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MEDICARE:
Durable Medical Equipment
Fee Schedules Have Widely
Varying Rates

Statement of
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Before the
Subcommittee on Health
Committee on Ways and Means
House of Representatives

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SUMMARY

In the Omnibus Budget Reconciliation Act of 1987, the Congress created a fee schedule system for Medicare reimbursement of durable medical equipment, orthotics, and prosthetics, commonly called DME. This reimbursement system became effective in 1989 and replaced the reasonable charge system of reimbursing for DME. The fee schedules were implemented on a carrier-area basis, with a fee schedule calculated for each of the 57 Medicare carrier areas in the country. At the request of Congress, GAO has reviewed the appropriateness of those fee schedules.

GAO found that the fee schedules implemented by the Medicare carriers have widely varying rates for the same or similar items in various parts of the country. These variances are not reasonable nor are they explained by differences in suppliers' costs. For 95 percent of the items GAO reviewed, the highest fee schedule amount was at least twice as much as the lowest, and for over 40 percent of the items, the highest amount was at least six times as much as the lowest.

In the fiscal year 1991 budget proposal for the Department of Health and Human Services, the Administration proposes several changes to the fee schedules for DME that the Administration estimates would save about $240 million in fiscal year 1991. These changes include (1) capping the carrier fee schedules at the national median for each item, (2) rebasing the fee schedules for one category of DME equipment (to make the base consistent with the other categories for which fee schedules were computed) and reducing the total amount that can be paid for this category of equipment, (3) reducing payments for oxygen and oxygen equipment by 5 percent, and (4) limiting the rental payments for items that require frequent servicing.

Capping the payments at the national median will lower payments in carrier areas where payments are relatively high while not adversely affecting those areas with relatively low payment rates. Also, there is precedent for this change. Since July 1986, the Medicare fee schedules for clinical diagnostic laboratory procedures have been capped at rates based on the national median.

GAO believes that the proposals to rebase the fee schedule for "Other DME" and to place an upper limit on the maximum amount of rental payments for items requiring frequent and substantial servicing also have merit.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the results of our analyses of the Medicare fee schedules for durable medical equipment (DME) authorized by the Omnibus Budget Reconciliation Act of 1987 (OBRA). We found extremely wide variations in the amounts paid for the same or similar items across the states. For 95 percent of the items we reviewed, the highest fee schedule amount was at least twice as much as the lowest, and for over 40 percent of the items, the highest amount was at least six times as much as the lowest. These wide differences are not explained by cost differences among areas. They are also not reasonable.

As an example of these differences, the fee schedule for purchasing crutches in Richmond, Virginia, is $20; in Washington, D. C., it is $36; and in Baltimore, Maryland, it is $72. In San Francisco, California, Medicare will pay a monthly rent of $78 for a self-contained nebulizer[1] for a beneficiary, but will pay $182 per month for that item in Reno, Nevada.

Our analysis shows another problem. For one category of DME, Medicare can pay more per month in rent under the fee schedules than it would have under the old reasonable charge system because of the way the fee schedule was computed.

The Administration has proposed legislation that would address the problems we found and several other issues about DME payments it believes need to be addressed. My statement will discuss those proposals.

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[1]A device that provides moisture to the respiratory system to prevent it from drying out.

BACKGROUND

Prior to 1989, DME was paid under Medicare's part B reasonable charge payment system. OBRA created the fee schedule payment system for DME, effective in 1989. The fee schedule system is based on six categories, and a different method of payment is used for each category. The categories and payment methods are:

DME Category	Payment method
1. Inexpensive or routinely purchased	Purchase or rental, with total rental payments limited to the purchase price for new equipment
2. Items requiring frequent and substantial servicing	Rental
3. Oxygen and oxygen equipment	Rental
4. Orthotics and prosthetics	Purchase
5. Items that must be uniquely constructed or substantially modified to meet the needs of an individual patient	Purchase, based on the Medicare carrier's individual determination of a reasonable price.
6. Other DME (items that do not fit in any of the other categories, including wheelchairs and hospital beds)	Rental, with a cap on the total rental payments. The monthly rent is 10% of the purchase price for a maximum of 15 months for a single period of continuous use. Beginning with the 21st month of continuous use and every 6 months thereafter, a service and maintenance fee may be paid to the supplier for the beneficiary's continued use of the item.

A fee schedule was not established for the customized equipment category because each item is uniquely constructed to meet specific patient needs. Suppliers will continue to be paid for this equipment based on Medicare's reasonable charge system.

OBRA required us to conduct a study of the appropriateness of the level of payments allowed for covered DME items under the Medicare program and to report on the results of the study by January 1, 1991. My testimony will be based to a large degree on work that we have performed in response to that requirement. We are continuing work under the required study and plan to issue the complete study results later this year.

My testimony today will focus on the Administration's cost reduction proposals for DME. For some analyses of those proposals, we used 1989 fee schedule data from all Medicare carriers[2] for selected items[3] of DME. For other analyses, we analyzed 1989 fee schedule data from 23 of Medicare's 57 carrier areas. Our selections were made judgmentally to include a relatively high-volume and low-volume state from each of the

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[2]Medicare carriers are private firms, such as Blue Shield plans and commercial insurance companies, who contract with the Health Care Financing Administration to process and pay Medicare claims.

[3]Our analyses were based on 16 items in the inexpensive or routinely purchased category, 9 in the category of equipment requiring frequent servicing, 2 from the category for oxygen, 5 in the orthotic and prosthetic devices category, and 14 items from the category for "Other DME". In 1987, these items accounted for about 54 percent of the $1.5 billion in Medicare expenditures for the five categories of DME subject to fee schedules.

Health Care Financing Administration's (HCFA's) 10 regions. Additional carriers were included to obtain statewide data for those selected states that are served by two or more carriers.

NATIONAL CAPS AT THE MEDIAN OF ALL CARRIER-BASED FEE SCHEDULES

In looking at the fee schedule amounts among carrier areas, large differences in the amounts allowed for similar items are apparent. It is not unusual to find cases where the highest fee schedule amount is two or more times the lowest amount. Moreover, cases exist where the highest fee schedule amount is two or more times the median amount. We do not believe that such differences are reasonable or explained based on differences in suppliers' costs.

The Administration has proposed capping the DME fee schedules at the median of the carrier fee schedules for each item. We believe that a national cap at the median for these five categories of equipment is appropriate because of the wide disparity in fee schedule amounts for the same or similar products among the carriers.

The first category--inexpensive or routinely purchased equipment--includes seat lift chairs, a high-volume item in 1987. Colorado's fee schedule amount for seat lift chairs is $1,135, whereas in neighboring Wyoming the amount is $769, a difference of $366 or 48 percent. The median fee schedule amount for seat lift chairs is $866, the rate in Wisconsin, and the range among the 57 carriers is $518 in Iowa to $1,520 in Alaska.

For the second category--items requiring frequent and substantial servicing--the fee schedules are monthly rental amounts. The disparity in rental rates among the carriers can be illustrated by the rates established for a portable ventilator,[4] which ranges from $183 a month in New Mexico and Oklahoma to $1,124 a month in Michigan. The median rate for this item is about $585, the rate in Delaware.

Similar to the two categories of DME discussed above, there is also significant variation in the fee schedule amounts for prosthetic and orthotic devices. For example, the fee schedules for a lower limb prosthesis range from $1,700 in New Jersey to $4,154 in Nevada, and the national median is $2,739, the rate in Colorado and Florida.

Another category--"Other DME" which includes wheelchairs and hospital beds--also exhibited wide variation in fee schedule amounts. For example, the monthly rental payment for a hospital bed ranged from $45 in Oregon to $129 in western New York state. The median among the carriers for this item is $84.

OBRA established a special payment formula for oxygen equipment and oxygen contents. The formula combined approximately 25 separate oxygen product codes (equipment and contents) that could be either purchased or rented into four groups. Two rental rates, one for stationary oxygen equipment and another for portable oxygen equipment, are applicable to all oxygen equipment and oxygen contents provided to Medicare

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[4]A device that assists a patient to breathe.

beneficiaries who did not already own their equipment when the fee schedule system was implemented in 1989. Two other payment rates were established for oxygen contents for beneficiaries who already owned their equipment when the fee schedule system was implemented. Because oxygen equipment rental (including contents) will encompass most of the Medicare expenditures for oxygen now and in the future, we focused our analysis on the two oxygen equipment rental amounts.

The current monthly rental fees for stationary equipment range from $189 in North Dakota to $357 in Massachusetts. For portable equipment, the minimum fee schedule amount is about $19 for Texas as compared with the maximum of $86 in Maryland. The median fee schedule for stationary oxygen equipment is $254, and it is $41 for portable equipment.

We do not believe the wide variation in fee schedule amounts in these five categories is reasonable, and we support the Administration's proposals to cap the fee schedules. Moreover there is precedent in the Medicare program for national caps on fee schedules. Since July 1, 1984, Medicare has paid for clinical diagnostic laboratory services from a fee schedule. Beginning July 1, 1986, those fee schedules were capped and, as of January 1, 1990, the cap was set at 93 percent of the median.

CHANGE THE BASIS FOR CALCULATING THE FEE SCHEDULE FOR "OTHER DME"

The fee schedule for "Other DME" was based on average submitted purchase prices, while the fee schedules for the other categories were based on average reasonable charges as determined

by Medicare. This basis was chosen because of concerns raised about the validity or accuracy of the reasonable charge determinations made by some carriers. The Administration's proposal calls for changing the base for the fee schedules for "Other DME" to be consistent with the base used for the other fee schedules.

We reviewed HCFA's regional office validations of the carriers' fee schedules for 10 high-volume "Other DME" items for 23 carriers. We recalculated the fee schedules for those items using Medicare's prevailing charges. Basing the fee schedule on prevailing charges rather than submitted charges for these selected items in 23 carrier areas would reduce total Medicare payments by about $15.0 million a year. Beneficiary coinsurance would be reduced by about $3.8 million annually.

We believe the Administration's proposal to rebase the fee schedules for "Other DME" on allowed amounts is reasonable. Before the fee schedules became effective in 1989, all DME items were paid for based on reasonable charges. It is inconsistent to single out one category of items and base the fee schedule on submitted rather than reasonable charges. The information we reviewed showed that the 23 carriers had data they could use to compute a payment rate based on prevailing charges, and using that data would result in a reduction in Medicare payment rates of about 9 percent.

LIMIT TOTAL RENTAL PAYMENTS FOR ITEMS REQUIRING FREQUENT SERVICING

In a report issued in 1985,[5] we suggested that Congress consider limiting rental allowances for high-cost DME items to a percentage in excess of the purchase price. We concluded that such a limit would produce savings when compared to the practice at the time of making individual decisions to rent or purchase such items.

Under the current fee schedules, "Other DME" is rented, and the beneficiary has use of the items as long as necessary. The supplier is paid a monthly rental fee for 15 months of continuous use and then receives a maintenance and servicing fee every 6 months that the beneficiary still has need of the item. In contrast, for items requiring frequent servicing, the supplier receives a monthly rental fee for as long as the beneficiary needs the item. For example, the median monthly rental rate for a ventilator is $723. Ventilators cost suppliers about $3,500 to $5,000, so in half the carrier areas, suppliers may recoup their purchase price for ventilators in 8 months or less.

The Administration proposes to limit the payments for items requiring frequent servicing to the first 15 months of continuous rental and then to pay a periodic servicing fee every 6 months thereafter for as long as the item is rented to a

[5]See "Procedure For Avoiding Excessive Rental Payments For Durable Medical Equipment Under Medicare Should Be Modified", GAO/HRD-85-35, July 30, 1985.

beneficiary. The thrust of this proposal is reasonable and consistent with our earlier suggestion to the Congress.

ADDITIONAL ADMINISTRATION PROPOSALS

The Administration made two other proposals. One proposal would reduce the maximum amount of rental payments for the "Other DME" category from 150 to 120 percent of the purchase price of those items. The other would reduce by 5 percent the fee schedule amounts for oxygen and oxygen equipment. We do not have enough data to form an opinion on those proposals.

ADMINISTRATION COST SAVING ESTIMATES ARE NOT OVERSTATED

We used our data from the 23 carriers and selected high-volume items to estimate the Medicare savings that would accrue if the Administration's proposals were enacted. Our results were consistent with the Administration's cost savings estimate, and its estimate of $240 million does not appear to be overstated.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you have.