes for at least 13 months and for those beginning in February 1976 for as long as 18 months. However, for those episodes that had not ended in July 1977, Williams used a formula to project the episode lengths, whereas we used actual claims data to determine episode lengths of more than 13 months. Although we identified about twice as many episodes lasting over 12 months as Williams did, the relative distribution of these long-term rentals was generally comparable. Accordingly, we believe that this difference in methodology was not significant. This is illustrated by the following graph.



OUR FINDINGS AND CONCLUSIONS STILL DIFFER FROM WILLIAMS'

Our current findings about the extent of excessive DME rentals still differ from those of the Williams study. Based on the 1981-83 rental episode data at the four carriers, we identified excessive rental allowances of about 39 percent of allowed charges as compared with the 14 percent reported by Williams.

Regarding HCFA's instructions for low-cost items, as discussed in chapter 3, our current data indicate that under the assumption that all low-cost items would be reimbursed on a purchase basis, the allowed rental charges for these items would have been reduced by about 21 percent as compared with the 15 percent increased costs reported by Williams. However, our findings under this assumption significantly differed by location. Greater uniformity of savings occurred at three of the four locations when the use of a 1 month's waiting period was simulated. Providing for a 1 month's waiting period and limiting the reimbursement for the remaining items to a 1 month's rental charge plus the purchase allowance would increase the potential savings to about 30 percent of the allowed rental charges and result in greater uniformity of savings at three of the four locations. Only under the most optimistic of assumptions would HCFA's July 1982 instructions have resulted in any savings in Idaho because the percentage of low-cost items being purchased in Idaho was already high.

Regarding the higher cost items, as discussed in chapter 4, we found that the improvements in maintaining medical necessity forms had not occurred since our 1982 report. Further, even when the forms were available, the "error" rate, particularly where a purchase decision was indicated at the outset of a rental episode, was unacceptably high. Therefore, we generally agree with Williams' conclusions regarding the probability that savings from implementing the 1982 HCFA instructions for the high-cost items would be uncertain. However, because our episode analyses showed that the excessive rental allowances for these items at the four carriers were about 34 percent of total allowed charges, we believe that problem needs attention. Accordingly, in chapter 4 we discuss several alternative solutions that do not require the use of medical necessity forms.

CONCLUSIONS

We do not believe the Williams study, which was based on 1976-77 data, is representative of the current DME rent/purchase situation nationwide. Based on its data, the distribution of rental episode lengths at two locations was significantly different than those at the other five locations. Our more current rental episode data at the same two locations showed that the short-term (1- and 2-month) episodes were about 25 percentage points lower than Williams' and the long-term episodes (over 12 months) were about 10 percentage points higher. Further, we believe that the data from Idaho, which is the fourth smallest carrier location in the nation in terms of Medicare claims processed, were given too much weight in the Williams study.

Finally, two principal differences remain between the GAO and Williams findings and conclusions. These are (1) the extent of excess rental payments for DME and (2) the potential for savings by implementing HCFA's July 1982 instructions regarding the reimbursement of low-cost items. However, we generally agree with Williams that the probability of savings by implementing the HCFA instructions for high-cost items is uncertain.

WILLIAMS' COMMENTS

The two principal authors of the Williams College study were given an opportunity to provide written comments on a draft of this report. They did not provide any. However, Williams provided oral comments on an earlier preliminary draft of the report. One comment dealt with the perception that the term "excess rentals" could mean the same as "savings," and the other involved the added costs of carrier administration in implementing the HCFA instruction. Both comments have been addressed in the final report.

CHAPTER 3

SAVINGS WOULD RESULT IF LOW-COST DME ITEMS WERE REIMBURSED ON A PURCHASE BASIS

Under HCFA's July 1982 and December 1984 instructions, low-cost items (defined as costing $120 or less) would be reimbursed on a purchase basis. Although the beneficiaries could rent if they so desired, the total Medicare reimbursement would be limited based on the purchase allowance.

Our analysis of 15,629 rental episodes involving low-cost items at the four carriers showed that overall, the application of HCFA's July 1982 and December 1984 instructions would have resulted in savings. However, the extent of the savings would have varied by carrier and depended on whether (1) all low-cost items were reimbursed on a purchase basis, (2) the first month's rental charge was applied to the purchase allowance for rentals in excess of 1 month, or (3) the carriers had the option to allow rental charges for various "waiting" periods before limiting reimbursement to the purchase allowance for the items still being rented. Because many beneficiaries rent for only 1 month, we found that providing for a 1 month's waiting period and then limiting reimbursement to the episodes lasting 2 months or longer would result in much greater savings than if all low-cost items had been reimbursed on a purchase basis. Therefore, we believe HCFA's December 1984 instructions should be modified to authorize a 1-month rental before limiting reimbursement based on the purchase allowance. Our analysis also indicated that such savings would not be significantly increased or decreased if the HCFA definition of low-cost items was increased from $120 to $150.

COMPARISON OF RENTAL ALLOWANCES FOR LOW-COST ITEMS TO ALL ITEMS

The following table compares the number of episodes and the total rental allowances for all items to the number of episodes and total rental allowances for low-cost items.

Location and carrier	Total allowed rental charges for all items: Number of episodes	Amount	Total allowed rental charges for items costing $120 or less: Number of episodes	Percent of total	Amount	Percent of total
Idaho-Equitable	356	$ 84,604	173	48.6	$ 7,835	9.3
Georgia-Prudential	5,289	1,401,154	2,136	40.4	168,534	12.0
Southern California-Occidental	18,440	2,664,391	11,185	60.7	790,758	29.7
Kansas/Missouri-Kansas City Blue Shield	3,360	1,064,182	2,135	63.5	384,128	36.1
Total	27,445[a]	$5,214,331	15,629	56.9	$1,351,255	25.9

[a]This number excludes 960 episodes for which the prevailing purchase allowance could not be obtained.

As indicated by the above table, total rental allowances for low-cost items in relation to total rental allowances were relatively low in Idaho and Georgia when compared with southern California and Kansas City Blue Shield. We believe this occurred because most low-cost non-oxygen-related items were being purchased in Idaho and because high-cost oxygen concentrators were a large proportion of allowed DME rental charges in our episode analyses in both Idaho (about 59 percent) and Georgia (about 42 percent).

SUMMARY OF EXCESS RENTAL ALLOWANCES FOR LOW-COST ITEMS BY CARRIER AND TYPE

The following table summarizes the rental episodes, the total rental allowances, and the related excess rental allowances by carrier. For the purpose of this analysis, we defined excess rental allowances as the amount by which the total rental allowances for a particular episode exceeded Medicare's prevailing charge for the item's purchase.

Summary of Excess Rental Allowances for Items Costing $120 or Less by Carrier

Location of carrier	Total allowed rental charges: Number of episodes	Total allowed rental charges: Amount	Total excess rental allowances: Number of episodes	Total excess rental allowances: Percent excess	Total excess rental allowances: Amount	Total excess rental allowances: Percent excess
Idaho-Equitable	173	$ 7,835	28	16.2	$ 2,774	35.4
Georgia-Prudential	2,136	168,534	688	32.2	87,832	52.1
Southern California-Occidental	11,185	790,758	3,112	27.8	366,706	46.4
Kansas/Missouri-Kansas City Blue Shield	2,135	384,128	1,159	54.3	270,895	70.5
Total	15,629	$1,351,255	4,987	31.9	$728,207	53.9

We also classified the excess rental allowances into oxygen- and non-oxygen-related DME items. This was done because of the DME industry's contention that many oxygen-related items should always be rented because of their maintenance or service requirements. Under these two broad classifications we have further summarized the excess rental allowances by the general product type. The analyses are presented in the following tables.

Oxygen-Related DME Costing $120 or Less

Product type	Total allowed rental charges: Number of episodes	Total allowed rental charges: Amount	Total excess rental allowances: Number of episodes	Total excess rental allowances: Percent excess	Total excess rental allowances: Amount	Total excess rental allowances: Percent excess
Regulators[a]	3,219	$498,787	1,256	39.0	$302,680	60.7
Humidifiers	323	16,030	136	42.1	10,965	68.4
Carts and stands	2,257	77,513	568	25.2	29,931	38.6
Maxi-mists	148	33,177	65	43.9	21,885	66.0
Nebulizers	96	14,389	52	54.2	8,661	60.2
Other	306	22,662	184	60.1	15,748	69.5
Total	6,349	$662,558	2,261	35.6	$389,870	58.8

[a]Includes regulators, regulator/flowmeters, and regulator/humidifiers.

Non-Oxygen-Related DME Costing $120 or Less

Product type	Total allowed rental charges: Number of episodes	Total allowed rental charges: Amount	Total excess rental allowances: Number of episodes	Total excess rental allowances: Percent excess	Total excess rental allowances: Amount	Total excess rental allowances: Percent excess
Walkers and walk-aides	2,804	$168,351	866	30.9	$ 85,272	50.7
Commodes	2,554	220,446	836	32.7	117,951	53.5
Mattress and bed rails	2,353	213,834	607	25.8	94,662	44.3
Canes and crutches	849	26,276	232	27.3	12,870	49.0
Trapeze bars and other traction equipment	696	59,407	180	25.9	27,412	46.1
Other	24	383	5	20.8	170	44.4
Total	9,280	$688,697	2,726	29.4	$338,337	49.1

COULD EXCESS RENTAL ALLOWANCES BE AVOIDED?

In the absence of a policy which would provide that Medicare rental payments would stop when the rental allowance equaled the purchase allowance on an item-by-item or episode-by-episode basis, there is no practical way that all excess rentals can be avoided. However, we simulated various scenarios at each of the carriers to determine the circumstances under which the potential savings under HCFA's July 1982 instructions could be maximized.

Low-cost items were priced out under the following three scenarios:

1. All items would be reimbursed on a purchase basis. This involves a "worst case" assumption, which was necessary because we do not know how beneficiaries and suppliers will react to or behave under the new HCFA instructions.

2. The first month's rental would be allowed for each item. All items with a rental period of more than 1 month would be reimbursed on a purchase basis counting the first month's rental allowance as part of the purchase allowance. Some DME suppliers will apply the first month's rental charge to the purchase price. For example, we were told by a trade association official in California this was common practice in that state.

It would be economically advantageous for Medicare beneficiaries to select such suppliers for meeting their DME needs because (1) it would provide the beneficiaries with a 1-month period to assess their duration of need and (2) if they decided to purchase, their coinsurance liability would be lower because they would be liable only for the 20-percent coinsurance on the purchase allowance instead of being liable for the coinsurance on the purchase allowance plus the coinsurance on 1 month's rental.

3. Various "waiting" periods when rental allowances are permitted before limiting reimbursement. Allowed charges would include the allowed rental charge for the waiting periods plus the prevailing purchase allowance of the item.

The amount of excess rental allowances that could have been avoided under these scenarios is summarized in the following table.

Amount of Excess Rental Allowances That Could Have Been Avoided Under Various Assumptions

Location and carrier	Excess rental allowance	Amount of excess rental allowance that could have been avoided by: Purchase of all items — Amount avoided[a]	Purchase of all items — Percent of excess	Application of 1st month's rental allowance to purchase price — Amount avoided	Application of 1st month's rental allowance to purchase price — Percent of excess	Waiting period (monthly rental allowance plus purchase allowance) 1-month — Amount avoided	1-month — Percent of excess	2-month — Amount avoided	2-month — Percent of excess	3-month — Amount avoided	3-month — Percent of excess	4-month — Amount avoided	4-month — Percent of excess
Idaho (Equitable)	$ 2,774	$(3,509)	-	$ 767	27.6	$(113)	-	$ 29	1.0	$ 9	-	$ 326	11.8
Georgia (Prudential)	87,832	21,156	24.1	58,514	66.6	41,985	47.8	45,404	51.7	44,921	51.1	44,560	50.7
Southern California (Occidental)	366,706	32,663	8.9	238,203	65.0	140,361	38.3	160,890	43.9	165,745	45.2	155,427	42.4
Kansas/Missouri (Kansas City Blue Shield)	270,895	232,001	85.6	255,926	94.5	225,437	83.2	210,360	77.7	194,563	71.8	179,534	66.3
Total	$728,207	$ 282,311	38.8	$553,410	76.0	$407,670	56.0	$416,683	57.2	$405,238	55.6	$379,847	52.2

[a]These amounts have been adjusted upward by $21,089, which represents the amount of theoretical "losses" associated with the initial purchase of 649 low-cost items, of which 552 were in southern California. Although these purchases were initially included in our analysis as "losses" because they were rented for short periods, further analysis showed that these items were later purchased. Therefore, the purchase of these items initially would not have resulted in a loss. These items were identified by a computer program matching the rental episode file for each carrier with a computer tape of purchases for the same time periods. Items were matched based on procedure code and the Medicare number of the beneficiary and included only those purchases that were made after the start of the rental episode.

As shown by the above data, the potential for savings on low-cost items would have been greatly improved if HCFA's July 1982 and December 1984 instructions were modified to provide for a 1- to 3-month waiting period from the beginning of a rental episode before applying the limit on rentals based on the purchase allowance. Although the potential savings would be maximized if the beneficiaries were to use a supplier that would apply the first month's rental to the purchase price, over 55 percent of the excess rental allowances could have been avoided if Medicare reimbursed rental episodes lasting more than 1 month by allowing 1- to 3-month rentals plus the purchase allowance.

However, the net differences between the potential savings for the 1-, 2-, and 3-month waiting periods are relatively small and we believe that a 1-month waiting period would be easier to administer since carriers would not have to maintain records and make payments for the second and third months. As a practical matter, carriers may not learn that a beneficiary had started a rental episode until they receive a claim for the first month's rental. The December 1984 instructions tell the carriers to advise beneficiaries to ask the DME suppliers whether they would count rental payments toward the purchase price, and if a beneficiary selected a supplier that did so, many low-cost items may be rented initially. However, a beneficiary may elect to use a supplier that does not follow such a policy; therefore, we believe that the instructions should be modified to permit a 1-month rental before limiting the additional monthly rentals to the purchase allowance.

DME suppliers would not be required to rent any low-cost items under this proposed modification to the HCFA instructions, but would be free to furnish such items only on a purchase basis if they concluded it would be in their best interests to do so. However, we believe that such a modification would enhance the beneficiaries' options and thus could foster competition in the industry. Greater competition could result because, depending on the location, our data show that from 24 to 51 percent of the rentals of low-cost items were for only 1 month. In this situation, because of lower coinsurance amounts, it would be in a beneficiary's best financial interest to seek out a supplier who would rent the item rather than using a supplier who would only sell it at 3 or 4 times the cost of a 1 month's rental.

Explanation of the differences in the results of episode analysis in southern California (Occidental) and Kansas City Blue Shield

As shown in the table on page 32, there is a wide difference in the portion of excess rentals that could have been avoided by the purchase of all low-cost items at Occidental and at Kansas City Blue Shield. A principal reason for the difference is that at Kansas City Blue Shield about 62 percent of the excess rental allowances of $270,895 and about 69 percent of $230,883 in "savings" if purchased were applicable to an oxygen regulator/flow meter, for which the average monthly rental allowances of $22 equaled the prevailing purchase allowance of $98.00 in 4.4 months. There were 643 rental episodes associated with this item, of which 469 (or 73 percent) involved excess rentals. On the other hand, there were only 174 rental episodes lasting from 1 to 4 months for which there would have been offsetting "losses" if the items were reimbursed on a purchase basis. Such "losses" would have been minimal in relation to the excess rentals of about $167,200. This is illustrated in the following calculation.

Length of rental episode	Number of episodes	Purchase allowance in excess of average rental allowance	Total offsetting "losses"
1 month	60	$76	$4,560
2 months	34	54	1,836
3 months	34	32	1,088
4 months	46	10	460
Total	174		$7,944

In contrast, in southern California about 67 percent of the excess rental allowances of $366,700 consisted of four items (bed rails, stationary commodes, regulators/humidifiers, and walkaides), for which the average rental allowances equaled the prevailing purchase prices in 7.4, 4.2, 5.7, and 3.4, months, respectively. There were 5,906 rental episodes for these items, of which 1,717 (or about 29 percent) involved excess rentals. However, the offsetting "losses" if purchased would have been substantial in relation to the excess rental allowances. This is illustrated by the following computation involving the regulator/humidifier, which had excess rentals of about $100,500 in 498 of the 1,421 episodes. This item had an average monthly rental allowance of $19.00 and a prevailing purchase allowance of $108.00.

Length of rental episode	Number of episodes[a]	Purchase allowance in excess of average rental allowance	Total offsetting "losses"
1 month	411	$89	$36,579
2 months	207	70	14,490
3 months	136	51	6,936
4 months	93	32	2,976
5 months	70	13	910
Total	917		$61,891

[a]Because this computation is based on an average allowance and our computer program determined the excess rentals on an episode-by-episode basis, the 498 and 917 do not total 1,421.

The above computation also illustrates how the potential for savings would be greatly improved by permitting a 1-month waiting period before limiting reimbursement on the basis of the purchase allowance for the remaining items because if the beneficiaries did elect to wait before purchasing, the $36,579 in "losses" on the 1-month rentals could be avoided.

INCREASE OF $120 DEFINITION OF LOW-COST ITEMS WOULD NOT SIGNIFICANTLY CHANGE POTENTIAL SAVINGS

Our analysis of additional rental episodes involving low-cost items with prevailing purchase allowances of up to $150 showed that HCFA's $120 definition if adjusted for inflation is appropriate. Increasing the tolerance to $150 would add only eight items and 202 episodes. Of the eight items and 202 episodes, six items and 48 episodes resulted in $14,727 in excess rental allowances. As shown by the following table, this represents only a 2-percent increase in excess rental allowances applicable to items costing $120 or less.

Location and carrier	Total excess rental allowance for low-cost items based on $120 definition: Number of products	Number of episodes	Amount of excess	Total additional excess rental allowances for low-cost items based on a $150 definition: Number of products	Number of episodes	Additional amount	Percent increase
Idaho-Equitable	3	28	$ 2,774	0	0	$ 0	.0
Georgia-Prudential	12	688	87,832	1	19	7,226	8.2
Southern California-Occidental	36	3,112	366,706	4	6	2,279	0.6
Kansas/Missouri-Kansas City Blue Shield	19	1,159	270,895	1	23	5,222	1.9
Total	70	4,987	$728,207	6	48	$14,727	2.0

Of the $14,727 in additional excess rental allowances, from $1,500 to $9,400 could have been avoided by applying the various scenarios described on pages 30 and 31.

HCFA'S JULY 1982 INSTRUCTIONS WOULD RESULT IN GREATER SAVINGS THAN OTHER PROPOSALS

We also simulated the probable effects of two other proposals as they pertained to low-cost items. One proposal was from the National Association of Medical Equipment Suppliers and the other was from New York City Blue Shield. In addition, we simulated the probable effects at one carrier of reducing the rental allowances as was recently done by the carriers in HCFA Region VI, which consists of Texas, Louisiana, New Mexico, Arkansas, and Oklahoma.

NAMES proposal

The NAMES proposal is essentially the same as HCFA's July 1982 instructions, which define low-cost items as those costing $120 or less to buy, but it excludes "life support equipment," such as oxygen regulators and/or flowmeters.

Although the NAMES proposal clearly assumes the purchase of all non-oxygen items costing $120 or less, the following table simulates the probable effects of this proposal following the three scenarios previously described.

Location and carrier	Excess rental allowance	Amount of excess rental allowance that could have been avoided by: Purchase of all items — Amount avoided[a]	Purchase of all items — Percent of excess	Application of 1st month's rental allowance to purchase price — Amount avoided	Application of 1st month's rental allowance to purchase price — Percent of excess	Waiting period (monthly rental allowance plus purchase allowance) 1-month — Amount avoided	1-month — Percent of excess	2-month — Amount avoided	2-month — Percent of excess	3-month — Amount avoided	3-month — Percent of excess	4-month — Amount avoided	4-month — Percent of excess
Idaho (Equitable)	$ 2,774	$(3,593)	-	$(757)	-	$(1,121)	-	$(890)	-	$(816)	-	$(622)	-
Georgia (Prudential)	87,832	19,077	21.7	52,348	59.6	37,623	42.8	40,783	46.4	40,379	46.0	40,053	45.6
Southern California (Occidental)	366,706	(11,447)	-	138,966	37.9	72,676	19.8	90,726	24.7	97,334	26.5	92,312	25.2
Kansas/Missouri (Kansas City Blue Shield)	270,895	57,173	21.1	72,693	26.8	60,543	22.3	58,889	21.7	55,609	20.5	51,157	18.9
Total	$728,207	$61,210	8.4	$263,250	36.2	$169,721	23.3	$189,508	26.0	$192,506	26.4	$182,900	25.1

[a]These amounts have been adjusted upward by $16,264, which represents the amount of theoretical "losses" associated with the initial purchase of low-cost non-oxygen-related items that were rented for short periods and later purchased. As pointed out in the note on page 32, the purchase of these items initially would not have resulted in a loss.

Other supplier views as to appropriateness of including regulators

We discussed the exclusion of oxygen regulators from the purchase provision with two DME suppliers in Idaho, where oxygen regulators are sold more often than at the other three locations in our review. For the period October 1, 1980, to January 12, 1983, about 17 percent of the allowed charges for regulators in the state represented purchases as compared with about 4 percent at the other three carriers. The Idaho dealers told us that they had no reservations about selling oxygen regulators because their customers were not in a life-threatening situation in the event the equipment failed and needed to be repaired or replaced. They also told us that they would apply the first or the first 2 months' rental to the purchase price. According to HCFA's December 1984 instructions, carriers may require the purchase of regulators when more economical than rental. We agree with this provision unless a beneficiary's physician when ordering the equipment specifies that it be rented because it is life supporting.

New York Blue Shield proposal

This proposal also contemplates that low-cost DME items would usually be reimbursed on a purchase basis. Although it does not establish a specific amount, the types of items included in the proposal are generally the same as listed on pages 29 and 30 except for regulators, which would be rented. Because regulators represented about 87 percent of the excess rentals on oxygen related low-cost items and were also excluded from the NAMES proposal, the probable savings would be about the same as those attributed to that proposal.

Adjustment of rental rates

A principal reason that the percentage of excess rental allowances for low-cost items was relatively high is that the monthly rental allowances for such items often exceed 20 percent of the purchase price. Therefore, one way to avoid some excess rentals would be to reduce the rental allowances to a lower percentage of the purchase allowance so that it would take longer to reach the point where the accumulated rental allowances equaled or exceeded the purchase allowance. In July 1984, the carriers in HCFA Region VI (Dallas) instituted such a policy when it was determined that for some low-cost items, the rental allowance was 30 to 40 percent of the purchase allowance. We discussed the details of this change with HCFA personnel as it was applied by the carrier for Texas (Texas Blue Shield) and learned the carrier had adjusted the rental allowance for 21 items, of which 14 met the definition of low-cost items at our

locations. The rental allowances in Texas had been reduced to 10 percent of the prevailing purchase allowance for walkers and canes and to about 20 percent of the purchase allowance for commodes. We simulated the effects of this change to our rental episode data for Kansas City Blue Shield. The relationships of the rental allowances to purchase allowances at this carrier were comparable to the Texas carrier's before the change.

We matched eight low-cost items in our Kansas City episode analysis to similar items in Texas, where the rental allowances had been reduced. These eight items represented $81,913 of the $384,128 in total allowed rental charges and $51,493 of the $270,895 in excess rental allowances shown on the tables on page 29. If the rental allowances had been based on the adjusted Texas rental allowances, the effect for the eight items would have been as follows.

	Total allowed charges	Excess rental allowances	
		Amount	Percent
Total actual	$81,913	$51,494	62.9
Adjusted for lower rentals	54,531	27,170	49.8
Reductions	$27,382	$24,324	

Regarding the amount of excess rentals that could have been avoided by purchasing all items (see p. 32), the reduction in the rental allowances would have had the following effect:

	Excess rental allowances	Amount of excess rental allowance that could have been avoided:	
		Amount	Percent
Total actual	$51,494	$34,995	68.0
Adjusted for lower rentals	27,170	7,613	28.0

Thus, even with the lower rental allowances, HCFA's July 1982 instructions would still have resulted in savings at this particular carrier and for these specific items; however, both the amounts of the excess rentals and the amounts that could have been avoided are reduced significantly. We did not make such simulations in Georgia and southern California because of difficulties in matching the items in these locations and because the relationship of the rental allowances to the purchase

allowances did not appear to be comparable to the Texas carrier's before the change. We did not make such a simulation in Idaho because most of the items affected by the change were already being purchased.

CONCLUSIONS

Based on our analysis of 15,629 rental episodes involving low-cost items at four carriers, we believe that HCFA's December 1984 instruction should be implemented. However, at three of the four carriers the potential for savings was greatly improved or the probability of losses was reduced if HCFA modified the instructions to provide for a 1-month waiting period. In addition to increasing the potential for avoiding excess rental allowances, the 1-month waiting period should facilitate the administration of the instructions because carriers may not learn that a beneficiary started a rental episode until it received a claim for the first month's rent. At that time, the carrier could remind the beneficiary of the reimbursement policy to be applied, which would lessen the beneficiary's exposure to financial risk.

RECOMMENDATION

We recommend that the Secretary of HHS direct the Administrator of HCFA to modify the December 1984 instructions dealing with the reimbursement of low-cost DME items on a purchase basis to provide for a 1-month waiting period and that such modified instructions be implemented.

AGENCY AND SUPPLIER COMMENTS AND OUR EVALUATION

In commenting on this report (see app. III), HHS stated that it did not agree with our recommendation for permitting a 1-month rental for low-cost equipment before limiting reimbursement based on the purchase price of the item. According to HHS, the HCFA instructions encourage beneficiaries to rent low-cost DME if it is needed for only 1 or 2 months.

Although we acknowledge that the HCFA instructions do not mandate the purchase of low-cost DME, we believe that if Medicare reimbursement is limited to the purchase allowance for an item, beneficiaries would be placed at risk if they elected to rent at the onset of need because Medicare rental payments would generally stop after 3 to 6 months' rental. Also, suppliers may be unwilling to rent low-cost items under these circumstances because they would also be at risk when the Medicare payments for the item stopped. Therefore, we believe that HHS' position is based on an assumption as to how beneficiaries and suppliers

will behave under the new instructions that is not supported by empirical evidence.

As indicated by the table on page 29, depending on the location (excluding Idaho) from 46 to 71 percent of the number of rentals for low-cost items did not result in excess rentals. We believe that this provides good bench mark data with which to compare the carriers' actual experience under the new instructions. If most or all of the low-cost items are purchased, HCFA should realize that the implementation of its instructions has not maximized the potential savings and make modifications accordingly. On the other hand, if a substantial proportion of rentals terminate before the total rental payments reach the purchase allowance, then HHS' assumption may prove to be accurate. Therefore, the carriers should collect and maintain data on the number of rentals and purchases of low-cost items under the December 1984 instruction and HCFA should analyze the information to see whether the data support its assumption.

HHS also contends that implementation of our recommendation would complicate the claims process. We do not agree. The carriers already have in place systems to track the length of DME rentals for the purpose of redetermining the continued medical need of an item.

Neither supplier association--NAMES nor the Health Industry Distributors Association--commented on this recommendation.

In summary, until more is known about how beneficiaries and suppliers will react to the new instructions, we believe that our recommendation is valid because it is based on simulations of actual rental data, which showed that the potential savings would be greatly enhanced if beneficiaries were given incentives to rent for 1 month before applying the limitation based on the purchase price.

CHAPTER 4

SAVINGS FOR HIGH-COST ITEMS REIMBURSED ON A PURCHASE BASIS ARE UNCERTAIN

Under HCFA's July 1982 and December 1984 instructions, high-cost DME items (defined as costing over $120) would be reimbursed on a purchase basis if the expected duration of need warrants a presumption that purchase would be less costly than rental. Generally all high-cost items would be initially rented.[1] The carrier would have up to a 6-month "waiting" period to establish the expected duration of need, during which some rental charges would be allowed. Under these circumstances, total Medicare payments could be based on up to 6 months' rental allowances plus the purchase allowance. Also, the carriers could authorize rental even though the purchase would be more economical if a purchase would impose an undue financial hardship on the beneficiary because of large coinsurance amounts.

We analyzed 11,816 rental episodes involving high-cost items at the four carriers as well as samples of medical necessity forms[2] from Equitable in Idaho and Prudential in Georgia. Our analysis showed that although HCFA's 6-month waiting period was about right, the potential savings resulting from implementation of the instructions were uncertain because the information in the medical necessity forms, when available, was inadequate and often unreliable, particularly with regard to purchase decisions.

In addition, the administration of the rent/purchase instructions would be complicated for high-cost oxygen concentrators in Georgia because that carrier (Prudential) bases the rental allowance for this item on the least costly method for providing the oxygen. Accordingly, the rental allowances for some concentrators were based on the cost of a less costly oxygen gas system because such a system would have met the beneficiary's needs.

---

[1]HCFA's December 1984 instructions modified this language and indicated that the purchase option could be applied initially if it is clear from the outset that the beneficiary will need the equipment long enough to warrant purchase.

[2]These are forms filed by the beneficiary's physician accompanying the prescription for the equipment.

We believe that a reimbursement approach that would limit the accumulated rental allowances for a rental episode to a specified percentage of the purchase allowance would be easier to administer and would be more certain to avoid excessive rental allowance. We believe, however, that under existing legislation, such an approach would require that DME suppliers voluntarily agree to participate in it to be effective and not shift any differences in covered charges to the beneficiaries.

COMPARISON OF RENTAL ALLOWANCES FOR HIGH-COST ITEMS TO ALL ITEMS

The following table compares the number of episodes and the total rental allowance for all items to the number of episodes and total rental allowances for high-cost items.

Location and carrier	Total allowed rental charges for all items: Number of episodes	Total allowed rental charges for all items: Amount	Total allowed rental charges for items costing more than $120: Number of episodes	Percent of total	Amount	Percent of total
Idaho - Equitable	356	$ 84,604	183	51.4	$ 76,769	90.7
Georgia - Prudential	5,289	1,401,154	3,153	59.6	1,232,620	88.0
Southern California - Occidental	18,440	2,664,391	7,255	39.3	1,873,633	70.3
Kansas/Missouri - Kansas City Blue Shield	3,360	1,064,182	1,225	36.5	680,054	63.9
Total	27,445[a]	$5,214,331	11,816	43.1	$3,863,076	74.1

[a]This number excludes 960 episodes for which a prevailing purchase allowance could not be obtained.

As indicated by the above table, total rental allowances for high-cost items in relation to total rental allowances were relatively high in Idaho and Georgia as compared with southern California and Kansas City Blue Shield. As stated in chapter 3, we believe this occurred because most low-cost items were being purchased in Idaho and because high-cost oxygen concentrators were a large proportion of allowed DME rental charges in both Idaho (about 59 percent) and Georgia (about 42 percent).

SUMMARY OF EXCESS RENTAL ALLOWANCES FOR HIGH-COST ITEMS BY CARRIER AND TYPE

The following table summarizes the rental episodes, the total rental allowance, and the related excess rental allowances by carrier.

Summary of Excess Rental Allowances for Items Costing Over $120 by Carrier

Location and carrier	Total allowed rental charges: Number of episodes	Total allowed rental charges: Amount	Total excess rental allowances: Number of episodes	Total excess rental allowances: Percent excess	Total excess rental allowances: Amount	Percent excess
Idaho - Equitable	183	$ 76,769	21	11.5	$ 22,131	28.8
Georgia - Prudential	3,153	1,232,620	688	21.8	482,351	39.1
Southern California - Occidental	7,255	1,873,633	1,128	15.5	522,721	27.9
Kansas/Missouri - Kansas City Blue Shield	1,225	680,054	315	25.7	283,505	41.7
Total	11,816	$3,863,076	2,152	18.2	$1,310,708	33.9

Although the incidence of excess rentals for the high-cost items is much lower than the incidence for low-cost items (18.2 percent as compared to 31.9 percent (see p. 29)), in terms of absolute dollars the amount of excess rentals was almost twice as much for the high-cost items.

We have classified the excess rental allowances into oxygen- and non-oxygen-related DME items. This was done because of the DME industry's contention that many oxygen-related items should always be rented because of their maintenance or service requirements. Under these two broad classifications we have further summarized the excess rental allowances by general product type. The analyses are presented in the following tables.

Oxygen-Related DME Costing Over $120

Product type	Total allowed rental charges: Number of episodes	Total allowed rental charges: Amount	Total excess rental allowances: Number of episodes	Total excess rental allowances: Percent excess	Total excess rental allowances: Amount	Total excess rental allowances: Percent excess
Concentrators	601	$1,343,218	208	34.6	$504,631	37.6
Respirators	167	63,246	56	33.5	26,576	42.0
IPPBs[a]	522	251,581	167	32.0	116,052	46.1
Portable oxygen systems	338	72,433	95	28.1	30,701	42.4
Liquid oxygen systems	127	44,434	4	3.1	3,475	7.8
Gaseous oxygen systems	13	5,292	8	61.5	3,612	68.3
Nebulizers	99	24,195	17	17.2	7,091	29.3
Suction pumps	62	12,444	19	30.6	7,226	58.1
Other	113	19,277	13	11.5	5,919	30.7
Total	2,042	$1,836,120	587	28.7	$705,283	38.4

[a]Intermittent positive pressure breathing machines.

Non-Oxygen-Related DME Costing Over $120

Product type	Total allowed rental charges: Number of episodes	Total allowed rental charges: Amount	Total excess rental allowances: Number of episodes	Total excess rental allowances: Percent excess	Total excess rental allowances: Amount	Total excess rental allowances: Percent excess
Wheelchairs:						
Non-electric	4,482	$ 787,983	820	18.3	$252,789	32.1
Electric	40	30,117	10	25.0	8,601	28.6
Hospital beds						
Non-electric	2,487	563,160	362	14.6	161,081	28.6
Electric	1,072	419,483	113	10.5	104,078	24.8
Walkers	660	61,227	71	10.8	20,973	34.3
Patient lifts	120	34,699	24	20.0	11,232	32.4
Traction equipment	218	25,182	43	19.7	8,724	34.6
Pads	255	44,311	52	20.4	19,798	44.7
Mobile commodes	325	34,859	57	17.5	11,490	33.0
Other	115	25,935	13	11.3	6,659	25.7
Total	9,774	$2,026,956	1,565	16.0	$605,425	29.9

COULD EXCESS RENTALS BE AVOIDED?

We could not simulate the effect of HCFA's July 1982 instructions regarding the carrier's rent/purchase decisions because we did not know what kind of information the carriers would obtain during the waiting periods to facilitate their decisions. However, we were able to simulate the probable effects of various waiting periods--1 to 6 months--to test the hypothesis that once a beneficiary rents an item for a specified number of months, the chances of that particular rental episode eventually being a long-term episode increased to the point where the presumption that purchase would be more economical is warranted.

As shown by the following table, a 6-month waiting period would have resulted in avoiding some excess rental allowances. However, the total amount of potential savings is small (about 6.0 percent) because, in the aggregate, the use of waiting periods would not have avoided excess rental allowances in southern California but would have resulted in theoretical "losses" which offset the savings at the other three locations. The negative amounts represent the theoretical "losses" that would have resulted if the high-cost items had been purchased at the indicated times. For example, if all items costing over $120 had been purchased after a 1-month rental, the allowed charges would have been about $882,000 more than the $3.9 million actually allowed on rental charges.

Amount of Excess Rental Allowance That Could Have Been Avoided by Waiting the Indicated Number of Months and Then Purchasing (Monthly Rentals Plus Purchase Price)

Location and carrier	Excess rental allowance	1 month		2 months		3 months		4 months		5 months		6 months	
		Amount	Percent of excess	Amount	Percent of excess	Amount	Percent of excess	Amount	Percent of excess	Amount	Percent of excess	Amount	Percent of excess
Idaho - Equitable	$ 22,131	$(12,843)	-	$ 1,961	8.9	$ 5	-	$ 1,363	6.2	$ 5,762	26.0	$ 4,604	20.8
Georgia - Prudential	482,351	(97,777)	-	6,063	1.3	58,616	12.2	93,386	19.4	85,870	17.8	127,320	26.4
Southern California - Occidental	522,721	(700,249)	-	(389,431)	-	(253,272)	-	(168,766)	-	(122,472)	-	(88,728)	-
Kansas/Missouri - Kansas City Blue Shield	283,505	(71,484)	-	(12,571)	-	10,588	3.7	7,011	2.5	24,847	8.8	35,110	12.4
Total	$1,310,708	($882,353)	-	($393,978)	-	($184,063)	-	$(67,006)	-	$ (5,993)	-	$ 78,306	6.0

Reliability of medical necessity forms for estimating the duration of need is questionable

Our analysis of random samples of medical necessity forms at the carriers for Idaho and Georgia indicated that they are unreliable as a basis for estimating the duration of need, particularly for making purchase decisions. Also, the improvements in the retention of medical necessity forms that we recommended in our prior report (HRD-82-61) had not occurred.

A claim for a DME item must be accompanied by a physician's prescription to justify the need for the item. The physician's prescription is contained on a medical necessity form. We reviewed random samples of the forms for 102 beneficiary rental episodes for items costing over $120 for the carriers in Idaho and Georgia.

We selected Idaho because (as shown on the table on p. 9) a relatively large portion of the non-oxygen-related DME expenditures were for purchases, and we wanted to find out whether the carrier was using the forms to take any actions to influence such decisions.[3] We selected Georgia because it was included in our prior review and we wanted to determine whether improvements in the retention of medical necessity forms had occurred.

For 36 (or about 35 percent) of the episodes, the medical necessity forms could not be located by the carriers.[4] For the other 66 episodes, the duration of need shown on the forms is summarized on the following table.

---

[3]On the basis of our discussions with the carrier and supplier personnel, we concluded that the large portion of DME purchases in Idaho was due more to suppliers encouraging purchases rather than to any actions by the carrier.

[4]For comparison purposes, about 16 percent of the medical necessity forms in our samples at five of the six locations for HRD-82-61 could not be located.

Summary of Medical Necessity Forms by Location

Stated duration of need	Idaho		Georgia		Total	
	No. of forms	Percent	No. of forms	Percent	No. of forms	Percent
Duration of need:						
Lifetime or permanent (assume at least 12 months)	11	47.8	7	16.3	18	27.3
Indefinite (assume at least 6 months)	8	34.8	8	18.6	16	24.2
Time specific	4	17.4	28	65.1	32	48.5[a]
Total	23	100.0	43	100.0	66	100.0
Forms not available	14		22		36	
Total samples	37		65		102	

[a]For comparison purposes, only about 7 percent of the samples of forms in our prior review were time specific, which indicates an improvement in the forms being more specific as to the anticipated duration of need.

We compared the indicated duration of need shown on the 66 forms with the number of months of rental charges needed to equal or exceed the purchase allowance (break-even point). This analysis showed that 39 of the rented items should have been rented based on the anticipated period of need and that 27 of the rented items should have been purchased. Of the 39 rental decisions, 32 (or 82 percent) turned out to be correct based on the actual length of the rental episodes. However, we believe that this ratio is not particularly significant because, based on the 3,336 rental episodes for items costing over $120 at these two carriers, about 80 percent did not involve excessive rentals because the episode ended before the break-even point. Therefore, the chances of making a correct rental decision were very high. In contrast, of the 27 indicated purchase decisions based on the anticipated period of need, only 6 (or about 22 percent) turned out to be correct based on the actual length of the rental episode.

We could not simulate the effects of HCFA's July 1982 instructions because we did not know what information the carriers would obtain during the waiting periods. It appears, however, that based on the information shown on the medical necessity forms filed at the start of a rental episode, the chance of error (78 percent) for the indicated purchase decisions would be unacceptably high at the two carriers.

Administrative costs

Another issue relating to the implementation of the HCFA instructions for high-cost items involves the additional costs to the carriers of administering them. Overall, for fiscal years 1982 and 1983, carrier administrative costs were about 4 percent of benefit payments. Two of the carriers we reviewed (Prudential and Occidental) provided us with estimates of the additional costs to implement the HCFA DME instructions for high-cost items which we did not verify. Prudential estimated first year costs of $83,000 and recurring annual costs of $42,000, which represent about 1.5 percent and 0.7 percent of its DME benefit payments, respectively. Occidental estimated first year costs of $97,000 and recurring costs of $50,000, which represented about 1.1 percent and 0.6 percent of its DME benefit payments, respectively.

Medical necessity issue could complicate implementation of the instructions

In Georgia, the allowed rental charges for oxygen concentrators were often based on an oxygen regulator allowance plus the purchase of the equivalent amount of oxygen gas deemed adequate to meet the beneficiaries' needs. The amount of gas needed was calculated based on the patients' oxygen usage shown on their prescriptions. For the period July 1, 1982, through June 30, 1983, a beneficiary had to use at least 2,523 cubic feet of oxygen to qualify for the full rental allowance for an oxygen concentrator. Usage of less than this amount resulted in reductions in the allowed rental charge for the concentrator. These reductions often changed due to changes in a patient's needs or in the criteria used for calculating the allowable rentals. Based on claims paid for concentrator rentals during calendar year 1981, we estimate that the claims for about 16 percent of the beneficiaries' renting concentrators were reduced because of the medical necessity criteria.

Although we believe that the application of medical necessity criteria for oxygen equipment is a desirable policy, we also believe that it would complicate the implementation of HCFA's July 1982 instructions relating to rent/purchase decisions. In addition to the uncertainties involved in predicting the anticipated periods of need, the carrier would also have to anticipate a beneficiary's future usage requirements to make an accurate rent/purchase decision. Further, we question whether it would be reasonable to reimburse for a concentrator purchase when the carrier has determined that the beneficiary does not need it. Also, we do not know how a carrier could calculate the

equivalent lump-sum purchase allowance based on the purchase of a regulator plus the purchase of oxygen gas for an undeterminable period.

SAVINGS UNDER OTHER PROPOSALS

We also simulated the probable effects of two other proposals as they pertained to items costing over $120. One proposal was from NAMES, and the other was from New York City Blue Shield.

NAMES proposal

Under the NAMES proposal, rental charges would be paid for a maximum of 24 months for non-oxygen-related DME items, such as wheelchairs and hospital beds. At the end of the 2-year period, any item still being rented would be subject to a monthly maintenance fee in lieu of rental based on 30 percent of the latest allowable rental charge. Title to the items would remain with the supplier, and the item would be returned when no longer needed. The principal advantage of the NAMES proposal is that there is no risk of program "losses" as would be the case with the HCFA instructions and the New York City Blue Shield proposal.

As shown in the table on page 10, we could track rental episodes for maximum periods of 29 to 31 months in Georgia as compared to the maximum periods of 23 to 26 months at the other three locations. Therefore, we believe that the only location where we could fairly simulate the NAMES proposal providing for reduced rental payments after 24 months was in Georgia, where we had 5 to 7 months of excess rental payments to offset against the savings under that proposal. However because we knew the number of rental episodes that were still ongoing for 22- to 24-month periods at the other three locations, we could also determine the maximum number of episodes that would possibly qualify for reduced rental allowances under the NAMES proposal.

In Georgia, there were 208 rental episodes that met the 24-month criteria. The savings for those 208 episodes were distributed over periods of 1 to 7 months. Therefore, at the other three locations we took the maximum number of ongoing episodes that could qualify under the NAMES proposal and distributed their remaining lengths based on the Georgia distribution to develop an estimate of the total number of rental months for which reduced rental allowances could apply. We then multiplied the total number of rental months times the average monthly rental reduction for each location. For example, at Kansas City Blue Shield there were 26 ongoing rental episodes that would have qualified for additional reduced rentals under the NAMES

proposal. We distributed the remaining lengths for these episodes based on the Georgia data to produce an estimated 108 rental months for which the rental reduction would have applied. The rental reduction at this location under the NAMES proposal averaged $30.38 a month for the qualifying items, so we added $3,303 ($30.58 X 108 months) to the $1,774 in actual simulated reductions for a total estimated savings of $5,077.

The following table shows the estimated effect of the NAMES proposal in reducing (1) total excess rental allowances and (2) the excess rental allowances for non-oxygen-related items only. The NAMES proposal only applies to non-oxygen items.

Location and carrier	Total excess rental allowances	Amount of excess rentals avoided by NAMES proposal		Excess rental allowances (non-oxygen-related DME	Amount of excess rentals avoided by NAMES proposal	
		Amount	Percent of excess		Amount	Percent
Idaho - Equitable	$ 22,131	$ 0	-	$ 377	$ 0	-
Georgia - Prudential	482,351	19,125	4.0	180,675	19,125	10.6
Southern California - Occidental	522,721	11,091	2.1	295,579	11,091	3.8
Kansas/Missouri - Kansas City Blue Shield	283,505	5,077	1.8	128,793	5,077	3.9
Total	$1,310,708	$35,293	2.7	$605,424	$35,293	5.8

In its comments on this report (see app. IV), NAMES stated that it was prepared to modify its payment proposal to achieve greater savings. NAMES officials had previously asked us to calculate what the estimated effect would be in reducing excess rental allowances if its proposal was modified to a maximum maximum rental period of either 18 or 20 months instead of 24. In addition, they asked us to include oxygen-related items, which were excluded in NAMES' original proposal, in our simulations.

The following tables show the estimated effect of the modified NAMES proposal in reducing the excess rental allowances. The first table shows the effect for non-oxygen-related items only. The second shows the effect for both oxygen and

non-oxygen items. For consistency our calculations included the adjustment for ongoing rentals at three of the locations described beginning on page 51.

Estimated Effect of the Modified NAMES Proposal in Reducing the Excess Rental Allowances for Non-Oxygen-Related Items

Location and carrier	Excess rental allowances	Amount of excess rentals avoided by NAMES' 18-month proposal		Amount of excess rentals avoided by NAMES' 20-month proposal	
		Amount	Percent of excess	Amount	Percent of excess
Idaho - Equitable	$ 377	$ 61	16.2	$ 31	8.2
Georgia - Prudential	180,675	56,420	31.2	42,883	23.7
Southern California - Occidental	295,579	61,252	20.7	38,782	13.1
Kansas/Missouri - Kansas City Blue Shield	128,793	31,077	24.1	21,513	16.7
Total	$605,424	$148,810	24.6	$103,209	17.0

Estimated Effect of the Modified NAMES Proposal in Reducing the Excess Rental Allowances for Oxygen- and Non-Oxygen-Related Items

Location and carrier	Excess rental allowances	Amount of excess rentals avoided by NAMES' 18-month proposal		Amount of excess rentals avoided by NAMES' 20-month proposal	
		Amount	Percent of excess	Amount	Percent of excess
Idaho - Equitable	$ 22,131	$ 5,045	22.8	$ 2,678	12.1
Georgia - Prudential	482,351	160,297	33.2	122,979	25.5
Southern California - Occidental	522.721	102,371	19.6	62,642	12.0
Kansas/Missouri - Kansas City Blue Shield	283,505	67,354	23.8	46,550	16.4
Total	$1,310,708	$335,067	25.6	$234,849	17.9

New York Blue Shield Proposal

Under the New York Blue Shield proposal, a non-oxygen DME item would be rented until the rental payments equaled the purchase price, and then the item would be purchased. Blue Shield assumed that the purchased item would be new and would replace the rented item. Because a rental episode could end before the accumulated rentals equaled the second purchase price, our simulation of this proposal could result in theoretical "losses," which would have occurred at two of the four locations. For example, under our simulation, if a $500 item was rented for 12 months, and the rental payments of $50 a month equaled the purchase price in 10 months, then it would be purchased for $500 with total allowed charges of $1,000; however, because the actual rental allowances for the item for 12 months were $600, this would result in a $400 theoretical "loss." The simulation is summarized in the following table.

Location and carrier	Excess rental allowances (non-oxygen-related DME)	Amount of excess rentals avoided by New York Blue Shield proposal	
		Amount	Percent
Idaho - Equitable	$ 377	$ (264)	-
Georgia - Prudential	180,675	9,742	5.4
Southern California - Occidental	295,579	(7,384)	-
Kansas/Missouri - Kansas City Blue Shield	128,793	22,537	17.5
Total	$605,424	$24,631	4.1

Adjustment of rental rates

As pointed out in chapter 3, one alternative for avoiding excess rental allowances is to reduce the rental allowance to a lower percentage of the purchase allowance as was done by the carrier in Texas. In contrast to the effect of such a change on the excess rentals for low-cost items at one of our locations, this change would have had little impact for high-cost items. Of the seven high-cost items for which rental adjustments were made in Texas, two types of bed rails were included as low-cost items in the Kansas City Blue Shield simulation discussed on page 39 because the prevailing purchase allowance at that carrier was less than $120 for the period covered by our review. For the remaining five items, we identified two in our episode analyses (alternating pressure pads and mattress). However, the adjustment to the rental rates expressed in terms of a percentage of the purchase price would have had no significant effect on our simulations. This is illustrated in the following table.

	Rental allowance as a percent of purchase price									
	Texas		Idaho		Georgia		Southern California		Kansas/ Missouri	
	Old	New	No. of episodes	Percent	No. of episodes	Percent	No. of episodes	Percent	No. of episodes	Percent
Alternating pressure pads	21.2	16.6	3	16.4	108	17.5	70	12.2	58	15.2
Mattresses	20.0	15.0	-	-	1	13.2	42	12.0	-	-

Because the reduced (new) rental allowances in Texas were about the same or higher than the rental allowances (expressed as a percentage of the purchase allowance) at the four locations in our review, we concluded that using the new Texas percentages would have had no significant effect on avoiding the excess rentals on high-cost items at these locations.

ALTERNATIVE REIMBURSEMENT APPROACH

In view of (1) uncertainty as to whether the implementation of HCFA's July 1982 instructions regarding high-cost items will avoid excessive rental allowances and (2) the relatively small savings associated with the proposed alternatives we initially simulated, we believe that another alternative approach merits consideration by HHS and the Committee. This alternative, which is similar to the DME reimbursement practices of two state Medicaid programs, provides for a limit or cap on the amount of rentals based on a percentage of the purchase allowance of an item.

For example, in New Jersey, rental allowances under Medicaid are limited to 120 percent of the purchase allowances, at which time the item is "deemed" purchased. Ownership is with the state, but when the recipient no longer needs the item, it is returned to the supplier by paying a minimum rental charge of $35, and, if more than $35, a maximum of 1 month's rental (10 percent of the purchase allowance) to pick up, store, and redeliver the equipment to another recipient. New Jersey will also pay for repairs to the equipment, if authorized.

The Massachusetts Medicaid program takes a slightly different approach. In Massachusetts, DME provided to recipients not also eligible for Part B of Medicare may be rented for periods not to exceed 6 months. For items costing over $120 the monthly rental rates are limited to about 12 to 13 percent of the maximum purchase allowance. For the first 3 months, 70 percent of the rental allowance must be applied to the purchase price, and for the next 3 months 50 percent of the rental allowance must be applied to the purchase price. At the end of the maximum 6 months' rental period, the program has made rental payments equal to from 71 to 77 percent of the purchase price, of which 60 percent must be available to apply against the purchase price.

Thus, if the state elects to purchase the item, it is entitled to a credit of from 43 percent (60 percent of 71 percent) to 46 percent (60 percent of 77 percent) of the price, and the item could be purchased with a lump-sum payment equal to from 57 to 54 percent of the purchase price. This effectively results in a cap of about 130 percent of the purchase price for both the

rental and purchase payment (71 percent in rentals plus 57 percent for the purchase or 77 percent of rentals plus 54 percent for the purchase). The state then owns the equipment; any repair services are paid by the state, and the amount paid is determined by the state based on the suppliers' descriptive report of the services furnished.

Under Medicaid, however, HHS regulations (42 C.F.R. 447.15) require that the states must limit participation in the program to providers who accept, as payment in full, the amounts paid by the state plus any deductible, coinsurance, or copayments required by the state to be paid by the recipients. In contrast, under Medicare there are no comparable requirements with respect to DME suppliers.[5] Therefore, DME suppliers could shift any program savings to Medicare beneficiaries if the suppliers do not agree to accept Medicare's allowed rental charges as payment in full.

Our simulations of the excess rentals that could have been avoided based on limiting the rental allowances to various percentages of the purchase allowance for high-cost items are summarized on the following table.

---

[5]Many other types of providers--such as hospitals, nursing homes, home health agencies, and independent laboratories--are subject to a comparable requirement under Medicare.

Amount of Excess Rentals That Could Have Been Avoided by Limiting Rental Allowance to the Indicated Percentage of Purchase Allowance

Location and carrier	Excess rental allowance	125 percent Amount	125 percent Percent of excess	150 percent Amount	150 percent Percent of excess	175 percent Amount	175 percent Percent of excess	200 percent Amount	200 percent Percent of excess
Idaho - Equitable	$ 22,131	$ 15,400	69.6	$ 9,486	42.9	$ 5,012	22.6	$ 1,500	6.8
Georgia - Prudential	482,351	385,830	80.0	306,489	63.5	237,658	49.3	174,921	36.3
Southern California - Occidental	522,721	398,919	76.3	298,516	57.1	216,490	41.4	153,602	29.4
Kansas/ Missouri - Kansas City Blue Shield	283,505	228,513	80.6	181,176	63.9	142,547	50.3	108,172	38.2
Total	$1,310,708	$1,028,662	78.5	$795,667	60.7	$601,707	45.9	$438,195	33.4

In effect, such an approach would be similar to a lease/purchase arrangement with limits on rental payments set at the stated percentages except that suppliers could retain title to the DME. Repairs could be reimbursed either on an as-needed basis as done under Medicaid in New Jersey and Massachusetts or as part of a routine maintenance fee as proposed by NAMES.

Three of the four carriers included in this review had procedure codes to accumulate the allowed charges for the repair of DME. Assuming that most repairs would be for purchased rather than rented items, the total allowed charges for DME repairs in relation to the total allowed charges for all DME purchases for low- and high-cost items are shown on the following table.

Location and carrier	Period	Allowed charges for DME purchases	Allowed charges for DME repairs	Percent of allowed charges for DME purchases
		(000 omitted)		
Georgia - Prudential	10/1/80 to 6/30/83	$ 2,217	$ 99	4.5
Southern California - Occidental	10/1/80 to 12/31/82	6,243	660	10.6
Kansas/Missouri - Kansas City Blue Shield	10/1/80 to 1/31/83	2,032	16	0.8
Total		$10,492	$775	7.4

Considering that the allowed charges for purchases relate to purchases during the periods shown and that the repairs could apply to items purchased before October 1, 1980, we believe that repairs to purchased DME would not offset the excess rentals for rented DME.

Comparison of GAO and NAMES proposals

Although our alternative approach limiting rental payments to a percentile in excess of the purchase allowance and the NAMES proposal limiting rental payments after a specified number of months are somewhat similar, we believe our proposal is superior for two reasons. First, using a percentile of the purchase allowance would be more uniformly equitable to suppliers and beneficiaries in different localities. Second, over time we believe our proposal would be less susceptible to manipulation under Medicare's reasonable charge methodology through suppliers increasing their submitted rental charges. A discussion of these points follow.

Uniformity in reimbursement

We observed relatively significant variations by location in the relationship between Medicare's rental allowance and the prevailing purchase allowance. Under the NAMES proposal this situation would result in suppliers in one location receiving more in rentals for an item in relation to the purchase allowance than suppliers in another location. Similarly, beneficiary cost sharing requirements would also vary by location. The following table summarizes the variations by location between Medicare's rental and purchase allowance for the five high-cost items with the highest dollar volume in rentals.

Average Rental Allowance as a Percent of the Purchase Allowance

Items	Idaho	Georgia	Southern California	Kansas/ Missouri
Oxygen concentrators	9.3	7.5	7.8	10.6
Wheelchairs:				
Standard	7.7	9.1	11.8	10.6
Electric	7.8	7.9	10.3	7.1
Hospital beds:				
Standard	10.1	10.6	11.5	15.4
Electric	9.6	8.7	9.5	12.5

For example, under the NAMES 20-month proposal, a supplier in Idaho would receive rentals of 154 percent of the purchase allowance for standard wheelchairs, and beneficiaries would pay coinsurance totaling 30.8 percent of the purchase allowance. A supplier in southern California, however, would receive 236 percent of the price in that area, and beneficiaries would pay coinsurance totaling 47.2 percent. Similarly, a supplier in Idaho would receive rentals of 202 percent of the purchase allowance for standard hospital beds, and beneficiaries would pay coinsurance totaling 40.4 percent. In contrast, a supplier in parts of Kansas and Missouri would receive 308 percent of the price in that area, and beneficiaries would pay coinsurance equal to 61.6 percent.

Potential for manipulation

As discussed, in July 1984 Texas Blue Shield lowered a number of its DME rental allowances. This action was initiated when it was determined that the rental rates for some items equaled 30 or 40 percent of the purchase allowance. Theoretically over time under Medicare's reasonable charge methodology, this situation could occur at any carrier because the Medicare allowances are based on the suppliers' prior submitted charges. Because there are many more rental charges than there are charges for purchases, the rapid escalation of suppliers' rental charges could result in significant changes in the relationship between Medicare's rental and purchase allowances. Under our proposal based on a fixed percentile of the purchase allowance, the effect of such changes would be minimized. In contrast, under the NAMES proposal, which is based on rentals for a specified number of months, the effect of such changes would be fully reflected in the amounts that the program and its beneficiaries would be required to pay before the rentals would be limited.

Disadvantages of GAO and NAMES proposals

The principal disadvantage of our alternative as well as the NAMES proposal is that to protect the beneficiaries, suppliers would have to agree to abide by whatever percentile of the purchase allowance or rental period is adopted. Section 2306 of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (title III of Public Law 98-369) authorizes physicians and suppliers to voluntarily enter into agreements with HHS to accept the Medicare allowance as payment in full for all items and services provided during a given fiscal year. As incentives for physicians and suppliers to participate, carriers would be required to maintain toll-free telephone lines to provide beneficiaries with the names and addresses of participating physicians and suppliers, and HHS is required to publish directories also identifying them. We believe that this new provision could be a basis for implementing such an alternative approach for limiting rental payments, but we do not know how many, if any, DME suppliers would agree to participate on either of these bases. In addition, since the agreements would be limited to a fiscal year, beneficiaries with rental episodes extending beyond that period would not be adequately protected from additional charges. However, we believe that the language of any agreement could be modified to take this into account.

CONCLUSIONS

For our limited simulation of HCFA's July 1982 instructions, we assumed an automatic purchase after a 6-month rental period. The simulation showed that from about 12 to 26 percent of the excess rentals would have been avoided at three of the four locations included in our review, but more than 50 percent of the savings would have been offset by "losses" at the remaining location. In addition, we could not simulate and evaluate the probable effect of the instructions with regard to the carriers' rent/purchase decisions because we did not know what information the carriers would be obtaining during the waiting periods to aid in their decisions.

In view of these two factors, we believe that there is insufficient evidence to support a conclusion that the implementation of HCFA's July 1982 and December 1984 instructions would not result in program savings as HCFA assumes. Conversely, we believe that any savings would be uncertain and that there is some risk that implementing the instructions could result in increased costs if the carriers' purchase decisions proved to be incorrect. Further, the implementation of the instructions could be complicated to the extent that carriers' adopt oxygen usage criteria for determining the type of equipment needed by beneficiaries and base reasonable charges on such determinations.

Of the two other proposals we simulated with our rental episode data, the NAMES proposal seemed to be preferable because it carried no risk of increased costs related to incorrect purchase decisions. However, under the original proposal the amount of the savings was relatively small when compared with the excess rental allowances. Our simulations of modifications to the NAMES proposals resulted in significantly increased savings.

The application of limits on rentals based on various percentages of the purchase allowances, similar to those adopted by a few state Medicaid programs, would be certain to result in savings even if established as high as twice the purchase allowances. However, as with the NAMES proposals, we do not know how many DME suppliers would be willing to participate in such reimbursement approaches under section 2306 of Public Law 98-369.

- - - -

Because of the uncertainty as to whether the implementation of HCFA's July 1982 and December 1984 instructions would result in avoiding excess rental allowances for items costing $120 or more, we are making no recommendations as to whether this portion of the instructions should be implemented.

MATTERS FOR CONSIDERATION BY THE COMMITTEE

Because of the potential savings involved, we believe the Committee should consider whether a legislative change is warranted that limits rental allowances for high-cost DME items to a specific percentage in excess of the purchase price. Such a change would provide that Medicare rental payments for high-cost DME items may be made only on the basis of an assignment where the supplier agrees to accept the Medicare allowances and related limitations.

AGENCY AND SUPPLIER COMMENTS AND OUR EVALUATION

In commenting on the contents of this chapter, HHS outlined the steps that HCFA planned to take to assure improvement in completing the medical necessity forms. These involved:

--Better education of physicians as to the significance of their DME prescriptions.

--Ways to improve carrier processing of the forms, including standards for making rent/purchase judgments.

--HCFA monitoring of the carrier administration of the process.

We believe that HCFA monitoring of the process is important, particularly if it includes matching carrier purchase decisions with readily available data on beneficiary hospital admission and death notices in order to develop objective data on carrier error rates involving purchase decisions.

Regarding our alternative proposal to cap reimbursements for DME at some fixed multiple of the purchase price, HHS acknowledged that it would be administratively simpler than the current system and would be likely to produce the most certain savings to the program at levels determined by the percentage at which the cap is fixed.

HHS also pointed out that our proposal should address the issue of beneficiary ownership of the equipment once the maximum amount of the cap has been reached. Our proposal contemplated that the beneficiary would keep the equipment as long as was needed; however, because of beneficiary contributions to the price of a DME item through their coinsurance and part B premium payments (as well as any payments in addition to Medicare's allowed charges), we believe that a strong argument could be made for beneficiary ownership of the item. In terms of total rental dollars, the most usually rented high-cost items consist of (1) oxygen concentrators, (2) hospital beds and side rails, and (3) wheelchairs. The unresolved question is when beneficiaries no longer need these items, what are they or their estates going to do with them? Because concentrators require periodic maintenance to be effective and wheelchairs require repairs, it is likely that beneficiaries would sell the items to suppliers and perhaps recover their investment.

At the four carriers we reviewed, few concentrators were purchased, but about 16 percent of the total allowed charges for wheelchairs and hospital beds and bed rails were for the purchase of these items. However, we did not obtain data on what the beneficiaries or their estates did with the purchased items when they were no longer needed. We believe this is the type of information that would be needed to address adequately the policy question of ownership.

In any event, we believe that the primary issue is to adopt a reimbursement approach that would result in assured program savings that is equitable to the suppliers and the beneficiaries. We believe that the issue of ownership of the equipment when it is no longer needed is an important but secondary issue.

The suppliers associations' comments expressed strong opposition to the implementation of HCFA's December 1984 instructions for high-cost items based on their belief that implementation would not result in program savings. Both associations supported our proposal or the NAMES proposal, both of which feature a reimbursement formula approach, as preferable to the HCFA approach, which features a case-by-case rent/purchase decision. As noted on page 52, NAMES offered to modify its proposal to produce greater savings. Also, the Health Industry Distributers Association comments provided useful information on how the waiting periods in HCFA's July 1982 instructions may have come about.

CHAPTER 5

OTHER ISSUES

This chapter deals with the remaining issues we were asked to address. Specifically. we were asked to

--assess the appropriateness of lease/purchase as a cost-saving mechanism;

--determine the equity of requiring new equipment warranties on used equipment; and

--assess the adequacy of Medicare reimbursement levels, which according to suppliers involved the amounts allowed for DME purchases, which they considered too low.

Our responses to these three issues are as follows.

USE OF LEASE/PURCHASE AGREEMENTS AS A COST-SAVING MECHANISM

HCFA's July 1982 and December 1984 instructions require the reimbursement of high-cost DME items (over $120) under lease/purchase agreements when such agreements are available and are most equitable and less costly than lump-sum purchase. According to the instructions, the carrier shall pay for DME under a lease/purchase agreement between a supplier and a beneficiary when the carrier determines that purchase is more practical or less costly than the total reasonable rental charges for the expected period of need. The instructions also provide for the lump-sum purchase of equipment if more equitable and less costly than payment on the basis of an available lease/purchase agreement. Based on discussions with HCFA, carrier, and supplier officials, it is unlikely lease/purchase agreements that are less costly than lump-sum purchases will be available.[1]

In both versions of its instructions, HCFA acknowledges that lease/purchase agreements were not then available. The instructions encourage carriers to work with DME suppliers and their trade associations to develop such agreements for various items that Medicare beneficiaries use. However, the instructions also prohibit carriers from requiring the use of lease/

---

[1]In commenting on this point, HHS correctly pointed out that there could be a combination of circumstances involving rental coupled with the later purchase of an item or continued rentals in hardship cases where a lease/purchase arrangement could be cheaper than the lump-sum purchase.

purchase agreements and developing their own local requirements regarding lease/purchase agreements.

Officials of the four carriers included in our review were not aware of any suppliers willing to offer lease/purchase agreements to beneficiaries under Medicare. However, home office officials of the carrier for Georgia (Prudential) advised us of the Medicaid regulations in New Jersey, which for high-cost items essentially limited monthly rental payments for a year to 120 percent of the purchase allowance, at which time the items were "deemed" purchased. As discussed in the previous chapter, the reimbursement regulations under Medicaid programs in New Jersey and Massachusetts include features of lease/purchase agreements[2] that generally limit the rental allowances or the rental allowances plus an allowance for purchase (if the state elects to purchase) to about 120 or 130 percent, respectively, of the purchase allowance.

Because of differences between the methodologies for establishing rental and purchase allowances under Medicare and Medicaid programs in New Jersey and Massachusetts, it was not practical to simulate the precise effect of applying the Medicaid reimbursement formulas to the Medicare rental episode data at the four carrier locations we reviewed. Nevertheless, a rough comparison of the New Jersey and Massachusetts Medicaid reimbursement approaches to the Medicare rental episode data indicates that their potential as a cost-saving mechanism could be significant. This is illustrated in the following table.

---

[2]We did not characterize these arrangements as lease/purchase agreements because (1) they were established by regulations rather than by contracts with individual suppliers, (2) the states had no obligation to complete the transaction, and (3) the states (rather than the individual recipient or beneficiary) took title to the equipment.

Location and carrier	Total allowed rental charges for items costing more than $120 (p. 43)	Amount of excess rental allowance that could have been avoided by limiting rental allowance to 125 percent of purchase allowance (see p. 58)	Percent of total allowed charges
Idaho - Equitable	$ 76,769	$ 15,400	20.1
Georgia - Prudential	1,232,620	385,830	31.3
Southern California - Occidental	1,873,633	398,919	21.3
Kansas/Missouri - Kansas City Blue Shield	680,054	228,513	33.6
Total	$3,863,076	$1,028,662	26.6

Suppliers' views on lease/purchase

NAMES' officials told us that lease/purchase agreements are not common practice in the DME industry and will not be less expensive than lump-sum purchase. They offered the following example of a traditional lease/purchase agreement. Lease/purchase agreements, such as those used for computer systems, require first and last monthly payments up front, interest expense, service contracts, and a legal obligation to complete the contract. The NAMES official believes with these terms a lease/purchase agreement would never be less expensive than lump-sum purchase and will not be offered by suppliers.

NEW EQUIPMENT WARRANTIES FOR USED EQUIPMENT

Medicare will waive the coinsurance requirement and pay 100 percent of the reasonable charge for used equipment when three conditions are met. These conditions are:

1. The actual price must be at least 25 percent less than the reasonable charge for comparable new equipment.

2. The supplier must offer the same warranty that is offered to buyers of new equipment regarding the used equipment's functional capability.

3. The supplier must certify that the used equipment has been reconditioned as necessary and is in good working order and that the reasonable service and repair costs will not exceed those for comparable new equipment.

NAMES' officials told us that the requirement that suppliers provide warranties on used equipment comparable to those on new equipment is unfair and should be eliminated. They stated that manufacturers provide only limited warranties on new equipment and generally provide only parts to suppliers under warranty; the suppliers must provide the labor. They pointed out that by requiring similar warranties on used equipment, suppliers would be responsible for both parts and labor.

We reviewed the warranties offered by four manufacturers of DME items. The warranty periods lasted from 6 months to 3 years depending upon the item. The effective date of the warranty varied among the manufacturers from date of purchase to date of delivery. All four manufacturers warranted their products against defects in material and workmanship under normal use during the period the warranty was in effect. The four manufacturers agreed to replace or repair at their option defective equipment. Three of the four manufacturers would replace or repair warranted parts at no charge. None of the manufacturers would pay shipping charges for the return of defective equipment.

Requiring suppliers to offer similar warranties on used equipment appears unrealistic. The warranties of two of the manufacturers reviewed were limited to new equipment to the original purchaser so that on used equipment a supplier may not have any manufacturer's warranty to fall back on.

Carrier officials told us that the requirement to offer comparable warranties on used equipment was not equitable. Officials from one carrier stated that, traditionally, guarantees on used equipment have been less comprehensive than on new equipment and that this should not be different for DME. Another carrier official stated the requirement is not specific enough to properly administer it. The official questioned who would determine what is an adequate warranty on used equipment.

ARE MEDICARE REIMBURSEMENT LEVELS FOR DME ADEQUATE?

Since we were unable to obtain supplier invoice information on their purchases of DME from manufacturers, we cannot directly address the suppliers' concern about the adequacy of Medicare reimbursement levels for purchases. However, we did find suppliers who offered price discounts, some of which were based on Medicare allowances.

NAMES representatives told us that Medicare reimbursement allowances, particularly for DME purchases, were inadequate. Medicare usually updates its reimbursement allowances for Part B services (including DME) annually. The adjusted DME allowances are based on charges submitted during the previous calendar year. For example, the revised DME allowances that went into effect on July 1, 1984, were based on charges submitted during calendar year 1983. This method of adjusting Medicare allowances has been in effect for at least 10 years. Supplier officials contend that this method of updating allowable charges does not reflect current DME prices.

NAMES officials told us that some Medicare allowances are not high enough to cover supplier invoice costs from the manufacturers. To attempt to verify this assertion, we asked NAMES in January 1983 and again in June 1983 to try to obtain from suppliers current supplier invoice cost data for selected DME items. On both occasions, they agreed to try to get us this information. However, on January 17, 1984, they informed us they would not be able to provide us with any supplier invoice cost data.

However, we did find a few suppliers willing to offer price discounts to health maintenance organizations in Florida and home health agencies (HHAs) in Massachusetts. One supplier in Florida contracted to take a 20-percent discount from the Medicare prevailing allowance for rentals and agreed to negotiate a discount from the prevailing allowance on purchases on an item-by-item basis. Another supplier in Florida agreed to take a 30-percent discount from the Medicare-approved 75th percentile area prevailing charges for its rentals and sales to a health maintenance organization.

HHAs in Massachusetts also received discounts from DME suppliers. One HHA received a 20-percent discount directly on the supplier's invoice price. Another HHA used a bid process to obtain the lowest prices. Suppliers are asked to submit a price list periodically. The HHA selected the supplier who offers the lowest prices. In both cases, the HHAs billed Medicare based on the suppliers' charges to the HHA without any mark-up. A comparison of a sample of the Massachusetts HHAs' submitted charges with Medicare's allowable charge (the lower of customary or prevailing charge) showed that the submitted charges from the suppliers were about 66 percent of Medicare's allowable charges for rentals and about 97 percent of Medicare's allowable charges for purchases; however, about 76 percent of the total dollar amounts of the HHAs' submitted charges applied to rentals.

One test of the reasonableness of a price is the willingness of suppliers to accept it. Under Medicare, this test can be measured by the assignment rate. When claims are assigned, the supplier agrees to accept Medicare's allowable charge as the full charge. As shown in the following table, a large majority of the allowed rental charges at three of the four locations[3] were assigned, but less than a third of the allowed charges for purchases were assigned.

Location and carrier	Period	Allowed charges			
		Rentals	Percent assigned	Purchases	Percent assigned
		(000 omitted)		(000 omitted)	
Idaho - Equitable	10/01/80 to 01/12/83	$ 718	76.3	$ 299	9.2
Georgia - Prudential	10/01/80 to 06/30/83	18,379	96.0	2,217	44.4
Kansas/ Missouri - Kansas City Blue Shield	10/01/80 to 01/31/83	9,948	98.8	2,032	14.0
Total		$29,045	96.4	$4,548	32.8

The fact that the assignment rates for purchases were lower than the rates for rentals in the same locations could indicate that most suppliers had concluded that Medicare's purchase allowances were unacceptably low. On the other hand, the lower assignment rates on purchases could mean that suppliers refuse to accept assignment on purchases to give beneficiaries an incentive to rent.

CONCLUSIONS

Although we identified two state Medicaid programs with reimbursement regulations that included features of lease/purchase agreements for DME and that also represented potential cost-saving mechanisms, we identified no such arrangement under Medicare. Further, because Medicare's regulations provide that lease/purchase arrangements should be less costly than lump-sum purchases, we believe that it is unlikely that such arrangements will be used in the absence of the statutory change discussed in chapter 4 which would limit rental allowances to a specified percentage in excess of the cost of lump-sum purchases.

---

[3]Assignment rates could not be derived from Occidental's claims history tapes.

The requirement that suppliers provide warranties on used equipment comparable to those on new equipment appears unrealistic in view of the variations in the length and coverage on manufacturers' warranties and their uncertain application to used equipment.

We did not fully address the issue of whether Medicare reimbursement levels were adequate, particularly for purchases, because we were unable to obtain verifiable information on what suppliers actually paid for DME items. However, the variations in assignment rates between purchases and rentals suggests that whatever the reasons, suppliers are more willing to accept Medicare's rental allowances than its purchase allowances.

AGENCY AND SUPPLIER COMMENTS AND OUR EVALUATION

In commenting on the contents of this chapter, HHS stated that HCFA would continue to work with industry representatives to see what needs to be done to foster lease/purchase arrangements, including regulatory changes. It also said it would change the regulation which now requires that suppliers provide warranties on used equipment that are the same as for new equipment. Both suppliers associations also agreed that the existing requirement involving warranties on used equipment was unrealistic.

NAMES said that we did not devote sufficient time and effort to support its position that Medicare's allowances for DME purchases were too low. As discussed in our analysis of NAMES' comments in appendix IV, we believe that under the circumstances, we made an adequate effort to obtain verifiable data that were to be based on actual verifiable supplier purchase transactions.

SUMMARY OF TYPES OF OXYGEN-RELATED DME ITEMS

RENTED AND PURCHASED AT THE FOUR CARRIERS REVIEWED

Type of item	Amount allowed		
	Rental	Purchase	Total
Concentrators	$15,094,494	$ 230,174	$15,324,668
Regulators[a]	4,126,506	177,250	4,303,756
Liquid oxygen systems	2,860,092	12,696	2,872,788
IPPB machines[b]	2,764,267	139,915	2,904,182
Portable oxygen systems	1,290,091	246,496	1,536,587
Cylinder carts and stands	933,854	58,341	992,195
Respirators	774,751	60,601	835,352
Nebulizers	465,581	97,375	562,956
Maxi-mists	352,531	43,840	396,371
Suction pumps	319,524	17,406	336,930
Humidifiers	213,734	5,761	219,495
Other	307,629	79,256	386,885
Total	$29,503,054	$1,169,111	$30,672,165

[a]Includes regulators, regulator/humidifiers, and regulator flow-meters.

[b]Intermittent positive pressure breathing machines.

SUMMARY OF TYPES OF NON-OXYGEN-RELATED DME ITEMS RENTED AND PURCHASED AT THE FOUR CARRIERS REVIEWED

Type of item	Amount allowed		
	Rental	Purchase	Total
Commodes	$ 3,442,212	$ 475,906	$ 3,918,118
Walkers and walk aides	2,784,353	732,238	3,516,591
Wheelchairs:			
Non-electric	10,640,485	3,227,361	13,867,846
Electric	296,932	599,665	896,597
Hospital beds:			
Non-electric	7,050,792	439,380	7,490,172
Electric	5,718,751	756,610	6,475,361
Bed rails	2,746,669	127,792	2,874,461
Canes and crutches	316,209	289,205	605,414
Trapeze bars	1,084,722	70,440	1,155,162
Traction equipment	92,954	30,085	123,039
Pads	622,664	78,589	701,253
Patient lifts	416,324	43,768	460,092
Mattresses	56,562	34,776	91,338
Seat lift chairs	29,218	1,616,812	1,646,030
Infusion pumps	184,927	10,396	195,323
Other	834,770	1,089,043	1,923,813
Total	$36,318,544	$9,622,066	$45,940,610

APPENDIX III

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

MAR 28 1985

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report "Procedures for Avoiding Excessive Rental Payments for Durable Medical Equipment Under Medicare Should be Modified." 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,

Richard P. Kusserow
Inspector General

Enclosure

APPENDIX III

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Procedures for Avoiding Excessive Rental Payments for Durable Medical Equipment Under Medicare Should Be Modified"

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to modify the December 1984 instructions dealing with the reimbursement of low-cost DME items on a purchase basis to provide for a 1-month waiting period and that such modified instructions be implemented.

Department Comment

We are pleased that GAO agrees that we should proceed with the policy of limiting reimbursement for low cost DME items to the reasonable purchase price. We do not agree with GAO's recommendation for a 1-month waiting period. GAO's cost saving estimate assumes that all low cost items will be purchased and that a 1-month waiting period would add to program savings in situations where the equipment is needed for a very short time and should be rented rather than purchased. However, our instructions do not mandate the purchase of low cost DME. Rather, our instructions in fact encourage beneficiaries to rent equipment if it is needed for only one or two months. Adding a 1-month waiting period would not only complicate the claims process but, in our judgment, could reduce cost savings since it would add an additional month's rental before the purchase price limitation is applied in all situations when equipment is rented.

GAO Recommendation

Because of the uncertainty as to whether the implementation of HCFA's July 1982 and December 1984 instructions would result in avoiding excess rental allowances for items costing $120 or more, we are making no recommendations as to whether the instructions should be implemented.

Department Comment

Current instructions for items costing more than $120 provide that carriers are to determine whether purchase is more economical than rental no later than the 5th month. If purchase is determined to be more economical, and the beneficiary continues to rent the equipment, Medicare rental payments beginning with the second month after the month the beneficiary is notified will be limited to the reasonable purchase price. GAO's reservations seem to focus on whether carriers will be able to administer the instructions in the manner intended. GAO therefore, concludes that savings are uncertain. This conclusion is based on GAO's judgment that the reliability of the medical necessity forms they examined was questionable and thus carriers will make errors in their rental/purchase decisions.

However, we believe that the carriers will be able to administer the instructions properly and that the anticipated savings will be achieved. In that regard, HCFA will take steps in the following areas to assure that improvements are required in the completion of medical necessity forms:

- Better education of physicians through carrier newsletters and general trade press informational activities as to the significance of their DME prescriptions;
- Identification and implementation of ways to improve carrier processing of medical necessity forms, including standards to be applied by carriers in making rental/purchase judgments; and,
- Initiation of regional office and central office monitoring of carrier administration of the process.

After further experience has been gained, we also will initiate further regulatory or operational changes needed to improve the administration of this provision.

Matters for the Consideration of the Committee

Because of the potential savings involved, we believe the Committee should consider whether a legislative change is warranted that limits rental allowances for high-cost DME items to a specific percentage in excess of the purchase price. Such a change would provide that Medicare rental payments for DME items may be made only on the basis of an assignment where the supplier agrees to accept the Medicare allowances and related limitations.

Department Comment

GAO's proposal to cap reimbursements for DME at some fixed multiple of the purchase price (e.g., 125%, 150%, etc.) is not unlike our current policy: both create a schedule of maximum payments for each item of DME. In addition, GAO's position could even set the allowed increment to approximate the portion of the purchase price that, on average, is paid in rentals during the decision period under existing policy.

However, we agree that this approach would be administratively simpler than the current system. Additionally, the cap is likely to produce the most certain savings to the program, at levels determined by the percentage at which the cap is fixed. We think it may be worthwhile to consider a combination of having carriers make rent/purchase decisions but have the overall cap on rental allowances. We note that the cap proposal does not address the issue of ownership of DME after the maximum amount of the cap has been reached. We think consideration should be given to this area, including the possibility that once the cap amount is reached, suppliers be required to treat DME as the property of the beneficiary. We will consider the issue further as we develop our legislative proposals. We also plan to explore with our Office of General Counsel the possibility of accomplishing such a change through modification of our regulations.

APPENDIX III

Other Issues

— Use of Lease/Purchase Agreements as a Cost Saving Mechanism

GAO notes that lease/purchase arrangements are not common and will not be less expensive than lump sum purchase. We agree that they are not cheaper than lump sum purchase in a case where it is clear that the beneficiary will have long term need for the items; however, they may be cheaper than rental coupled with later purchase, or than the continued rental which occurs in hardship cases. In addition, they avoid some of the risk associated with carrier determinations as to future medical necessity. (This assumes rental can be terminated prior to purchase of the item.) They also offer the advantage over a cap on rental payments that the beneficiary is assured use of the item once the purchase price is reached. Although lease/purchase agreements are not currently offered by all suppliers, HCFA will continue to work with industry representatives to see what needs to be done to foster lease/purchase arrangements, including regulatory changes.

— New Equipment Warranties for Used Equipment

GAO believes that requiring the same warranty for used equipment as that used for new equipment is unrealistic. We agree, and will take steps to change the regulation which establishes this requirement. Our present policy provides that if used equipment costing no more than 75 percent of the price of new equipment is purchased, Medicare will pay 100 percent with no beneficiary cost sharing. However, for equipment to qualify for 100 percent payment, the supplier must offer the same warranty that is offered for buyers of comparable new equipment.

March 13, 1985

Richard Fogel, Director
General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

Thank you for providing NAMES with an opportunity to review and comment on the draft GAO report on durable medical equipment (DME) under Medicare. Your analysis of the issues concerning the rental or purchase of DME should not be overlooked by Congress in reviewing the Health Care Financing Administration's premature implementation of the December 1984 rent/purchase guidelines.

GAO Note: The following is a word-for-word copy of NAMES' detailed comments. Our analysis follows its comments.

NAMES COMMENT:

In particular your analysis, if not your conclusions and recommendation, strongly support the following positions advocated by NAMES.

• implement the guideline provisions on inexpensive equipment because they would achieve cost saving and would not disrupt the administration of DME claims by carriers.

• do not implement the guideline provisions on expensive equipment because they would not achieve cost savings and would significantly disrupt the administration of DME claims by carriers.

• the original statute is flawed because lease/purchase agreements would never be less costly and more practical.

• new equipment warranties for used equipment are unrealistic.

• evidence suggests that the reimbursement levels for purchases of DME are not adequate.

GAO ANALYSIS:

As indicated in the introduction of NAMES' comments, our conclusions and recommendation are not necessarily consistent with the above positions advocated by NAMES. Specifically we did not conclude that implementation of HCFA's instructions for high-cost items would result in increased Medicare costs (see p. 61). However, we concluded that the regulations and related HCFA instructions were flawed by requiring that lease/purchase arrangements be less costly than lump-sum purchase (see p. 65). Section 16 of Public Law 95-142 does not include such a requirement. Finally, we believe that the evidence is mixed as to the adequacy of Medicare reimbursement levels for the purchase of DME (see p. 68).

NAMES COMMENT:

In summary, GAO's analysis confirms NAMES longstanding position that inexpensive equipment should be purchased rather than rented, that the NAMES proposal to curtail long-term rentals of more expensive equipment was not only a responsible position, but a method which the GAO has indicated is a better approach to resolving the problem of excessive rentals than the method offered by either HCFA or Blue Cross/Blue Shield of Greater New York.

Moreover, the point NAMES has made and which the Williams College study verified, regarding the inability to accurately predict the beneficiary's period of need for equipment is now fully supported in the draft GAO report. The NAMES alternative for reimbursement of expensive equipment recognizes this flaw in the rent/purchase guidelines and thus, proposes a procedure which avoids the need for such information. This would require no guessing by carriers.

NAMES remains prepared to modify its payment proposal to achieve greater savings. Such modification might include reducing the period of rental, reducing the percentage for continuing maintenance, and adding certain oxygen equipment (if life support and maintenance issues are addressed).

GAO ANALYSIS:

The modifications to NAMES' payment proposal, as previously communicated to our staff, are presented on pages 53 and 54.

NAMES COMMENT:

With respect to the GAO analysis conclusions and recommendations, we have the following comments:

Excessive Rental Definition: GAO premises expected savings on an unrealistic definition - e.g.: excessive rental. Such definition uses "prevailing purchase price" to calculate the point at which savings can be achieved. The guidelines and, we believe, Williams College, both use "submitted purchase price", not "prevailing." The definition also fails to include an assessment of additional Medicare expenditures for that purchased equipment (i.e.: covered repairs, maintenance, replacement, disposable supplies, delivery) and an assessment of implementation and ongoing administrative expenses. To the extent "excessive rentals" is interpreted as "possible savings", each of these faults in the definition result in an unrealistically high expectation of savings. Moreover, such savings are the maximum possible achievable and only achievable in a perfect world -- as Williams College pointed out, such perfect world is unattainable. GAO fails to assess the degree to which such savings represent a perfect world, and, therefore, mislead readers into believing all excess rentals could be saved.

GAO ANALYSIS:

We do not believe that we equated expected savings with the excess rental definition. On page 30, we specifically pointed out that "in the absence of a policy that would provide that Medicare payments would stop when the rental allowance equaled the purchase allowance on an item-by-item or episode-by-episode basis, there is no practical way that all excess rentals can be avoided." We used Medicare's "prevailing" charges for purchases (which we obtained from the carriers) to compare with the actual allowed rental charges because prevailing charges represented the maximum amounts that Medicare would allow. To some extent our computation of excess rental allowances was understated.

For about 32 percent of items analyzed, we used more current and consequently higher prevailing purchase allowances than were in effect during the December 1980 through February 1981 period, when the rentals started. Moreover, if a particular supplier's actual or customary charge for the purchase of an item at the beginning of an episode was less than the maximum allowable, our computations of excess rentals would be further understated. Also, under HCFA's instructions, submitted charges for the purchase of an item are used only to determine whether the item meets the definition of a low- or high-cost item. Thus, as a measure of excess program payments, prevailing charges are more realistic than "submitted" charges.

Finally, routine maintenance and delivery charges for purchased DME items are not covered by Medicare as separate charges and thus should not be factored into the excess rental allowance equation.

NAMES COMMENT:

Episode Analysis: GAO assumed that a two month period without a rental charge constituted a break in the rental period of an item while Williams College used a one month period. We believe that use of a two month period artificially increases the incidence of long term rental and incorrectly assumes that saving would be achieved from those rentals. GAO reports the decrease in long term rentals using a one month break but fails to translate such findings into reduced savings. The Williams College method presents a more realistic approach and reflects actual practice under the guidelines.

GAO ANALYSIS:

As pointed out on page 23, Williams used a 1-month break in service for terminating an episode on assigned claims and a 2-month break in service for nonassigned claims.

We believe that in terms of the rent/purchase issue, a 2-month break in service is more realistic. At the two largest carriers included in our review (Prudential in Georgia and Occidental in Southern California), about 13 percent of all our rental episode lengths would have changed by using a 1-month rather than a 2-month break. The types of items most commonly affected by such a change were (1) hospital beds and bed rails, (2) oxygen cylinder carts and stands, (3) regulator-humidifiers, (4) standard wheelchairs, and (5) commodes. If beneficiaries had purchased such items at the onset of need and were subsequently hospitalized or their need for the items at home was otherwise temporarily suspended, it does not seem reasonable to assume that they would dispose of the item and again buy the same item of equipment when their use for it resumed.

NAMES COMMENT:

GAO alludes to another serious flaw in their episode analysis, but never attempts to reconcile such flaw when determining potential savings. That is, the inability to track the use of different items of the same or similar equipment during an episode. For example, during a 10 month episode the beneficiary's condition may have changed necessitating a different wheelchair to meet his medical need but the billing is under the same code as the original wheelchair. Therefore, the GAO's episode analysis would not identify the actual use of equipment during the billing episode. Or, the wheelchair may have been replaced because the original wheelchair required repairs. The assumption of excessive rentals for an item would not apply in those examples, therefore the expected savings are not achievable.

GAO ANALYSIS:

We disagree with the implication that we never attempted to obtain information on the extent that different items of the same or similar equipment were used during an episode. During our review, a NAMES official had told us that this situation was occurring. However, he did not have any data to show how frequently this happens.

In the absence of such data from the suppliers, and considering that we were dealing with about 28,000 rentals, we would have had to contact a relatively large number of beneficiaries, which may or may not have produced reliable data. In our view this was not practical.

NAMES COMMENT:

Application of Sample to Universe: GAO notes that the projectability of data nationwide is limited. However, such summary statement was never fully explored. It is essential that GAO explain to Congress the extent to which the GAO report may be used for national policy.

GAO ANALYSIS:

This comment appears to assume that we have nationwide information on the distribution of the lengths of DME rentals that would be necessary to make the type of explanations NAMES suggests. As previously stated, the carriers and locations we reviewed were not selected at random; therefore, the results of

the review cannot be projected to all carriers and locations. However, as discussed on pages 22 and 23, the rental episodes from the four locations we reviewed using 1981-83 data closely parallel the results found by Williams at five of its locations during 1976-77.

Overall these nine locations represented about 14 percent of all Medicare part B claims processed in 1980.

NAMES COMMENT:

Prevailing Purchase Screens Too low: The GAO report's incomplete analysis of Medicare reimbursement levels for purchase is a major flaw of the report. Such analysis is essential, in view of HCFA's unyielding implementation timetable, to determine implications on quality, technology innovations and assignment. Certainly a greater effort, at a minimum, could have been made to obtain product acquisition data from manufacturers or directly from suppliers. Moreover, GAO completely neglected to frame the issue in a way that would provide assistance to policymakers in reviewing the subject. For example, identification of reasonable components of the purchase price e.g.: product acquisition cost including freight, beneficiary delivery, set-up and training costs, general overhead costs.

GAO ANALYSIS:

As indicated by the NAMES comment, the components of a DME supplier's sales price for a product would be the suppliers' costs, including the cost of acquiring the product from the manufacturer. However, DME providers are reimbursed under Medicare on the basis of reasonable charges, not reasonable costs; therefore, there are little verifiable data on DME supplier costs that we could use. We believe that if the DME industry wants to introduce the question of its overall costs for the purpose of establishing the reasonableness of Medicare's reimbursement levels, the suppliers should fill out certified cost reports, in accordance with Medicare cost reimbursement principles, which are subject to audit--similar to the requirements for other cost-based providers.

We had originally requested suppliers' acquisition costs based on their invoices for actual bona fide purchase transactions to verify allegations that Medicare's purchase allowances were less than the suppliers' current costs of acquiring the items. We believed this information would have been significant because it is not reasonable to expect suppliers to sell items for less than they pay for them. NAMES states that we

should have made a greater effort to obtain product acquisition data. Under the circumstances, we believe we made an adequate effort to obtain such information. As discussed on page 69, NAMES officials twice agreed to try to obtain verifiable supplier acquisition cost data for us. Eventually, about a year after the initial request, they told us they would not be able to provide such information.

NAMES COMMENT:

In addition, the trade off between a lower cost, lower quality product and a higher repair, higher replacement product as well as increased health costs for the patient with the less suitable product, needs to be addressed in GAO's analysis of reasonableness of purchase prevailing. A November 1984 Office of Technology Assessment case study is particularly relevant in this regard. This study found that: 1) the emphasis on price over performance in the reimbursement procedure has probably discouraged innovation, 2) cost comparisons are more meaningful if "total annualized costs," which includes maintenance and repair, are computed, 3) encouraging innovation may result in lower total annualized costs.

GAO ANALYSIS:

In November 1984, the Office of Technology Assessment case study referred to by NAMES was limited to wheelchairs.[1] It showed that over the 3.5-year life of a manual wheelchair, annual repair costs were about 26 percent of the purchase price. These data may be relevant to the rent/purchase issue and the computation of the excess rental allowance discussed in the report because repair costs are included in the rental allowances but not in the purchase allowance. However, we question how we could apply these data to the other product lines included in our analyses.

On the other hand, Medicare varies its purchase allowance depending upon the type and sophistication of the wheelchair ordered by the beneficiary's physician, and these allowances are, in turn, based on the suppliers' prior submitted charges, which presumably reflect higher charges for higher quality products. Therefore, the Office of Technology Assessment study does not seem directly relevant to the issue of whether Medicare's prevailing purchase allowances are adequate.

---

[1]Health technology case study 30. "The Market for Wheelchairs Innovations and Federal Policy." OTA-HCS-30.

NAMES COMMENT:

Administrative Costs

The GAO analysis fails to adequately take into consideration the implementation and ongoing administrative costs resulting from the new guidelines. Such analysis must include the change in administrative costs to HCFA, carriers, suppliers and beneficiaries from the new guidelines and from the alternative method proposed by NAMES. We believe the NAMES proposal to be virtually cost neutral with respect to administrative cost while the HCFA guidelines, based both on projection and actual experience since February 1, 1985 significantly increase administrative expenses. Finally, any increase in administrative costs, both implementation and ongoing, must be used to reduce the overall projected savings.

GAO ANALYSIS:

Although an important consideration, we believe that NAMES and the other supplier organization (HIDA) have placed too much emphasis on increased carrier administrative costs involved in implementing the HCFA December 1984 instructions for high-cost items. From fiscal years 1978 through 1983, total carrier administrative costs have increased by an average of about 7 percent a year despite inflation and an increase in workload (claims volume) of about 11 percent a year. In contrast, total Part B benefit payments (including DME) have increased at a rate of about 19 percent a year during the same period. Thus, we believe controlling the increase in benefit payments represents a more critical concern than carrier administrative costs.

As stated on page 50, two of the four carriers we reviewed gave us estimates of the additional costs to implement the HCFA DME instructions for high-cost items. These additional costs were about 1 percent of DME benefit payments. Finally, because we did not make a simulation of any savings resulting from the implementation of HCFA's instructions for making case-by-case rent/purchase decisions, there are no amounts in the report from which we could reduce the overall projected savings as suggested by NAMES.

NAMES COMMENT:

GAO Fails to Meet Responsibility

After months of analysis, investigation and research, it is inexcusable that the GAO cannot make a recommendation on whether

These formula approaches are readily susceptible to simulation as to their probable effects using actual rental periods and allowed charge data. In contrast, HCFA's approach involves a case-by-case determination of when it would be more economical and practical to buy a specific DME item rather than rent it. Although it may be possible to model such an approach, this would require that we make a number of arbitrary assumptions to arrive at the number of items in our rental episode data that would be purchased under HCFA's instructions and, more critical, given that assumed number, the specific items in our rental episode data that would be purchased. Because we believe that such an exercise would be too speculative, we did not attempt it.

NAMES COMMENT:

In summary, the GAO report is a valuable resource for Congress, the administration and industry which must not be ignored. The analysis demands that HCFA proceed with implementation of the provision for inexpensive items and withdraw the guideline provisions for expensive items. The NAMES and GAO cap proposals must be utilized in developing a substitute for HCFA's withdrawn provision. Finally, the GAO final report should include a summary chart which reduces the anticipated savings by the additional expenses noted in the preceding paragraphs.

Thank you again for providing NAMES with an opportunity to review and comment.

Sincerely

Sanford J. Linden
President

cc: Finance Committee
Ways & Means Committee
Dr. Carolyne Davis
James L. Scott
Mac Haddow

APPENDIX V

HIDA HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

1101 CONNECTICUT AVENUE, N.W., SUITE 700 WASHINGTON, D.C. 20036 202-857-1166

March 18, 1985

Richard L. Fogel
Director,
Human Resources Division
United States General Accounting Office
441 G Street, N.W.
Room 6864
Washington, DC 20548

Dear Sir:

The General Accounting Office has done an excellent job in outlining many of the uncertainties and difficulties inherent in the recent decision of the Health Care Financing Administration to require carriers to make payment for durable medical equipment, in many cases, on the basis of purchase rather than rental. The conclusions reached by the GAO parallel many of those made previously by the Health Industry Distributors Association and its predecessor organization, the American Surgical Trade Association. Most specifically:

1. We have long advocated that the Medicare program should purchase all low-priced equipment. We do not have additional data at this time on which to base an opinion on the GAO's recommendation that this equipment should be rented for one month prior to purchase. Clearly, the decision to purchase low-cost equipment is the one part of the HCFA program which has the clear potential of reducing Medicare program costs.

2. HIDA (actually ASTA, at that time) advocated in meetings with the HCFA staff in 1980 and 1981 that all higher-priced equipment should be rented for an initial period of five months, with a decision made by the carrier subsequently as to whether purchase or continuing rental would be more economical and advantageous. Our reason for this recommendation was evidence that the majority of all rentals terminate before six months. The system we recommended would therefore avoid the time-consuming and costly process of carrier review which would be required if all claims were reviewed immediately by the carriers in the attempt (often futile) to decide if rental or purchase would be more economical. Second, we pointed out that the medical necessity forms submitted with initial rental claims are often too imprecise - or even misleading - for carriers to use in making a rational decision whether purchase would be more economical than rental.

The initial rent/purchase guidelines issued to the carriers in July 1982 followed this HIDA recommendation. However, the revised December 1984 guidelines changed this, directing carriers to review claims in the second month. Although the carrier can delay a decision until the fifth month and then review and further develop the claim at that time, he would in this case have the added expense of a second manual review of the claim. In this situation, we believe that many carriers will prefer to review the claim only once, making a decision - often incorrect - at the first-month review.

The GAO study shows conclusively that this will be a mistake. Based on a review of the medical necessity forms at two carriers, GAO concludes that "the information in the medical necessity forms, when available, was inadequate and often unreliable, particularly with regard to purchase decisions". The GAO further observes that "based on the information shown on the medical necessity forms, filed at the start of a rental episode, the chance of error (78 percent) for the indicated purchase decisions would be unacceptably high at the two carriers".

HIDA therefore recommends that HCFA should revise the guidelines to provide, as in the 1983 instructions, that rentals for high-priced equipment should be approved initially and diaried for review after the fifth month. Review at that time could include claims development and, where appropriate, contact with the physician to further develop the information on the medical necessity form. As most rentals will have terminated by that time, the carriers work load will be greatly reduced and careful development of the limited number of claims will be possible.

3. We believe the proposal of the National Association of Medical Equipment Suppliers (NAMES) also deserves serious consideration. The GAO review validates that this proposal provides assured savings. Implementation is based on a number of months rental rather than on prescriptions. Carrier administrative costs would be reduced and the risk would be removed of mistaken purchase decisions which could increase program costs.

4. HIDA (then ASTA) noted in formal comments to HCFA on the proposed rent/purchase regulation in 1979 that it was unrealistic to expect a supplier to provide the same warranty on used equipment as on new. We are glad the GAO agrees and trust that HCFA will revise this requirement. As HIDA noted at that time:

"The American Surgical Trade Association supports most provisions of paragraph (k) concerning waiver of co-insurance for purchase of used equipment. However, the provisions of paragraph (2) (i), requiring

the supplier to certify that reasonable service and repair expenses would not exceed that of new equipment and that the suppliers must give the beneficiary the same warranty that is given buyers of comparable new equipment, seem unrealistic."

"These tests would require that the used equipment must in all ways equal new equipment; that the used equipment would last as long and require as little service as equipment which had never been used. Is this reasonable? Who among us, in buying a re-conditioned automobile, would expect that automobile to carry the same warranty and require no more services and repair than a new car directly for the manufacturer? Requiring such assurances will hardly encourage suppliers to offer used durable medical equipment eligible for the waiver of co-insurance."

"To solve this problem the American Surgical Trade Association recommends that paragraph (2) (i) should read, 'if the used equipment is purchased from a commercial supplier, the supplier must certify that the used equipment has been reconditioned and is in good working order'."

Sincerely,

Robert E. Altstock
Chairman

(106243)

For sale by:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

Telephone (202) 783-3238

Members of Congress; heads of Federal, State, and local government agencies; members of the press; and libraries can obtain GAO documents from:

U.S. General Accounting Office
Document Handling and Information
Services Facility
P.O. Box 6015
Gaithersburg, Md. 20760

Telephone (202) 275-6241

to implement HCFA's December 1984 instructions as it applies to items costing more than $120. After carefully reading the GAO report, it is clear that HCFA's December 1984 instructions, as they relate to items costing $120 or more, do not meet the statutory criterion that purchase of equipment would be less costly or more practical than rental.

The fact is that HCFA's inferior approach is not an effective or efficient method of meeting the statutory requirements. Other approaches, including NAMES' recommendations could work better. HCFA's approach is mediocre at best; it does not reduce cost and is less practical than the current system. GAO has taken a position on its recommended approach, on NAMES' approach and on Blue Shield's approach. Therefore, GAO should not be afraid to publicly state that HCFA's approach does not save money, does not comply with the law and, therefore, should be withdrawn.

GAO ANALYSIS:

We believe that we have a responsibility to reach conclusions and make recommendations that are fully supported by the empirical evidence developed during our reviews and presented in the reports.

As discussed on page 61, we believe that there is insufficient evidence to support a conclusion that implementing HCFA's July 1982 and December 1984 instructions relating to high-cost items would not result in program savings as HCFA assumes. The rationale for this view involved two factors. First, our simulation of the probable effect of purchasing after various waiting periods showed that from 12 to 26 percent of the excess rentals could have been avoided at three of the four locations if there was an automatic purchase decision after a 6-month waiting period. This approach is consistent with the maximum waiting period in the HCFA instructions. Second, we could not simulate the probable effect of the instruction involving the carriers' rent/purchase decisions on a case-by-case basis because we did not know what information the carriers would be obtaining to facilitate such decisions.

Also, we believe that it is neither fair nor completely accurate for NAMES to state that we took a position on our proposed approach, its approach, and on Blue Shield's approach, but not on HCFA's approach. There is an important difference between the first three reimbursement approaches and HCFA's in that the former involve reimbursement formulas based on either percentages of a purchase allowance or various rental periods.