REPORT TO THE CONGRESS

Need For Legislation To Authorize More Economical Ways Of Providing Durable Medical Equipment Under Medicare

B-164031(4)

Social Security Administration

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

MAY 12, 1972

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

B-164031(4)

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

This is our report on need for legislation to authorize more economical ways of providing durable medical equipment under Medicare. The Medicare program is administered by the Department of Health, Education, and Welfare.

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

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Elmer B. Staats

Comptroller General
of the United States

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
PHS	Public Health Service
SRS	Social and Rehabilitation Service
SSA	Social Security Administration
VA	Veterans Administration

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

NEED FOR LEGISLATION TO AUTHORIZE MORE ECONOMICAL WAYS OF PROVIDING DURABLE MEDICAL EQUIPMENT UNDER MEDICARE

Social Security Administration
Department of Health, Education, and Welfare B-164031(4)

D I G E S T

WHY THE REVIEW WAS MADE

Because of the expressed interest of the cognizant legislative committees of the Congress, the General Accounting Office (GAO) made a review in five States (California, Illinois, Michigan, Washington, and Wisconsin) to see if the current Medicare law was promoting the most economical ways of providing durable medical equipment--a term used to mean such things as wheelchairs, hospital beds, and respirators--used by Medicare patients in their homes.

Background

Payments for physicians' services and certain other medical and health benefits, including durable medical equipment, are made for the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW), by paying agents--or carriers--under contract. The patient usually is responsible for sharing in these costs by paying the first $50 of charges for services covered by Medicare and 20 percent of the remaining charges (coinsurance) each year.

The original Medicare law provided only for rental of equipment for use in a patient's home. In January 1968 the Congress amended the law to authorize either purchase or rental of such equipment. If the patient elects to purchase the equipment, Medicare pays, subject to the patient's share:

--A lump sum for "inexpensive" equipment, defined by HEW regulations as equipment costing $50 or less.

--Periodic installments equal to rental payments for "expensive" equipment costing over $50.

The amendment was intended to prevent Medicare payments for the purchase of costly equipment used or needed for only a short time. If a Medicare patient dies, recovers, or is hospitalized, Medicare installment payments are stopped even though the patient or his estate may not have been reimbursed fully for Medicare's share of the purchase price.

The law does not limit the total amount of rental charges. The Congress relied on the 20-percent-coinsurance feature to encourage economical rent-or-purchase decisions by the patients. (See p. 8.)

FINDINGS AND CONCLUSIONS

Medicare patients often rented durable medical equipment even when the periods of need--as estimated by their physicians--were long enough to justify purchase.

At five carriers in four States, GAO analyzed a statistical sample of patients' claims selected from the claims of the 13,000 patients whose claims for durable medical equipment were processed in 1970. For the 13,000 patients, GAO estimated that savings of $234,000--including the patients' share of $47,000--could have been realized if the equipment had been purchased when the anticipated periods of need indicated that purchases would have been more economical than rentals. (See p. 12.)

At a sixth carrier in the fifth State, GAO analyzed a sample selected from the claims of the 7,000 patients whose claims were processed during August 1971. For the 7,000 patients, GAO estimated that savings of $763,000--including the patients' share of $153,000--could have been realized. (See p. 12.)

Most of the estimated savings were applicable to about 15 percent of the rental items--where the aggregate rentals for those items were at least three times the purchase prices. For example:

--A patient with heart trouble rented a walker for 16 months at rental charges totaling $290. Her physician's prescription stated that she would need the walker for 1 year. The monthly rental charges would have equaled the $90 purchase price for the item in 5 months. (See p. 15.)

--A patient with a chronic, destructive skin condition rented a hospital bed with a trapeze bar for nearly 4 years. His physician had indicated that the patient would need the equipment indefinitely. The rental charges totaled $1,996, compared with the purchase price of $318. (See pp. 15 and 17.)

Factors inhibiting purchases of durable medical equipment

A variety of factors led patients to rent equipment even though their physicians had indicated long-term needs.

--Equipment suppliers would not accept patients' assignments of their rights to reimbursement for purchases because Medicare could discontinue payments, as noted above. (See p. 26.)

--Patients had to rent equipment because they could not afford to make lump-sum purchase payments which were reimbursable by Medicare only through installments. (See p. 26.)

--Patients had little incentive to reduce costs by purchasing equipment because their coinsurance share of the rental charges were forgiven by suppliers or were paid by others. (See p. 27.)

--Patients were unaware of their option to purchase. (See p. 27.)

Incompatibility of Medicare restrictions on purchases with Medicaid

Four of the five States furnished durable medical equipment under their Medicaid programs. In three States Medicare's restrictions on lump-sum reimbursements for equipment costing over $50 tended to encourage long-term rentals by patients enrolled in both Medicare and Medicaid. (See p. 29.)

In the fourth State arrangements had been made to encourage purchasing by these dual enrollees. HEW believes that a feature of that State's Medicaid program--under which certain equipment was made available to Medicaid patients only on a loan basis from the State's equipment pool--is contrary to the "freedom of choice" provision of the Medicaid law. GAO believes that the intention of the Congress in this regard is not clear. (See p. 31.)

Equipment prices under Medicare higher than prices under other federally financed health programs

Under the Medicare law HEW or its carriers are not allowed to negotiate with suppliers to secure lower prices for durable medical equipment.

Such equipment is purchased by the Veterans Administration (VA), the Public Health Service, and a State Medicaid agency at discounted prices--often considerably less than the suppliers' list prices which are the basis for charges to Medicare. VA prices are specified in contracts which usually are awarded on the basis of competitive bids. (See p. 34.) For example:

--A supplier's Medicare price for a standard wheelchair was $122. The price for the same wheelchair under the VA contract was about $86, or 30 percent less.

--A supplier's Medicare price for a hospital bed having safety sides was $336. The same bed under the VA contract was $270, or 20 percent less.

RECOMMENDATIONS OR SUGGESTIONS

The best solution to this problem may differ from area to area, depending on such factors as the provisions of the State Medicaid programs and the practices of the suppliers. Therefore GAO believes that HEW should have flexibility in finding the best solution in a given locality.

Recommendations to the Congress

The Congress should amend the Medicare law to authorize HEW to find more economical methods for paying for durable medical equipment, including authority to:

--Make lump-sum payments for purchases of equipment when, on the basis of anticipated periods of need, purchase appears to be more economical than rental; require the early submission of such claims; and limit payments to the amounts payable under the recommended rent-or-purchase decision.

--Enter into agreements with suppliers aimed at limiting rental payments after they exceed the purchase prices by specified percentages and at obtaining prices for the purchase of equipment that are comparable to those obtained by other federally financed health programs.

Also the Congress may wish to clarify its intent as to whether an arrangement whereby a State maintains pools of equipment which is required to be used by Medicaid patients on a loan basis is inconsistent with the freedom-of-choice provision of the statute.

Recommendations to HEW

If the recommended legislative changes are adopted by the Congress, HEW should make the most of the new authority. (See p. 38.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW was given an opportunity to review a draft of this report and agreed with GAO's recommendations. Further, on March 17, 1972, the Senate Committee on Finance announced that, in connection with the Committee's deliberations on the Social Security Amendments of 1971 (H.R. 1), it had decided to initiate an amendment to the Medicare law along the lines recommended by GAO. (See p. 40.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report contains specific recommendations for legislative action by the Congress, as set forth above.

CHAPTER 1

INTRODUCTION

Titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395, 1396), enacted on July 30, 1965, as the Social Security Amendments of 1965, established the Medicare and Medicaid programs to protect eligible persons against the cost of health care services.

Under Medicare, which became effective on July 1, 1966, eligible persons aged 65 and over may receive two basic forms of protection:

--Part A, designated as Hospital Insurance Benefits for the Aged, covers inpatient hospital services and certain posthospital skilled nursing care in extended-care facilities and in the patients' homes. Benefits paid are financed by special social security taxes collected from employees, employers, and self-employed persons. Over 20 million persons have part A coverage.

--Part B, designated as Supplementary Medical Insurance Benefits for the Aged, is a voluntary program and covers physicians' services and other medical and health benefits, including durable medical equipment for use in beneficiaries' homes. Benefits paid are financed by premiums collected from eligible beneficiaries who have elected to be covered by the program and by matching amounts appropriated from the general revenues of the Federal Government.

A beneficiary usually is responsible for paying the first $50 (the deductible) for covered medical services provided each year. Medicare usually pays 80 percent of the reasonable charges for covered services in excess of $50 each year; the remaining 20 percent (coinsurance) usually is the responsibility of the beneficiary. Medicare payments may be made to a beneficiary or to the physician or others providing the services under the beneficiary's assignment of

his right to reimbursement. About 19 million persons have part B coverage.

Under Medicaid, a grant-in-aid program which became effective January 1, 1966, the Federal Government shares in the costs of the States in providing medical assistance to eligible persons--regardless of age--who are unable to pay for health care. Since its inception, State Medicaid programs have been required to provide inpatient and outpatient hospital services, laboratory or X-ray services, skilled-nursing-home services, and physicians' services. Additional services, such as prescribed drugs, dental care, and durable medical equipment for use in a patient's home, may be included in its Medicaid program if a State so chooses.

States having Medicaid or other medical assistance programs may enter into agreements with the Federal Government to obtain part B Medicare benefits for persons aged 65 and over who are eligible for both Medicare and State medical assistance. As of December 1971, 46 States and three jurisdictions--the District of Columbia, Guam, and the Virgin Islands--had such agreements. Under these agreements the States and the jurisdictions pay the monthly Medicare premiums on behalf of such persons and, depending on the services covered by the State plans, the annual deductible of $50 and the 20-percent coinsurance.

As of December 1971 about 2 million persons were covered under both Medicare and Medicaid under these agreements, including 1.9 million persons in States and jurisdictions which, under their medical assistance programs, provided durable medical equipment for persons aged 65 or over.

ADMINISTRATION OF MEDICARE AND MEDICAID

HEW has overall responsibility at the Federal level for the administration of Medicare and Medicaid. Within HEW, SSA administers Medicare and the Social and Rehabilitation Service (SRS) administers Medicaid. SSA and SRS develop program policies, set standards, and ensure compliance with Federal legislation and regulations.

SSA has contracted with public and private organizations and agencies to act as carriers[1] to administer most benefits under part B of Medicare. The carriers process and pay Medicare claims, determine the rates and amounts of payment, and determine the medical necessity of the services as a condition for payment.

Under Medicaid the States initiate and administer their own programs. The nature and scope of a State's Medicaid program are specified in a State plan which, after approval by HEW, provides the basis for Federal grants to the State. The Federal Government pays for 50 to 83 percent (depending on the per capita income in each State) of the costs incurred by the States under their Medicaid programs.

The States may contract with private organizations for assistance in administering their programs. The functions and responsibilities assigned to the contractors, called fiscal agents,[1] may differ, depending on the contractual arrangements established by the States.

As of December 1971, 48 States and four jurisdictions--the District of Columbia, Guam, the Virgin Islands, and Puerto Rico--had adopted Medicaid programs and, except for four of the States--Idaho, Michigan, Missouri, and Wyoming--had provided for the rental and/or purchase of some form of durable medical equipment for persons aged 65 or over for use in their homes.

---

[1] In many geographical areas the Medicare carriers and the Medicaid fiscal agents are the same organizations.

DURABLE MEDICAL EQUIPMENT

As defined in SSA instructions, durable medical equipment is equipment which

--can withstand repeated use,

--primarily and customarily is used to serve a medical purpose, and

--generally is not useful to a person in the absence of illness or injury.

To be covered under part B of Medicare, the equipment must be used in the patient's home and must be necessary and reasonable for the treatment of the patient's illness or injury or for improving the functioning of the patient's malformed body member.

Such items as hospital beds, wheelchairs, respirators, medical regulators, crutches, inhalers, commodes, and traction equipment are considered to be durable medical equipment. Conversely such items as air conditioners, dehumidifiers, elevators, and posture chairs ordinarily are not considered by SSA to be durable medical equipment but are considered to be primarily nonmedical or convenience items.

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

Under the Social Security amendments of 1965 (79 Stat. 286), which established Medicare, part B covered only the rental of durable medical equipment.

The Social Security Amendments of 1967 (81 Stat. 821), approved January 1968, provided for reimbursement for either purchase or rental of durable medical equipment. Under the 1967 amendments, if a beneficiary elected to purchase equipment after December 31, 1967, reimbursement, subject to the deductible and coinsurance provisions, could be made under part B of Medicare

--on a lump-sum basis for inexpensive equipment, defined by HEW regulations as equipment costing $50 or less, or

--in periodic installments equal to the rental payments for expensive equipment costing over $50.

These provisions were intended to prevent the use of Medicare funds for the purchase of costly equipment used or needed for only a short time. If a beneficiary dies, recovers, is hospitalized, or is confined to an extended-care facility, Medicare payments are terminated even though the beneficiary may not have been reimbursed fully for 80 percent of the purchase price.[1]

The rationale underlying the foregoing provisions was included in the reports[2] of the House Committee on Ways and Means and the Senate Committee on Finance on House bill 12080. The House and Senate reports both state that:

"*** To avoid paying the full purchase price of costly equipment used only a short time and thereby allowing the patient or his estate to profit upon its disposition, the bill would provide that benefits for the purchase of relatively expensive items of durable medical equipment would be paid in monthly installments that are equivalent to the payments that would have been made had the patient chosen to rent the equipment. Moreover, benefits would be paid only for that period of time during which the equipment was certified to be medically necessary or until the purchase price of the equipment had been fully reimbursed, whichever came first. The patient would wish to

---

[1] About 3 percent of the purchases in excess of $50 included in our sample were terminated for one of these reasons before the recovery of 80 percent of the purchase price.

[2] H. Rept. 544, 90th Cong., 1st sess.
S. Rept. 744, 90th Cong., 1st sess.

make the purchase under these circumstances if the purchase was less costly than rental because through the purchase his coinsurance payments would be reduced."

In other words the Congress designed the present law so that Medicare could not lose in the event that the beneficiary elected to purchase an item. Also the Congress relied on Medicare's coinsurance feature to discourage long-term rental of equipment when purchase would be more economical because 20 percent of the excess cost would be incurred by the beneficiary.

In June 1971 the House of Representatives passed the Social Security Amendments of 1971 (H.R. 1) which would further amend the durable medical equipment provisions of the Medicare law. Under the bill the Secretary of HEW would be authorized to limit part B Medicare payments, as well as Federal participation in Medicaid payments, for medical supplies, equipment, and services which do not differ in quality from one supplier to another to the lowest levels of charges at which such supplies, equipment, and services can be readily obtained in a locality. As of March 1972, this bill was being considered by the Senate Committee on Finance.

SSA instruction to carriers pertaining to claims for durable medical equipment

Under SSA instructions the beneficiary, rather than the carrier, decides whether to rent or purchase durable medical equipment, and he may rent even though purchase appears more economical.

Because payment cannot be made under Medicare unless the items of equipment or services furnished to a beneficiary are medically needed, SSA instructions provide that a physician's prescription accompany a claim for reimbursement of the rental or purchase cost of durable medical equipment. The instructions provide also that the physician's prescription include his diagnosis and prognosis of the patient's condition, his reason for prescribing the equipment, and his estimate of the number of months the equipment will be needed. The instructions provide further that, when any of

this information is lacking, the carrier make reasonable inferences from the other information on the prescription and that, if the information cannot be inferred, is not available in its files, or cannot be obtained from other readily available sources, the carrier request the information from the physician.

When a physician estimates that a patient needs an item of equipment indefinitely or when he fails to furnish a time estimate and the carrier, on the basis of available evidence, establishes that the time will be more than 6 months, a reevaluation of medical necessity must be made no later than 6 months following the original determination. In all cases the carrier's records are supposed to show how the estimated period of need for the equipment was determined.

CHAPTER 2

SAVINGS AVAILABLE BY PURCHASING DURABLE MEDICAL EQUIPMENT WHEN WARRANTED BY ANTICIPATED PERIOD OF NEED

Under the present law Medicare beneficiaries often rent durable medical equipment even though the periods of need--as estimated by their physicians or as indicated by other information supporting their claims--were long enough to justify its purchase.

To determine whether savings to the Government and to the beneficiaries could result if the Medicare law were amended to authorize alternative methods of providing durable medical equipment, we analyzed the claims histories for a statistically selected group of 560 beneficiaries for whom durable medical equipment reimbursement claims had been processed by six carriers in five States.

At five carriers in four States (Illinois, Michigan, Washington, and Wisconsin), we analyzed the claims histories for durable medical equipment reimbursements for statistical samples of 420 of the approximately 13,000 beneficiaries for whom such claims were processed by the carriers during calendar year 1970. On the basis of our analysis, we estimate that savings of about $234,000--including savings to beneficiaries of about $47,000 for their coinsurance amounts--could have been realized had equipment been purchased when the anticipated period of need indicated that purchase would have been more economical than rental.

At a sixth carrier in another State (California), our sample was limited to beneficiaries whose durable medical equipment reimbursement claims were processed during August 1971, because it was impracticable for the carrier to identify claims processed during calendar year 1970. On the basis of our analysis of claims histories for a statistical sample of 140 of the approximately 7,000 beneficiaries for whom claims were processed during August 1971, we estimate that savings of about $763,000--including savings to beneficiaries of about $153,000 for their coinsurance amounts--could

have been realized had the equipment been purchased when the anticipated period of need indicated that purchase would be more economical than rental.

Other cases at the six carriers in which rental charges exceeded the purchase prices were not included in the above estimated savings. These were cases for which (1) the required data on the estimated periods of need at the time the equipment was acquired had not been obtained by, or was not available from, the carriers or (2) the physicians' prescriptions showed estimated periods of need which would have justified rental rather than purchase but for which subsequent events showed that the actual periods of need were longer than anticipated.

CHARACTERISTICS OF CASES SAMPLED

The 560 beneficiaries acquired--purchased or rented--765 items of durable medical equipment. The charges applicable to the 765 items from the time of acquisition through August 1971 totaled about $135,000, of which about 18 percent was for purchases and about 82 percent was for rentals.

The frequency with which equipment items in various purchase price ranges were either purchased or rented is summarized below.

Current or actual purchase price	Number of equipment items			Percent rented
	Total	Rented	Purchased	
$ 50 or less	247	146	101	59
$ 50.01 to $100	159	134	25	84
$100.01 to $200	181	123	58	67
$200.01 to $300	69	58	11	84
$300.01 to $400	52	38	14	73
$400.01 to $500	33	28	5	84
$500.01 and over	24	20	4	83
Total	765	547	218	71

Of the 547 items that were rented, 401, or 73 percent, were priced in excess of $50. Of the items priced at $50 or less, 59 percent were rented compared with 77 percent of the items priced over $50. This indicates to us that beneficiaries

are more likely to purchase an item when they can be reimbursed on a lump-sum basis. On the other hand the authority to make a lump-sum reimbursement does not always ensure that an item will be purchased when warranted, because, of the items under $50 that were rented, about 12 percent were rented even though the physicians' prescriptions or other information indicated that purchases would have been more economical.

RESULTS OF ANALYSIS OF EQUIPMENT RENTALS

For those beneficiaries in our samples who rented durable medical equipment, we analyzed the claims histories and other data available at the carriers and compiled the savings that could have been realized from the date of acquisition through August 1971 by purchase of those items for which the physicians' prescriptions, or other data, indicated that purchases would be more economical than rentals. When the indicated purchase of an item did not prove to be more economical than rental, we considered the excess of the purchase price over the rental to be a loss and deducted the amount from the computed savings for the other items.

Our projection of the net savings that could have been realized by purchasing the equipment included in our samples to the universes from which the samples were drawn indicated that the total estimated savings shown below could have been attainable.

Sample universe	Number of beneficiaries in sample	Number of beneficiaries in universe	Projected estimated savings had rented equipment been purchased
Calendar year 1970 (five carriers combined)	420	13,064	$234,300
August 1971 (one carrier)	140	6,982	763,400

Sampling errors for the projected estimated savings were calculated at the 90-percent-confidence level. This

tells us that there are nine chances in 10 that the true value of savings for the five carriers is plus or minus about $130,000, or 56 percent of the $234,300, and for the sixth carrier is plus or minus about $420,000, or 55 percent of the $763,400.

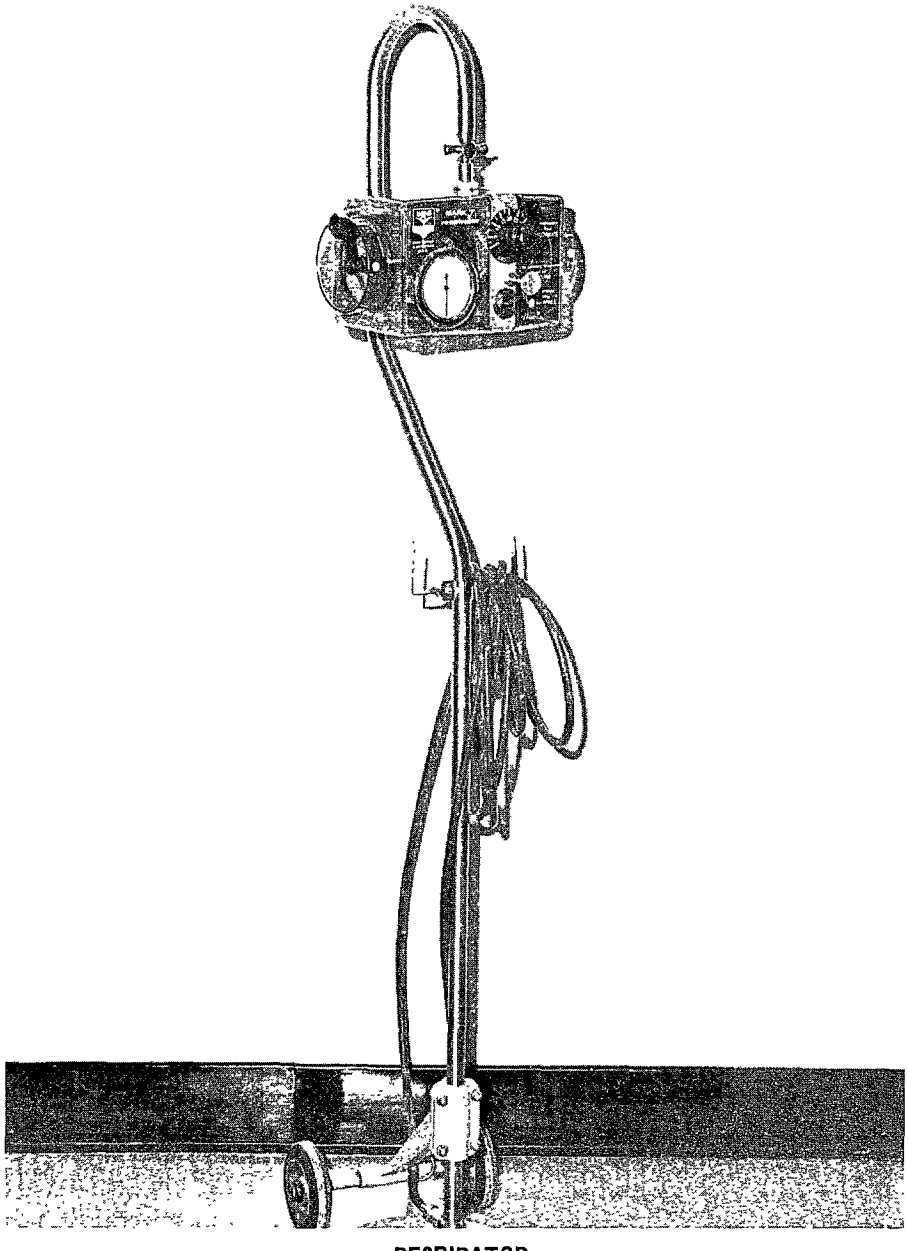
A significant factor contributing to the relatively large sampling errors was the fact that the majority of the computed sample savings were applicable to about 15 percent of the rental items; the aggregate rentals for these items were at least three times the amounts for which the items could have been purchased. Examples of items for which rentals were three or more times the purchase prices and for which physicians' prescriptions or other data indicated that purchase was warranted follow.

--A Medicare patient having heart trouble rented a walker for 16 months. Her physician's prescription stated that the duration of medical necessity was 1 year. The monthly rental charges would have equaled the $90 purchase price for the item in 5 months. The rental charges through August 1971 were $290.

--A Medicare patient having emphysema rented a respirator for 3 years. (See picture on p. 16.) His physician's prescription indicated that the patient would need this equipment indefinitely. The rental charges from September 1968 through August 1971 were $1,932. The purchase price of this item was $396.

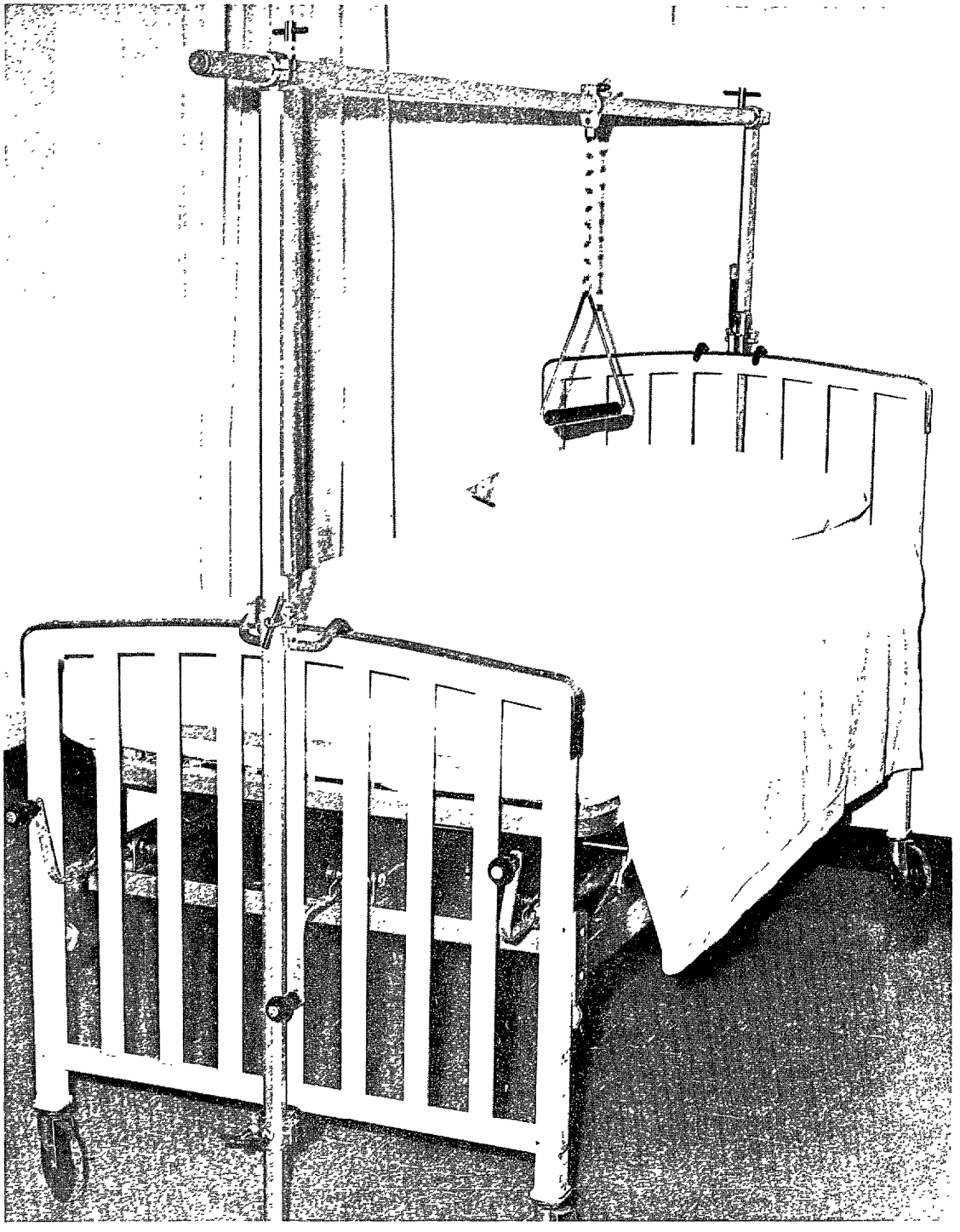
--A Medicare patient having a chronic, destructive skin condition rented a manual-crank bed with a trapeze bar for nearly 4 years. (See picture on p. 17.) His physician's prescription indicated that the patient's condition was irreversible and that the equipment would be needed indefinitely. The rental charges from November 1967 through August 1971 for the bed and trapeze bar were $1,654 and $342, respectively. The purchase prices for the items were $284 and $34, respectively.

--A Medicare patient suffering from paralysis rented a wheelchair (see picture on p. 20) and a portable



RESPIRATOR

RENTAL CHARGES FROM SEPTEMBER 1968 THROUGH AUGUST 1971	$1,932.00
PURCHASE PRICE	396.00
EXCESS OF RENTAL CHARGES OVER PURCHASE PRICE	$1,536.00



TRAPEZE BAR MOUNTED ON MANUAL CRANK BED

TRAPEZE BAR

RENTAL CHARGES FROM DECEMBER 1967 THROUGH AUGUST 1971 . . . . . $342.07

PURCHASE PRICE 33.60

EXCESS OF RENTAL CHARGES OVER PURCHASE PRICE $308.47

MANUAL CRANK BED

RENTAL CHARGES FROM NOVEMBER 1967 THROUGH AUGUST 1971 . . . . . $1,654.20

PURCHASE PRICE 283.50

EXCESS OF RENTAL CHARGES OVER PURCHASE PRICE $1,370.70

bedside commode (see picture on p. 21) for about 2 years. His physician's original prescription stated that the duration of medical need was indefinite, and an updated prescription stated that the duration of need was permanent. The rental charges for the wheelchair from July 1969 through August 1971 were $551. The purchase price was $161. The rental charges for the commode from August 1969 through August 1971 were $487. The purchase price was $36.

--A patient having congestive heart failure and emphysema rented an oxygen regulator for about 3 years. Although, contrary to SSA instructions, the carrier had not required that the physician's prescription indicate the length of medical need for the equipment, the carrier's consulting physician advised us that, on the basis of the diagnosis on the original claim, a long-term need was indicated. The rental charges for the regulator from January 1967 through April 1970 were $406. The purchase price was $78.

OTHER CASES IN WHICH RENTALS EXCEEDED PURCHASE PRICES

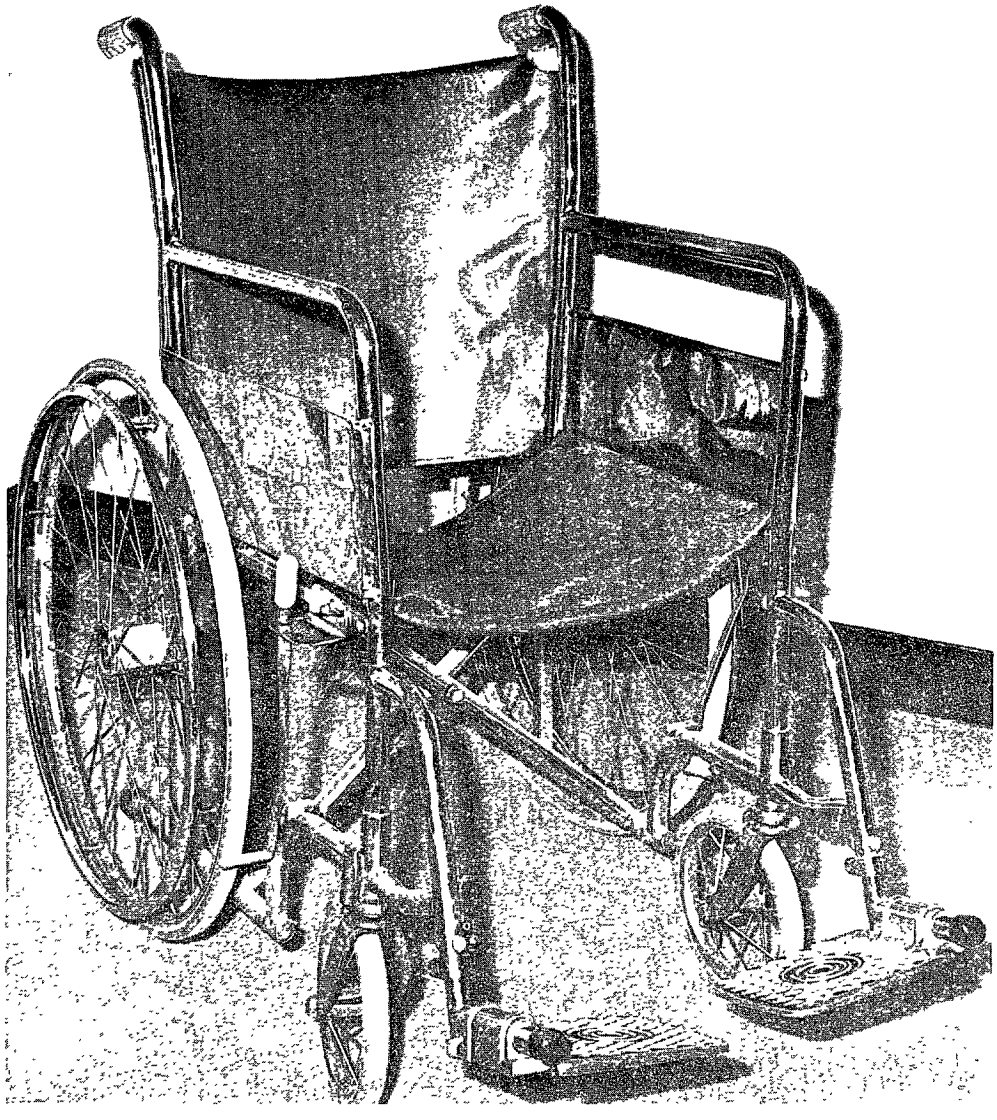
In addition to including those cases in which rental charges in excess of purchase prices reasonably could have been foreseen on the basis of the anticipated periods of need, our samples included cases in which other beneficiaries had rented durable medical equipment for periods of time that had resulted in rentals in excess of the purchase prices.[1] These cases were not included in our projections of the estimated savings because (1) the required data on the estimated periods of need was not available at the carriers or (2) the physicians' prescriptions indicated that rentals would be more economical than purchases but the anticipated periods of need had been underestimated.

Lack of data on prescriptions

As discussed on page 10, SSA instructions to its carriers provide that claims for reimbursement of rentals or purchase cost of durable medical equipment be accompanied by physicians' prescriptions indicating the estimated number of months that the equipment will be needed. About 700 prescriptions for one or more items of durable medical equipment were applicable to the 560 beneficiaries in our samples. A breakdown of the type of information regarding length of medical necessity shown on those prescriptions is summarized below.

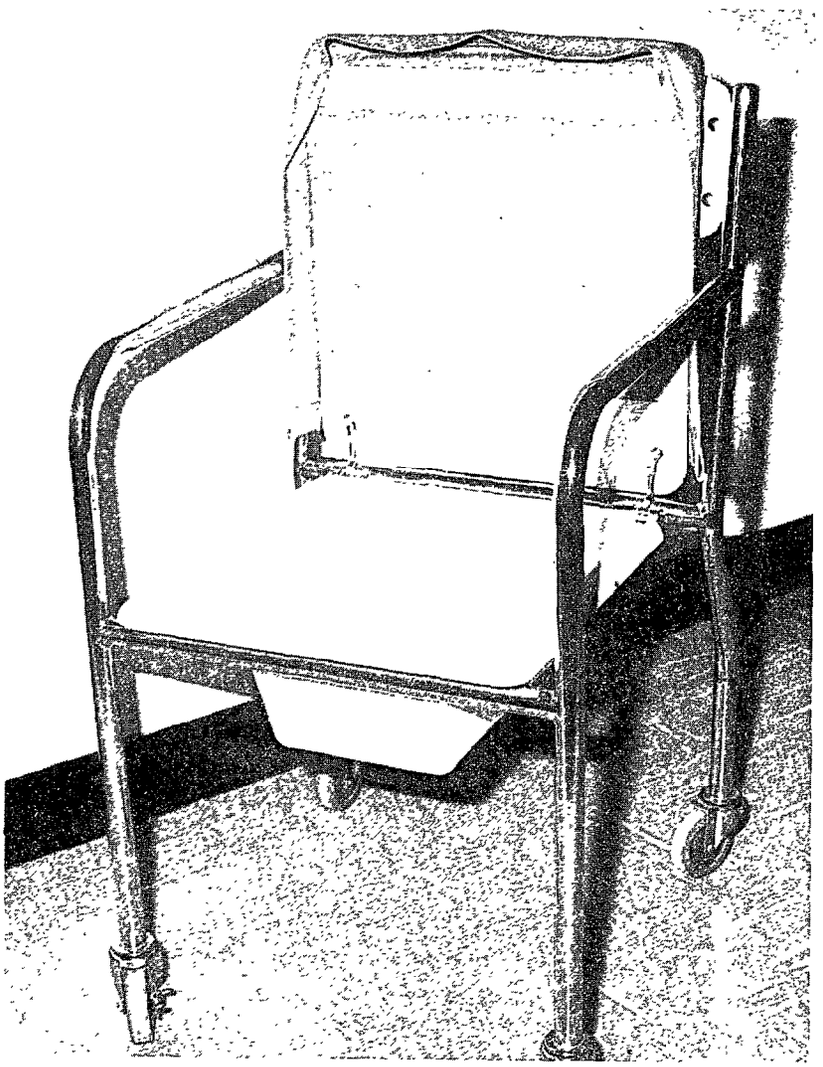
Information on physicians' prescriptions	Percent
Duration of need not stated	45
Duration of need expressed in months	24
Duration of need indicated as indefinite	21
Duration of need indicated as permanent or for life	10
Total	100

[1]For the five carriers in four States, we estimate that, for those beneficiaries in the 1970 universe, the overall rental charges exceeded the purchase prices by about $550,000 with a sampling error at the 90-percent-confidence level of $147,000, or about 27 percent of the $550,000. For the sixth carrier, we estimate that, for those beneficiaries in the August 1971 universe, the overall rental charges exceeded the purchase prices by about $1,010,000 with a sampling error at the 90-percent-confidence level of $357,000, or about 35 percent of the $1,010,000. These estimates included those cases for which we made rent-or-purchase analyses.



ADULT WHEELCHAIR

RENTAL CHARGES FROM JULY 1969 THROUGH AUGUST 1971	$550.50
PURCHASE PRICE	160.65
EXCESS OF RENTAL CHARGES OVER PURCHASE PRICE	$389.85



PORTABLE BEDSIDE TOILET

RENTAL CHARGES FROM AUGUST 1969
THROUGH AUGUST 1971..... $486.51
PURCHASE PRICE 35.70
EXCESS OF RENTAL CHARGES OVER
PURCHASE PRICE..... $450.81

In those cases where specific periods of need for equipment were not shown, the carriers often were able to infer estimated durations of need based on the physicians' diagnoses and prognoses. Nevertheless we believe that stricter compliance with SSA instructions would have indicated more clearly whether it would have been more economical to rent or purchase the equipment.

Anticipated period of need understated

Our sample analyses revealed a number of cases where the rental of the equipment seemed to be economical on the basis of physicians' estimates of the periods of need. The equipment, however, was rented for longer than had been estimated, with the result that rentals exceeded the amounts for which the equipment could have been purchased. Such unanticipated long-term rentals occurred, for example, for about 10 percent of the beneficiary rentals in our sample at the carrier in California. By projecting these excess rental charges to the carrier's August 1971 universe, we estimate that excess rental charges which could not have been reasonably foreseen because of underestimates of the anticipated periods of need were $110,000. To illustrate:

--The physician's prescription for a patient suffering from a variety of ailments stated that she would need a wheelchair for 6 months. Because the rental charges would not have exceeded the $161 purchase price of the wheelchair until the 9th month, the decision to rent the wheelchair seemed appropriate. As of August 1971, the beneficiary had rented the wheelchair for 16 months and the rental charges had totaled $304, or almost twice the amount for which the item could have been purchased.

CARRIERS' COMMENTS

Our analyses showed, that when the beneficiaries, rather than the carriers, decide whether to rent or purchase durable medical equipment, the beneficiaries often rented even though the anticipated periods of need were long enough to justify purchase. Therefore we requested the carriers' views as to the feasibility of adopting a system of acquiring durable medical equipment for Medicare beneficiaries on the basis of the carriers' evaluation of whether to rent or purchase.

Officials of the six carriers included in our review advised us that the carriers were capable of making rent-versus-purchase decisions, if SSA requested them to do so and provided them with specific guidelines for making such decisions. Officials at two carriers indicated that administrative costs would be increased if the carriers assumed this responsibility. Some of the potential problems cited by the carriers' officials in administering such a system are summarized below.

Need for prescriptions showing specific durations of need

Carriers' officials stated that the patients' physicians were in the best position to make judgments as to the estimated periods of need for equipment and that it would be difficult for carriers to judge the probability of rent-versus-purchase economies unless the physicians' prescriptions included specific estimates of the periods for which the equipment would be needed. The carriers said that existing Medicare instructions did not ensure specificity because a physician's statement that the equipment was needed "indefinitely," "until cured," etc., was acceptable.

Officials at one carrier pointed out, however, that this potential problem might be solved once the physicians understood what was required from them in order for the carriers to process claims for the physicians' patients.

Timeliness of
rent-versus-purchase evaluation

Carrier officials said that beneficiaries should not be delayed in acquiring equipment when it is medically needed and that, to avoid delays, equipment might have to be acquired before a rent-versus-purchase decision could be made. They also pointed out that a carrier's decision would be based on the physician's prescription accompanying the claim but that the claim was allowed to be submitted up to 27 months after the equipment had been acquired.[1]

Officials of one carrier advised us that a program under which carriers would evaluate physicians' prescriptions as the bases for advising beneficiaries of the most appropriate choices between rental and purchase of equipment would necessitate the submission of claims sooner than then allowed.

Of 23 suppliers interviewed, 19 informed us that they allowed the 1st month's rental of an item of equipment to be applied toward its purchase price. Therefore rent-versus-purchase decisions for equipment acquired from those suppliers would not have to be made at the time of acquisition but could be made within the 1st rental month, to permit exercise of the purchase option if warranted.

Mandatory nature of any carrier evaluations

Some carrier officials said that a beneficiary should decide whether to rent or purchase equipment but that, if the equipment was acquired by a means not indicated by the carrier's evaluation, the beneficiary should be reimbursed only to the extent of the method indicated by the carrier as being the more economical. Another carrier official said that third-party evaluations should be mandatory for beneficiaries covered under both Medicare and Medicaid so that the benefits under both programs could be administered consistently. (See p. 27.)

---

[1]Section 1842 of the Medicare law allows reimbursement of bills submitted by the beneficiaries or suppliers up to 27 months after the services have been rendered.

CHAPTER 3

FACTORS INHIBITING PURCHASE OF DURABLE MEDICAL EQUIPMENT ALTHOUGH WARRANTED BY ANTICIPATED PERIOD OF NEED

A variety of factors led beneficiaries to rent, rather than purchase, durable medical equipment even though their physicians had estimated long-term periods of need. The more important factors noted during our review are summarized below.

--Suppliers usually would not accept assignments of beneficiaries' rights to reimbursement for purchases of equipment because the Medicare periodic reimbursements could be discontinued if the beneficiaries died, recovered, or were hospitalized.

--Beneficiaries often found it necessary to rent equipment priced at more than $50 because they did not have the funds to make lump-sum purchase payments which were reimbursable under Medicare only through a series of periodic payments.

--Many beneficiaries had little incentive to reduce costs by purchasing equipment because their coinsurance shares of the rental charges were forgiven or were carried as accounts receivable by suppliers, were paid by Medicaid, or were paid under supplemental insurance policies.

--Beneficiaries sometimes were unaware of their options to purchase equipment.

In addition, Medicare's prohibition against making lump-sum payments for purchases in excess of $50 had discouraged purchases for those persons covered under both Medicare and Medicaid (dual enrollees).

SUPPLIERS DID NOT ACCEPT ASSIGNMENTS FOR PAYMENT OF EQUIPMENT PURCHASES

A Medicare patient may pay the supplier for the purchase of durable medical equipment and obtain reimbursement from the Medicare carrier, or he may assign his right to reimbursement to the supplier and the supplier may then obtain payment directly from the carrier. We interviewed 23 suppliers to determine their policies and procedures for providing such equipment. Most of the suppliers advised us that, although they accepted assignments for the payment of equipment rentals, they did not accept assignments for payment of equipment purchases priced over $50 because of the risk that the periodic payments by the carriers would be terminated if the beneficiaries no longer needed the equipment because of death, recovery, or hospitalization. Most of the suppliers also stated that they would not sell equipment on an installment basis because they did not want to get involved in the financing business.

Three suppliers indicated that they had accepted assignments for payment of equipment purchases, and two of these suppliers indicated that they had sold equipment on an installment basis. Two suppliers stated that, at the time that rental payments exceeded the purchase prices, the equipment was given to the beneficiaries without further charge.

BENEFICIARIES UNABLE TO FINANCE LUMP-SUM PURCHASES

About 70 percent of the items of durable medical equipment in our sample were valued at over $50 and therefore, if the items were purchased, the beneficiaries could not have been reimbursed on a lump-sum basis.

We interviewed 31 beneficiaries who had rented equipment that could have been purchased at a savings, and 14 of them advised us that they had rented the equipment because suppliers had required full payment of the purchase prices. The 14 beneficiaries also stated that they could not afford full lump-sum payments, particularly when Medicare would reimburse them only through periodic payments. In one of the examples discussed on page 15, the Medicare beneficiary, who had rented a manual-crank bed with a trapeze bar for

almost 4 years at rentals of about six times the purchase prices, stated that he had rented the equipment because the supplier required a lump-sum payment which he could not afford.

LIMITED EFFECTIVENESS OF COINSURANCE TO ENCOURAGE PRUDENT RENT-VERSUS-PURCHASE DECISIONS

Although the Congress relied on Medicare's 20-percent coinsurance to encourage beneficiaries to acquire equipment on the most economical basis, coinsurance was not effective because some suppliers did not require beneficiaries to pay their share of the equipment rental costs but provided the equipment on the basis of receiving only Medicare reimbursement. In other cases beneficiaries did not share in the rental costs of the equipment because the deductible and/or coinsurance amounts were paid under supplemental insurance policies or by Medicaid.

Six vendors told us that they sometimes either had forgiven the beneficiaries' shares of the rental charges or had treated their shares as accounts receivable which were expected to be outstanding indefinitely or perhaps never to be paid.

Of the 31 beneficiaries interviewed who had rented equipment but could have purchased it at a saving, 16 told us that they were enrolled in Medicaid or had supplemental insurance policies which were responsible for charges not paid by Medicare. Thus they were not directly affected by the savings aspects of rent-versus-purchase decisions.

BENEFICIARIES' LACK OF KNOWLEDGE OF ALTERNATIVES

Of the 31 beneficiaries interviewed, 17 indicated that they did not know that the equipment could have been purchased or that purchasing the equipment would have been more economical than renting it. Nine other beneficiaries who had purchased equipment rather than rented it at greater costs said that they had done so without guidance from their physicians, suppliers, or other parties.

Carrier officials advised us that they usually did not attempt to influence beneficiaries' equipment acquisition decisions, because, under the Medicare law and SSA instructions, such decisions clearly are to be made by the beneficiaries and not by the carriers. Some suppliers, however, indicated that their catalogs and literature on durable medical equipment clearly specified purchase prices as well as rental rates.

INCOMPATIBILITY OF MEDICARE RESTRICTIONS ON PURCHASES WITH STATE MEDICAID PROGRAMS

Of the five States in our review, four States (California, Illinois, Washington, and Wisconsin) furnished durable medical equipment to beneficiaries under the State Medicaid programs. These States also had agreed with HEW to pay the monthly Medicare part B premiums and all or part of the deductible or coinsurance amounts for persons aged 65 and over who were eligible for both Medicare and Medicaid benefits (dual enrollees).

In three States (California, Illinois, and Wisconsin) we noted that Medicare's restriction on lump-sum reimbursements for the purchase of equipment items costing over $50 tended to encourage long-term rentals for dual enrollees. In the fourth State (Washington) Medicaid and Medicare officials had made arrangements designed to encourage purchases of equipment for use by dual enrollees.

California

Under the Medicaid program in California, the acquisition of durable medical equipment must be prescribed by a physician and must be approved in advance by a State Medicaid consultant. To avoid excessive long-term rentals, the Medicaid consultant decides whether the equipment should be rented or purchased. Claims for payment submitted by suppliers are not payable if the acquisitions had not been approved or if the methods of acquisition were contrary to those approved.

In the case of a dual enrollee, this means that the State would not pay deductible or coinsurance amounts for items of equipment that were rented when the prior approval had indicated that they should be purchased.[1] As discussed

---

[1] In January 1972 SRS advised the State that it would be required to pay the deductible or coinsurance on durable medical equipment up to an amount equal to what the deductible or coinsurance would have been had the item been acquired in the manner recommended by the State (e.g., 20 percent of the purchase price).

on page 26, suppliers usually will not accept Medicare reimbursement assignments for the payment of the purchase price of equipment costing more than $50 nor sell equipment on an installment basis. As a result dual enrollees--who, by definition, are indigent--have been effectively precluded from purchasing equipment even when purchase was indicated by the State's Medicaid consultant.

We were advised by a State Medicaid official that the State never had considered advancing the lump-sum purchase prices for expensive equipment items needed by dual enrollees and then seeking periodic reimbursement from Medicare. An official of a major supplier of durable medical equipment advised us that, although the State had approved the purchase of equipment for a dual enrollee, the supplier would rent the equipment to the enrollee in order to obtain 80 percent of the rental charges from Medicare. The remaining 20 percent, which, the official stated, usually was not collected, was treated as an account receivable from the State.

Illinois

Under the Medicaid program in Illinois, the responsibility for furnishing durable medical equipment has been delegated largely to the counties. We were informed that the county included in our review operated a pool[1] of durable medical equipment for loan to Medicaid beneficiaries who were not covered also by Medicare. The dual enrollees, however, have been permitted to decide whether to rent or purchase equipment. Because Medicaid beneficiaries ordinarily would be unable to finance the purchase of equipment, they would tend to rent equipment, irrespective of the anticipated period of need and of whether rental would result in excessive costs to both Medicare and Medicaid.

In November 1970 the Medicare carrier proposed to SSA that, to avoid such excess rental charges, the State, on behalf of the dual enrollees, buy equipment costing more than $50 and that Medicare make periodic reimbursements to the

---

[1]As discussed on p. 32, HEW has advised us that such pools are inconsistent with the freedom-of-choice provision included in the Medicaid law.

State up to 80 percent of the purchase prices. As of December 1971 this proposal had not been implemented.

Wisconsin

Under the Medicaid program in Wisconsin, a claim for durable medical equipment generally is subjected to a prior authorization procedure under which the State determines whether to rent or purchase the equipment on the basis of data furnished by a patient's physician. This procedure, however, has not been followed for persons eligible for both Medicare and Medicaid benefits. For a dual enrollee, the State generally will not authorize the purchase of equipment costing $50 or more, because the State would have to await periodic Medicare reimbursement up to 80 percent of the purchase price.

Wisconsin Medicaid officials advised us that, under the present Medicare system for limiting reimbursement for equipment purchases, the State could finance the equipment needs for several dual enrollees for the same capital investment needed to purchase equipment for one dual enrollee. In our sample, about 85 percent of the rental charges in excess of purchase prices in this State involved dual enrollees.

Washington

In the State of Washington, the administration of Medicaid benefits for durable medical equipment for dual enrollees had been designed to accommodate Medicare's restrictions on lump-sum payments for the purchase of equipment costing $50 or more.

Under its Medicaid program, the State will not pay for durable medical equipment purchased or rented without its prior approval. As a matter of practice, the State purchases most of its durable medical equipment and lends it to program beneficiaries but retains title to it. The beneficiaries are required to return the equipment to a pool when they no longer need it. For those beneficiaries covered by both programs, the State, the Medicare carrier, and SSA have arranged for the State to pay the suppliers the full purchase prices, take title to the equipment, and bill Medicare for periodic reimbursements up to 80 percent of the purchase

prices. According to this arrangement, Medicare would not be charged again for equipment which a dual enrollee had obtained from the State's pool and which had already been paid for by Medicare on behalf of another beneficiary.

Although this arrangement was designed to avoid excess rental charges, some of the cases in our sample where rental charges had exceeded purchase prices involved dual enrollees. According to our interviews with selected beneficiaries, this situation apparently occurred when a dual enrollee rented equipment under Medicare without regard to Medicaid's prior-approval requirements. State officials advised us that under these circumstances the State would not pay the 20-percent-coinsurance part of the rental.

State Medicaid officials advised us that the practice of purchasing equipment to lend to needy persons had started in about 1951--long before the enactment of the Medicaid law. They advised us also that, because an item of equipment could be used and reused by several beneficiaries over a period of years, substantial savings to Medicare and Medicaid programs had resulted from the operation of this pool.

The equipment pool, however, appeared to conflict with the freedom-of-choice provision contained in section 1902(a)(23) of the Medicaid law, which provides that:

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

In response to our questions, the HEW General Counsel advised us that in his opinion the State's practices, under which certain items of equipment were obtainable by beneficiaries only on a loan basis from the State's equipment pool, were contrary to the Federal law. (See app. I, p. 44.)

In our opinion, however, it is not clear that the Congress intended that the freedom-of-choice provision of the Medicaid law apply to State pools of durable medical equipment.

--Durable medical equipment, by definition, is equipment which can withstand repeated use by more than one patient. In this respect it differs from other medical supplies or services which are furnished to patients by institutions or medical practitioners and which generally are consumed by, or serve only, those patients initially receiving them.

--The legislative history (S. Rept. 744, 90th Cong.) applicable to the freedom-of-choice provision under the Medicaid law indicates that the Congress intended that a Medicaid patient's free choice of medical service be subordinate to the State's authority under the law to establish schedules of charges or standards of care. In the case of durable medical equipment which the State had bought, paid for, and had on hand, it could be argued that the State's schedule of charges was zero and that there was no basis for paying a supplier's claim when the patient had elected to acquire the equipment elsewhere at a higher cost.

CHAPTER 4

BETTER PRICES COULD BE OBTAINED UNDER AGREEMENTS BETWEEN HEW AND SUPPLIERS OF DURABLE MEDICAL EQUIPMENT

Pursuant to the Medicare law, benefits are provided by institutional providers of service (hospitals, extended-care facilities, and home health agencies) under "provider" agreements between the Secretary of HEW and the institutions. Under these agreements the institutions are reimbursed for the reasonable costs of services provided to Medicare patients and are precluded from charging the patients for any covered services except in specified deductible or coinsurance amounts. We believe that a similar concept--HEW's entering into agreements for providing services--could be applied to the suppliers of durable medical equipment with regard to their reasonable charges for items furnished to Medicare patients.

Durable medical equipment has been purchased from suppliers by the Veterans Administration, the U.S. Public Health Service (PHS), and the Washington State Medicaid agency at discounted prices that often were considerably less than the suppliers' list prices which were the basis for the suppliers' charges to Medicare and which were considered reasonable by the Medicare part B carriers for reimbursement under the program.

VA buys durable medical equipment under open-end contracts[1] with manufacturers or suppliers of such equipment. Most VA contracts included provisions under which durable medical equipment would be furnished at the same prices to other Federal agencies--including HEW--if those agencies so desire.

---

[1]Contract prices are firm but quantities are not. The contractor agrees to supply all items ordered by VA during the contract period at the agreed-upon prices.

For 12 items of durable medical equipment, we compared the prices under the VA contracts with two suppliers with the suppliers' retail list prices. This comparison showed that most of the VA prices--which usually were based on competitive bids--were substantially lower than the prices Medicare would consider reasonable.

Type of equipment	Retail list prices	Prices under VA contracts (note a)	Difference	
			Amount	Percent
Amputee wheelchair	$256.00	$174.10	$81.90	32
Standard wheelchair	122.00	85.64	36.36	30
Bed with single crank and safety sides	367.50	310.48	57.02	16
Bed with two cranks and safety sides	336.00	269.97	66.03	20
Mattress	65.00	53.35	11.65	18
Patient helper-trapeze	58.50	42.73	15.77	27
Trapeze assembly	59.98	57.20	2.78	5
Commode	35.70	27.73	7.97	22
Patient lift	252.00	193.75	58.25	23
Walker	18.70	11.38	7.32	39
Stair-climbing walker	27.00	21.45	5.55	21
Portable respirator	440.00	440.00	-	-

[a]For items delivered to the patients' homes.

Washington State Medicaid officials advised us that purchase discounts of as much as 15 percent had been obtained from large suppliers on purchases of durable medical equipment. An official of a PHS hospital in California advised us that durable medical equipment was purchased by PHS at the same prices as those paid by VA.

The HEW General Counsel advised us, and we concur, that the present Medicare law precludes HEW or its Medicare part B carriers from entering into negotiations with suppliers of durable medical equipment to secure preferential pricing agreements for such equipment. (See app. I, p. 48.)

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

TO THE CONGRESS AND TO HEW

CONCLUSIONS

Substantial savings in the acquisition of durable medical equipment under Medicare could be attained if the law were amended to authorize certain alternatives to the present methods of providing the equipment.

We recognize that the best solution to the problem of excessive long-term rentals of durable medical equipment under Medicare may differ from area to area, depending on such factors as the corresponding provisions of the State Medicaid programs and the practices of the suppliers. Therefore we believe that HEW should have administrative flexibility in finding the best solution in a given locality and that the Medicare law should be amended to authorize the Secretary of HEW to:

--Make lump-sum payments under part B of Medicare for purchases of durable medical equipment when, on the basis of the anticipated periods of need, purchase appears to be more economical than rental; require the early submission of such claims; and limit payments to the amounts payable under the recommended rent-or-purchase decision.

--Enter into agreements with suppliers of durable medical equipment.

Our conclusions with respect to the foregoing alternatives are based on the following considerations.

Authority to make lump-sum payments for purchases of equipment based on anticipated periods of need

Our analysis of statistical samples of beneficiaries' claims histories, discussed on pages 12 to 14, showed that decisions to rent or purchase equipment on the basis of the

anticipated periods of need as estimated by the beneficiaries' physicians or as indicated by other data supporting the claims could have resulted in savings to the Medicare program and perhaps to the beneficiaries. Further, we believe that the potential for savings evidenced by our analyses could be increased by the carriers' more strict enforcement of SSA instructions pertaining to the information to be included on the physicians' prescriptions.

As discussed on page 24, the Medicare law allows reimbursement of claims of beneficiaries and suppliers up to 27 months after the services have been provided. We believe that, to facilitate timely rent-or-purchase decisions which could be advantageous to both the program and the beneficiary, the Secretary of HEW should be authorized to require the submission of claims for durable medical equipment within a much shorter period after the equipment is acquired.

Although, under the present law and regulations, lump-sum reimbursements may be made for the purchases of equipment priced at $50 or less, about 59 percent of such inexpensive equipment included in our samples had been rented and about 12 percent of the rented equipment had been rented even though purchase seemed to be more economical at the time the equipment was acquired. Accordingly, the authority to reimburse a beneficiary on a lump-sum basis for such a purchase does not necessarily mean that the most economical acquisition method will be selected by the beneficiary. Therefore we believe that, to limit the program costs, the Secretary of HEW should be authorized to restrict Medicare reimbursement to the amount that would have been payable had the recommended rent-or-purchase decision been followed, particularly if the beneficiary is a dual Medicare-Medicaid enrollee and if the State has a prior-approval requirement that includes a similar restriction.

Authority to enter into agreements with suppliers of durable medical equipment

The majority of the savings that we estimated could have been obtained through purchasing durable medical equipment applied to a comparatively few extreme cases in which the cumulative rental charges were three or more times the purchase prices of the equipment. Further, our analysis

revealed other cases in which rentals had exceeded purchase prices but in which (1) informed rent-or-purchase decisions could not be made because of inadequate information or (2) the periods of time that the equipment was needed were longer than originally anticipated.

To protect the Government and the beneficiaries from unreasonable rental charges under the foregoing circumstances, agreements could be entered into with suppliers providing that, when rental charges for equipment exceed a predetermined percentage of the purchase price, title to the equipment pass to the beneficiary and no further rental charges be payable.

The need for the timely submission and processing of claims could be minimized under this alternative because, under the agreements, rental charges could be limited on the basis of a predetermined formula, irrespective of when the beneficiaries or suppliers submitted their claims.

As discussed on pages 9 and 10, certain proposed legislation presently being considered by the Congress would authorize the Secretary of HEW to limit part B Medicare payments for medical equipment which does not differ in quality from one supplier to another to the lowest levels of charges at which such equipment can be readily obtained in a locality. In our opinion a logical adjunct to this proposed authority would be authority for the Secretary to enter into agreements with suppliers--through competitive bids or through negotiations--to firmly define for the carriers and the beneficiaries what the lowest levels of charges are for purchasing equipment. As indicated on pages 34 and 35, substantial evidence exists that Medicare presently is not obtaining prices which are as favorable as those obtained by other Government-financed health programs.

RECOMMENDATIONS TO THE CONGRESS

In connection with its current deliberations on legislation aimed at improving the operating effectiveness of the Medicare and Medicaid programs, we recommend that the Congress amend title XVIII of the Social Security Act to authorize the Secretary of HEW to find more economical methods of paying for durable medical equipment, including authority to:

--Make lump-sum payments, under part B of Medicare, of 80 percent of the purchase price of an item of durable medical equipment when, on the basis of the anticipated period of need, purchase appears to be more economical than rental; require the early submission of claims by waiving the provision of law allowing reimbursement for bills submitted up to 27 months after the equipment is provided; and limit Medicare payments to the amounts payable under the recommended rent-or-purchase decision.

--Enter into agreements with suppliers of durable medical equipment aimed at (1) limiting rental payments after they exceed the purchase prices by specified percentages and (2) obtaining prices for the purchase of equipment that are comparable to those obtained by other federally financed health programs.

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

RECOMMENDATIONS TO THE SECRETARY OF HEW

If the recommended legislative changes are adopted by the Congress, we recommend that HEW--through SSA--take the following steps to make the most effective use of its new authority.

--Obtain strict compliance with existing instructions pertaining to the information to be included on physicians' prescriptions for durable medical equipment.

--Enter into agreements with suppliers of durable medical equipment and consider obtaining prices on the basis of competitive bids.

AGENCY COMMENTS AND CONGRESSIONAL ACTION

HEW was given an opportunity to review a draft of this report. HEW, in commenting on the foregoing recommendations to it and to the Congress, advised us that, because the identification and testing of alternative methods of making payments for durable medical equipment held the potential for reducing the costs of Medicare services while maintaining their quality, it concurred in our recommendations.

On March 17, 1972, the Senate Committee on Finance announced that, in its deliberations on the Social Security Amendments of 1971 (H.R. 1), it had decided to initiate an amendment to the Medicare law which would authorize the Secretary of HEW to test and implement, without further legislation, reimbursement approaches designed to eliminate unreasonable expenses to the program which had resulted from prolonged rentals of durable medical equipment. This proposed amendment would include authority for the Secretary of HEW to contract with suppliers of equipment and to make lump-sum payments for durable medical equipment when the carrier determines, in accordance with guidelines from the Secretary, that outright purchase probably would be more economical than rental.

The Committee's decision was based on the study discussed in this report.

CHAPTER 6

SCOPE OF REVIEW

Our review was focused on procedures for furnishing durable medical equipment and payments made in five States by:

--Four carriers (also serving as fiscal agents) administering Medicare and Medicaid in California, Illinois, and Wisconsin.[1]

--Two carriers administering Medicare only in Michigan and Washington.[2]

--A State agency responsible for Medicaid only in Washington.

Our review was made at SSA and SRS headquarters in Baltimore, Maryland, and Washington, D.C., respectively, and at the SSA and SRS regional offices responsible for the Medicare and Medicaid programs in the above States.

Among the factors we considered in the selection of locations were the ability of carriers' information retrieval systems to define universes of beneficiaries for whom durable medical equipment claims had been processed, the existence of Medicaid programs in the States, and the overall volume of Medicare activity.

Our review included an analysis of random samples of Medicare beneficiaries whose claims for reimbursement had been processed by the six carriers. For five of the carriers, the universe was defined as those 13,064 beneficiaries who had durable medical equipment claims processed during calendar year 1970. For the sixth carrier (in California) the

---

[1] Two carriers were located in Wisconsin.

[2] The Medicare carrier in Washington had about 20 subcontractors (bureaus that process claims in designated geographical areas of the State). Our review involved the two largest bureaus.

universe was limited, because of constraints on the availability of information for the entire year, to those 6,982 beneficiaries who had equipment claims processed during August 1971.

Our review also entailed:

--Obtaining information on the States' policies and procedures for furnishing durable medical equipment under their Medicaid programs with emphasis on determining whether the Medicare and Medicaid policies and procedures were compatible with regard to those persons who were eligible for benefits under both programs.

--Interviews with 23 suppliers of durable medical equipment and 40 beneficiaries using the equipment.

--Discussions with carrier, fiscal agent, State, SSA, and SRS officials responsible for administering durable medical equipment benefits.

--Inquiries into the methods used by other Government agencies, such as VA, in providing durable medical equipment to their beneficiaries.

As part of our review, we examined into the basic legislation authorizing Medicare and Medicaid and the pertinent HEW regulations and SSA and SRS instructions implementing these programs. We also obtained and reviewed legal opinions from HEW pertaining to its authority, under the present law, to adopt various alternative methods of providing durable medical equipment under the Medicare program.

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

OFFICE OF THE
GENERAL COUNSEL

JAN 26 1972

Mr. John W. Moore
Assistant General Counsel
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Moore:

In your letter of December 6, 1971 to Secretary Richardson you asked several questions regarding the provision of durable medical equipment in the Medicare and Medicaid programs under Titles XVIII and XIX of the Social Security Act.

In response to your first question relating to the Medicare program, I can advise you that, in our view, neither the Social Security Administration nor the carriers under Part B of Title XVIII have authority to act as suppliers by purchasing durable medical equipment and stocking it for use by Medicare beneficiaries.

With respect to your second question, it is our view that the provisions of 42 USC 1395(a) preclude both the Social Security Administration and its Part B carriers from limiting the beneficiaries' choice of a supplier of durable medical equipment to those with whom arrangements have been negotiated for the type of rental which you describe in your letter.

Third, we believe an argument could be made that the Administration has authority under the Social Security Act to redefine "inexpensive equipment" along the lines suggested in your letter. We are not prepared at this time, however, to render a definitive legal opinion, and any decision to alter the regulations, and the form which any change would take, would, of course, be subject to administrative as well as legal considerations.

For your information, I am enclosing a staff memorandum which discusses in more detail your questions relating to Medicare.

With respect to your questions about the provision of durable medical equipment under the Medicaid program of the State of Washington, I have the following comments.

It is a requirement for a State plan for medical assistance that the plan provide that eligible individuals are allowed free choice of providers of medical services when they need to obtain the services available under the plan. Section 1902(a)(23) of the Social Security Act, 42 USC 1396a(a)(23); 45 CFR 249.11. This applies where items of durable medical equipment are provided under the plan.

You noted that the State of Washington's general practice with respect to needed durable medical equipment is to provide such equipment to program beneficiaries from an equipment pool maintained by the State rather than allowing them to obtain the equipment from vendors of their choice. According to our information, the State plan includes provision of prosthetic devices. Under the plan, certain items of this nature, e.g., wheel chairs and walkers, are obtainable by program beneficiaries only on a loan basis from the State's equipment pool. We understand that this practice had also applied to hearing aids, but that it was changed recently to allow individuals to select the providers of these devices. To the extent that the practice still exists under the plan as to other items of medical equipment, we believe it is contrary to the Federal law and regulations.

Sincerely,

Wilmot R. Hastings
General Counsel

Enclosure

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO : Office of the General Counsel
Attention: St. John Barrett

DATE: December 30, 1971

FROM : Edwin Yourman EY
Assistant General Counsel

SUBJECT: Reimbursement of Durable Medical Equipment Under Medicare

This is with reference to your Route Slip of December 20, 1971, requesting our comments with respect to a memorandum from the General Counsel of the General Accounting Office which makes general inquiry into the provision of durable medical equipment under Medicare and also solicits our views regarding possible alternative methods of providing such durable medical equipment to Medicare beneficiaries.

As to Medicare, the memorandum asks:

> "1. May SSA or its part B carriers under the law act as suppliers by purchasing durable medical equipment and stocking it for use by Medicare beneficiaries with the Government retaining title to the equipment?
>
> "2. May SSA or its part B carriers under the law enter into negotiations with suppliers of durable medical equipment on behalf of Medicare beneficiaries and then limit the beneficiaries' choice of a supplier to those with whom successful arrangements (such as rental agreements with a 6-month option to purchase) had been negotiated?
>
> "3. May SSA under the law revise its definition of inexpensive equipment to take into account the estimated period of use, thus allowing lump sum reimbursement payments for items now considered as inexpensive [sic]? For example, a $50 item may be considered inexpensive if it is to be used for 3 months, but a $100 item may also be so considered if needed for 6 months."

Initially, we believe that we should address our reply to the Social Security Administration instructions (section 6325.2, Item 7E, Part B Intermediary Manual; Section 3113, Part A Intermediary

Manual) which state that the decision of whether to rent or purchase rests with the beneficiary, not the carrier (insurance organization). It undoubtedly could be argued with some force that the freedom of choice provision of section 1802 of the Social Security Act, 42 U.S.C. 1395a, allows a beneficiary to determine whether he will purchase or rent durable medical equipment. An even stronger reason for beneficiary choice, however, is the fact that this is the intent of the 1967 Amendments to the Social Security Act. Prior to that amendment, Medicare covered only rental situations; a beneficiary could not obtain any Medicare reimbursement for the purchase of equipment. The Senate Finance Committee Report on House Bill No. 12080 (Sen. Rep. No. 744, 90th Cong., 1st Sess., 1967, page 74) explains the 1967 Amendment:

> "The committee's bill would make benefits covering durable medical equipment more responsive to the needs of the patient by including a provision which would permit medical insurance benefits to be paid in situations where an individual chooses to purchase rather than to rent the equipment. However, this provision would operate only as an economical alternative to the present coverage. To avoid paying the full purchase price of costly equipment used only a short time and, thereby, allowing the patient or his estate to profit upon its disposition, the bill would provide that benefits for the purchase of relatively expensive items of durable medical equipment would be paid in monthly installments that are equivalent to the payments that would have been made had the patient chosen to rent the equipment. Moreover, benefits would be paid only for that period of time during which the equipment was certified to be medically necessary or until the purchase price of the equipment had been fully reimbursed, whichever came first. The patient would wish to make the purchase under these circumstances if the purchase was less costly than rental because through the purchase his coinsurance payments would be reduced.
>
> With respect to the purchase of inexpensive equipment, on the other hand, the committee's bill would permit a lump-sum payment of benefits where the carrier determines a single payment to be more practical than periodic payments."

It is, as you observe, conceivable that, if a beneficiary elected to rent an item rather than to purchase it, the rental cost might exceed the purchase price of the item. The Congress, however,

recognized this fact when it noted that a beneficiary would wish to purchase if to do so were less costly because he would then reduce his out of pocket coinsurance costs by so doing. Of course, it is not always possible to determine in advance whether purchase or rental will be more costly in a particular case. In fact, any determination in advance could turn out to be wrong because, for example, a patient dies sooner than expected or his condition unexpectedly improves (or worsens) so that he no longer needs the equipment.

The amendment to the Act in 1967 allowing a beneficiary to elect to purchase an item rather than renting it thus seems to presuppose that such election would be made on an economically rational basis. Although it is possible that psychological, or other considerations other than rational ones, may enter into the process of deciding whether to purchase or rent durable medical equipment, we do not know the extent that non-rational choices occur, nor do we know the effect they may have, if any, upon program costs. One thing is clear, however, and that is that once a beneficiary does elect to purchase an item of durable medical equipment, he may receive only monthly payments, equivalent to payments which would have been made had the equipment been rented, and he receives such payments only during the time such equipment is medically necessary or until the purchase price is fully reimbursed (less applicable deductible and coinsurance amounts)--in no event may the payments exceed the purchase price (less deductible and coinsurance). See section 1833(f), 42 U.S.C. 13951(c); Sen. Rep. pp. 75 and 242.

We do not believe the Social Security Administration or its Part B carriers could act as suppliers of durable medical equipment for rental to Medicare beneficiaries with the Government retaining title to the equipment. The Part B program was originally conceived of and enacted as a voluntary insurance program to provide medical insurance benefits by way of indeminification to its enrolled beneficiaries, with such benefits to be financed by beneficiaries' premium payments and matching Government contributions. (Section 1831 of the Act, 42 U.S.C. 1395j; see also Sen. Rep. No. 404, Part I, 89th Cong., 1st Sess., 1965, page 24). In fact the entire Medicare program was conceived of and enacted as a Federal indemnity insurance program to provide beneficiaries with protection against costs incurred for covered medical, hospital, and related health services. (Sections 1811, 1812, 1831, 1832, 1833, 42 U.S.C. §§1395 c, d, j, k, and l; see also Sen. Rep. pp. 23 and 24, also pp. 25-45). Thus under Part B a beneficiary is entitled to have payments made to him or payments made on his behalf for covered services, including durable medical equipment, he receives for which he incurs expenses, i.e., a legal obligation to pay under section 1862(a)(2), 42 U.S.C. 1395y.

It is thus well established that the thrust of Government involvement in the field of health care, as directed and limited by Title XVIII of the Social Security Act, is as an insurer for, not as a supplier of, health services. There is no provision in Title XVIII which authorizes or directs the government to set itself up as a supplier of medical and other health services. Section 1835(d), 42 U.S.C. 1395n, authorizes a Federal provider of services (hospital, extended care facility, or home health agency) to receive Part B reimbursement for services furnished to beneficiaries if the Secretary determines that it provides such services "to the public generally as a community institution or agency," providing, that such Federal provider of services is not obligated by a law of, or a contract with, the United States to render such services "at public expense". This provision is only authority for reimbursement; it does not authorize the purchase, property management and rental of equipment. We know of no other statutory authority which gives the Secretary or a carrier either substantive authority or the funds which would be required to acquire, maintain, store, and distribute such equipment.

In answer to your second question, we believe that neither the Secretary nor a carrier could enter into negotiations with suppliers of durable medical equipment to secure preferential pricing agreements for such equipment, and then limit program beneficiaries' choice of suppliers of durable medical equipment to the suppliers having such agreements with the Government.

Such arrangements would be in direct contravention of the freedom of choice guaranteed to Medicare beneficiaries which entitles them to obtain health services from any qualified institution, agency, or person which undertakes to provide them with such services. (Section 1802 of the Act, 42 U.S.C. 1395a). Additionally, as mentioned before, the function of the Government under Title XVIII, as we view it, is to operate an insurance program - - and not to interfere with the existing market mechanism of providing medical, hospital, and other health services except as fairly authorized by Title XVIII. Part B, as you are aware, does grant considerable authority to the Government and its carriers acting as agents to control the market for durable medical equipment (and other health services) by virtue of the stricture that the costs recognizable therefor under the program shall be 80 percent of the "reasonable cost of the services". (Section 1833(a)(2) of the Act, 42 U.S.C. 1395 l(a)(2)). 1/

Your third question is whether the Social Security Administration could, under the law, revise its definition of inexpensive equipment to consider the estimated period of use, thus allowing lump sum reimbursement for

1/ See section 1814(b) of the Act, 42 U.S.C. 1395f(b), for the comparable Part A provision

"items now considered as inexpensive [sic]." We assume that you are inquiring as to whether items, now considered "expensive," could be paid for on a lump sum basis as "inexpensive" providing the time factor of duration of use (in combination with price) indicated the item to be "inexpensive". Presently, under Section 6325.2, Item 7E, Part B Intermediary Manual and Section 3113 Part A Intermediary Manual an inexpensive item is defined to be any item of durable medical equipment for which the reasonable cost is $50 or less.

We believe that such a time, or estimated period of use, factor could well be incorporated into the definition of "inexpensive equipment". The Act and the legislative history clearly establish that the period of time durable medical equipment (whether purchased or rented) is medically required is the only time for which Part B benefits may be paid. And, in fact, the time or period of use factor is presently being used to determine whether items costing less than $50 are actually "inexpensive". Section 6325.2, Item 7 of the Part B Intermediary Manual states:

> "a. Lump-Sum Payment for Inexpensive Equipment.-- Payment for inexpensive equipment will be made in a lump sum subject to the deductible and coinsurance when it is determined to be less costly or more practical to do so. Inexpensive equipment is any item of durable medical equipment for which the reasonable charge is $50 or less. A presumption should be made that it is less costly and more practical to pay a lump sum for inexpensive equipment. However, this presumption would not apply where the estimated period of medical need is relatively short. For example, a walkerette (purchase price $47.50) rents for $5 a month. If the physician estimates that the item would be needed for 4 months, it would be less costly to make four periodic payments, as explained below, than to pay a lump-sum amount based on the reasonable purchase price."

We would, however, point out that, at least on the example given in your letter, incorporating the factor of time into the definition of expensive would directly result in greater immediate expenditures of trust fund monies on a lump sum basis for "inexpensive equipment". In the event that the beneficiary recovered or died before the estimated period of use had run, either he or his estate would profit upon its disposition. This was one of the reasons for Congress' limitation that payment of benefits for relatively expensive items be in installments equivalent to the payments that would have been made had the individual decided to rent the equipment.

(Sen. Rep., No. 744, 90th Cong., 1st Sess., 1967, p. 75). Such considerations may have entered into the Secretary's determination not to have a variety of period of use factors. The Act requires the Secretary to find that the lump sum payment method is "less costly or more practical than periodic payments" in addition to finding the equipment itself is inexpensive.

There is, however, as is implicit in your inquiry, some point at which the administrative costs of determining and making periodic payments for an item of durable medical equipment (when added to the purchase price of the item) make it more economical to reimburse on lump-sum rather than rental basis even when the individual does not use the equipment long enough to make rentals equivalent to purchase price. Concomitantly, we would also anticipate that introduction of the relatively more subjective standard of period of use into the determination of "inexpensive equipment" could itself result in higher program administrative costs in making claims determinations at the carrier level. These, however, are administrative considerations.

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR ADMINISTRATION OF THE ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
DIRECTOR, BUREAU OF HEALTH INSURANCE:		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
John D. Twiname	Mar. 1970	Present
Mary E. Switzer	Aug. 1967	Mar. 1970

Copies of this report are available from the U. S. General Accounting Office, Room 6417, 441 G Street, N W., Washington, D.C., 20548.

Copies are provided without charge to Members of Congress, congressional committee staff members, Government officials, members of the press, college libraries, faculty members and students. The price to the general public is $1.00 a copy. Orders should be accompanied by cash or check.