Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Reimbursement for Hospital Beds in the Home

Payment Methodology

JUNE GIBBS BROWN
Inspector General

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OEI-07-96-00222

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To compare Medicare's rental reimbursement methodology and utilization patterns for hospital beds used in the home to policies utilized by other Federal, State, private insurance companies, and managed care organizations.

BACKGROUND

The Medicare Supplemental Medical Insurance program pays for the rental or purchase of medically necessary Durable Medical Equipment (DME) used in a beneficiary's home when determined by a physician to be medically required. Suppliers receive monthly reimbursement from the Medicare Durable Medical Equipment Regional Carriers based upon a fee schedule. This schedule is limited by the Health Care Financing Administration's (HCFA) established national payment ceilings, and is adjusted annually for inflation based upon the Consumer Price Index. Certain categories of DME, including hospital beds, are reimbursed as "capped rental" items. The fee schedules reimburse a supplier:

- 10 percent of the allowed purchase price for new equipment for each of the first 3 months of rental; and
- 7.5 percent of the allowed purchase price for new equipment for each of the remaining months for which Medicare will make payment.

We surveyed sampled entities from Medicare risk managed care organizations, Medicaid State Agencies, the top 50 health insurance companies as ranked by policies in force, and a listing of companies providing national and local coverage in the Federal Employees Health Benefits program. Overall, we achieved an 82 percent response rate.

This is one of two reports examining Medicare's policies and reimbursement for hospital bed equipment. A companion report, ***"Medicare Reimbursement for Hospital Beds in the Home: Prices" OEI-07-96-00221,*** compares the reasonableness of Medicare's reimbursement rates for this equipment to those of other medical insurance payers.

FINDINGS

Only Medicare Provides Suppliers Enhanced Reimbursement for Initial Rental Months

Of the respondents surveyed, Medicare was the only insurer that allows a higher rate of reimbursement for rental periods lasting less than 4 months (10 percent of the allowed charge for purchase as compared to 7.5 percent of the allowed charge for purchase for rentals lasting from 4 to 15 months duration).

Almost Half of Medicare Beneficiaries Only Rent Beds During Enhanced Payment Months.

Claims information from January 1995 - December 1996 established that 47 percent of the Medicare beneficiaries rented beds for 3 months or less, two-thirds rented for 7 months or less, and only 12 percent completed 15 months of rental. The relative short rental periods for Medicare patients means that the enhanced rate, which the program pays for the first 3 months, is an important reason Medicare pays more for hospital bed rental than other payers.

Medicare and Most Other Payers Cap the Duration of the Rental Period and the Amount Paid

Medicare caps rental reimbursement at 15 rental months. This policy is comparable to industry practices that limit both the duration and amount of rental reimbursement for hospital beds. Of the 74 respondents, 72 (97 percent) pay for the rental of hospital beds used in the home, with 56 (75.7 percent) capping the duration of rental.

RECOMMENDATION

Eliminate Enhanced Rates for the First 3 Rental Months

The HCFA should seek legislation to eliminate the 2.5 percent enhanced rate for the first 3 months of rental. We estimate Medicare would annually save approximately $15 million. Projected over 5 years, Medicare would save over $74 million.

We realize that legislative action could take some time. Therefore, in the interim, we recommend that HCFA use the authority under the Balanced Budget Act of 1997 to reduce rates overall. This action would make Medicare's method of payment comparable to methods used by other payers. This is further explained in the companion report. Overall, we believe that a combination of both approaches would be best. However, the savings would not be additive.

The savings estimates are based on CY 1996 payments and are not indexed for inflation.

AGENCY COMMENTS

The HCFA concurs with the intent of our recommendation. However, it is deferring a decision on this matter pending receipt of information on hospital bed pricing. At that time, HCFA will assess whether the approach presented in our report is appropriate or whether an alternative pricing method is preferable. Appendix D contains the complete text of these comments. We remain available to provide technical assistance to HCFA on this issue.

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INTRODUCTION

PURPOSE

To compare Medicare's rental reimbursement methodology and utilization patterns for hospital beds used in the home to policies utilized by other Federal, State, private insurance companies, and managed care organizations.

BACKGROUND

The Medicare Supplemental Medical Insurance program pays for the rental or purchase of medically necessary Durable Medical Equipment (DME) used in a beneficiary's home when determined by a physician to be medically required. Certain categories of DME, including hospital beds, are reimbursed as "capped rental" items.

Medicare Reimbursement Methodology for DME

Medicare Part B pays for the rental or purchase of durable medical equipment (DME), used in the patient's home when determined by a physician to be medically required. There are six payment categories:

- Inexpensive or other routinely purchased equipment;
- Items requiring frequent and substantial servicing;
- Customized items;
- Other prosthetic and orthotic devices;
- Oxygen and oxygen equipment; and
- Capped rental items.

Medicare's Policies for Capped Rental DME

Capped rental items include hospital beds, wheelchairs, support surfaces and other pieces of DME. Suppliers receive monthly reimbursement from the Medicare Durable Medical Equipment Regional Carriers (DMERC) based upon a fee schedule. This schedule is limited by the Health Care Financing Administration's (HCFA) established national payment ceilings, and is adjusted annually for inflation based upon the Consumer Price Index. The fee schedules reimburse a supplier:

- 10 percent of the allowed purchase price for new equipment for each of the first 3 months of rental; and
- 7.5 percent of the allowed purchase price for new equipment for each of the remaining months for which Medicare will make payment.

Under Medicare capped rental DME rules, a hospital bed is initially furnished to a beneficiary as a rental item. The beneficiary is offered the option of purchasing a new or used bed at the

10th rental month, which is effective with the 14th month. If the beneficiary uses a purchased bed for its entire useful life, the item can be replaced and Medicare will reimburse the supplier for the replacement equipment. Medicare currently recognizes a 5 year useful life for hospital beds.

If the beneficiary elects to continue to rent the bed, Medicare payments will end upon completion of the 15th month. After rental payments end, Medicare will pay for necessary servicing and maintenance of capped rental equipment once every 6 months (which cannot exceed the charge for a 1 month rental). When the hospital bed is no longer needed by the beneficiary (due to death or medical improvement) the supplier is free to reclaim the used item for rental or sale to other clients.

Medicare's Payment for Capped Rental DME

Medicare allowed charges for all capped rental items totaled $886 million in 1995. There are 16 codes for hospital beds and Medicare's allowed charges for these codes totaled more than $287 million in 1995.

Table 1 is a summary of the Medicare fee schedule. Medicare allows 105 percent for a purchased item or 120 percent if rented through the 15th month.

Table 1
Medicare Reimbursement Schedule for Capped Rental Items

Rental Month	Percent of Fee Schedule	Cumulative Percent
1	10.0%	10.0%
2	10.0%	20.0%
3	10.0%	30.0%
4	7.5%	37.5%
5	7.5%	45.0%
6	7.5%	52.5%
7	7.5%	60.0%
8	7.5%	67.5%
9	7.5%	75.0%
10	7.5%	82.5%
11	7.5%	90.0%
12	7.5%	97.5%
13 [1]	7.5%	105.0%
14	7.5%	112.5%
15 [2]	7.5%	120.0%

[1] If elected, the purchase option is effective with the 14th rental month.
[2] Rental payments terminate upon completion of the 15th rental month.

In 1996 the DMERC allowed charges of over $272 million for the four categories of hospital beds included in this study. Semi-electric beds (code E0260) comprised 86 percent of this total while total electric beds accounted for less than one-half of one percent (refer to Table 2).

Table 2
Allowed Charges for Hospital Beds
January 1, 1996 - December 31, 1996 [1]

Item	Allowed Charges
Manual Hospital Bed (E0250)	$7,085,989
Manual Adjustable Hospital Bed (E0255)	$30,720,446
Semi-Electric Hospital Bed (E0260)	$233,607,390
Total Electric Hospital Bed (E0265)	$1,084,068
Total:	**$272,497,893**

[1] Source: Statistical Analysis DMERC (Palmetto Government Benefits Administrators)

Previous Office of Inspector General (OIG) Study

A May 1993 OIG report, ***"Review of Medicare Part B Reimbursement of Hospital Beds," A-06-91-00080***, found that Medicare reimbursement rates for "capped rental" hospital beds were excessive because HCFA failed to take into account the useful life of the bed and how many times it can be rented. The OIG estimated Medicare savings of $6.2 to $7.8 million in just one State. HCFA did not accept OIG's recommendations to change the way they reimburse for hospital beds in part because the study was limited to rentals in only one State.

METHODOLOGY

We researched the Federal laws, regulations and HCFA policies that cover the establishment, reimbursement, and purchase options for capped rental hospital beds. We also reviewed various private and governmental entities' reimbursement methodologies for these items.

We obtained listings of Medicare risk managed care organizations (MCOs), Medicaid State agencies, the top 50 private health insurance companies in the United States as ranked by number of policies in force, and a listing of the companies providing national and local coverage in the Federal Employees Health Benefits Program. We selected a sample from each of these groups to request completion of a mailed survey questionnaire (for MCOs we included in the universe only those with 450 or more members). For the sampled private insurance companies which have multiple components, we surveyed their private, MCO, and government insurance divisions. In total, we contacted 90 entities.

As a means to obtain direct information and validate it, we selected a sub-sample from each of the above organizations for on-site visits. The criteria for selection was based upon size, location, and proximity to other on-site contacts for economy of travel. In addition, we sent surveys to the Department of Veterans Affairs, the Indian Health Service, and the Department of Defense Tri-Care program , formerly the Office of Civilian Health and Medical Program of the Uniform Services (CHAMPUS).

As part of all surveys, we requested the entities' written procedures and policies for reimbursement methods, schedules, and rates for the following types of new and used hospital beds:

- Manual Hospital Bed (HCPCS Code E0250)
- Manual Adjustable Hospital Bed (HCPCS Code E0255)
- Semi-Electric Hospital Bed (HCPCS Code E0260)
- Total Electric Hospital Bed (HCPCS Code E0265)

We inquired if these purchasers of hospital beds maintain on-going data or have conducted studies to address supplier costs (i.e., equipment acquisition, delivery, setup, patient education, maintenance, tear down, pick up, sanitation, billing, supplier profit and life of the product). We also asked if they are utilizing competitive bidding for either the rental or purchase of these items. Any unclear responses were clarified by telephone and follow up contacts were made to non-responders. Overall we achieved a 82 percent response rate. Appendix A breaks out the various entities surveyed and identifies responders by sample category. It should be noted that since all responders did not provide answers to each question on the survey instrument, we reported our data based on the percentage of responders who answered the question. Appendix B lists the response rates for each of the sample categories.

We queried the Medicare DMERC to validate particular aspects of claims processing for rented hospital beds. We also requested information on payment methodology for capped as compared to non-capped items.

We utilized a 1 percent sample of HCFA's National Claims History File for January 1994 through March 1996 to obtain information on beneficiary rental patterns for the four procedure codes listed in Table 2 (E0250, E0255, E0260, and E0265). The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) updated this information for rentals commencing in 1995.

This is a companion report to ***"Medicare Reimbursement for Hospital Beds in the Home: Prices" OEI-07-96-00221***, which compares the reasonableness of Medicare's reimbursement for rental of hospital beds to other Federal, State, private insurance companies and managed care organizations.

We conducted our review in accordance with the ***Quality Standards for Inspections*** issued by the President's Council on Integrity and Efficiency.

FINDINGS

ONLY MEDICARE PROVIDES SUPPLIERS ENHANCED REIMBURSEMENT FOR INITIAL RENTAL MONTHS

Medicare is the only insurer that allows a higher rate of reimbursement for rental periods lasting less than 4 months (10 percent of the allowed charge for purchase as compared to 7.5 percent of the allowed charge for purchase for rentals lasting from 4 to 15 months duration). When we compared Medicare's rental reimbursement for the first 3 months of rental to the rates paid by other insurers. We found that Medicare's rates for months 1 - 3 were from 18 percent to 38 percent higher

ALMOST HALF OF MEDICARE BENEFICIARIES ONLY RENT BEDS DURING ENHANCED PAYMENT MONTHS.

We analyzed claims information from 1994 through 1995 and determined that 47 percent of the Medicare beneficiaries rent beds for 3 months or less, two-thirds rent beds for 8 months or less, and only 16 percent complete 15 months of rental. [1]

The chart on the following page depicts the declining duration of rental for the four hospital beds surveyed in this study. As is noted, the majority of the rentals are semi-electric, with very few total-electric beds rented after the second month.

MEDICARE AND MOST OTHER PAYERS CAP THE DURATION OF THE RENTAL PERIOD AND THE AMOUNT PAID

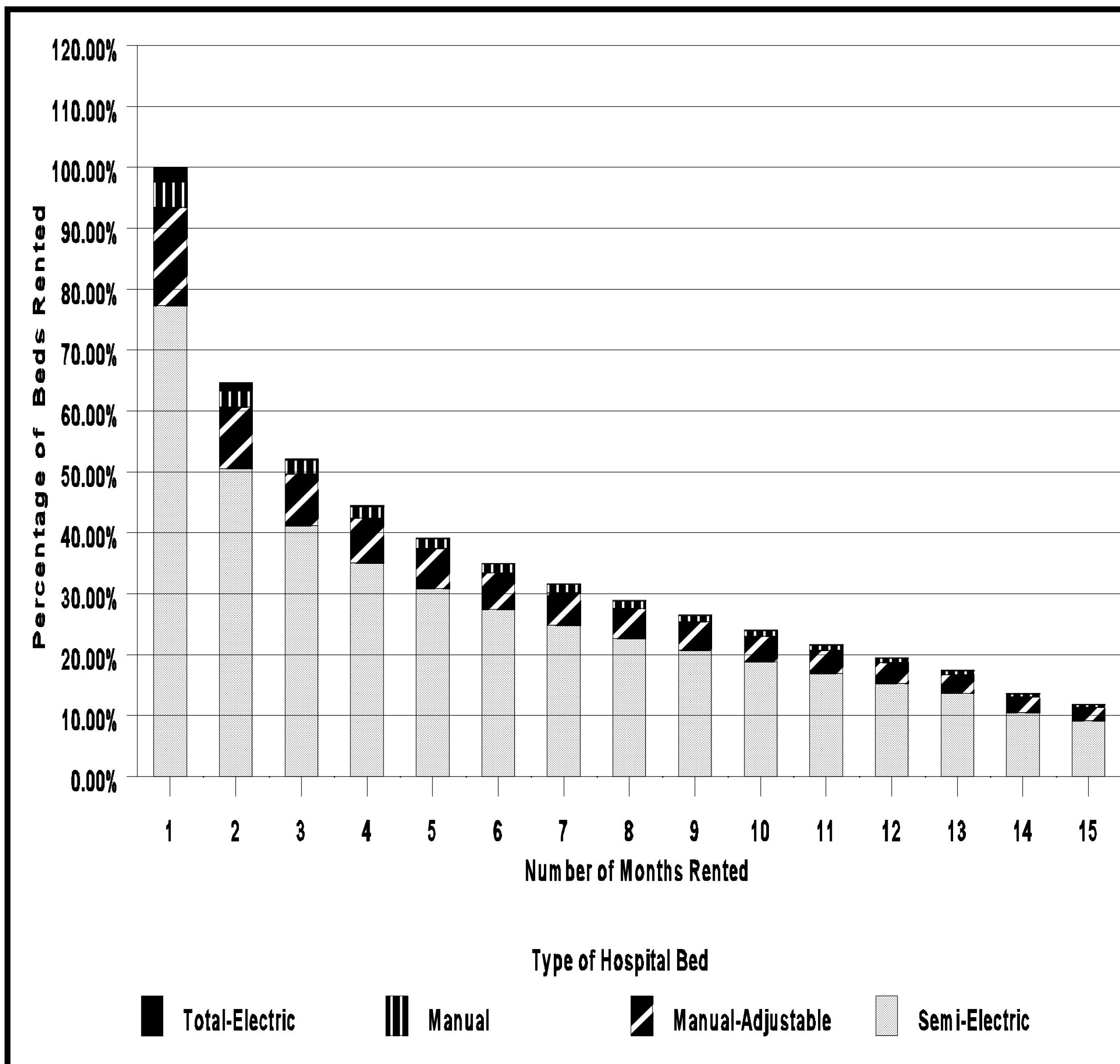
Three-fourths of the Payers Cap the Duration of the Rental Period

Medicare caps the duration of rental at 15 rental months. Total reimbursement is limited to 120 percent of the purchase price of the bed. This method of payment is comparable to industry practices that limit both the duration and amount of rental reimbursement for hospital beds.

Of the 74 respondents, 72 (97 percent) pay for the rental of hospital beds used in the home, with 56 (75.7 percent) capping the duration of rental. Over half (38 of 74 respondents) limit rental payments to 12 months or less. Sixty percent (44 respondents) limit the aggregate rental payments for each rental period to the purchase price of the item.

[1] The SADMERC updated this information for claims with dates of service from January 1995 through December 1996 and found that the duration of rental remains virtually unchanged from the 1994/1995 data with half of the Medicare beneficiaries rented beds for 4 months or less, two-thirds rented for 7 months or less, and only 12 percent completed 15 months of rental.

Duration of Monthly Hospital Bed Rental
by Medicare Beneficiaries
(January 1995 - December 1996)



RECOMMENDATION

Eliminate Enhanced Rates for the First 3 Rental Months

The HCFA should seek legislation to eliminate the 2.5 percent enhanced rate for the first 3 months of rental. We estimate Medicare would annually save approximately $15 million. Projected over 5 years, Medicare would save over $74 million. [2]

We realize that legislative action could take some time. Therefore, in the interim, we recommend that HCFA use the authority under the Balanced Budget Act of 1997 to reduce rates overall. This action would make Medicare's method of payment comparable to methods used by other payers. This is further explained in the companion report. Overall, we believe that a combination of both approaches would be best. However, the savings would not be additive.

Our calculations for these savings are described in detail in Appendix C.

AGENCY COMMENTS

The HCFA concurs with the intent of our recommendation. However, it is deferring a decision on this matter pending receipt of information on hospital bed pricing. At that time, HCFA will assess whether the approach presented in our report is appropriate or whether an alternative pricing method is preferable. Appendix D contains the complete text of these comments. We remain available to provide technical assistance to HCFA on this issue.

[2] These savings estimates are based on calendar year 1996 payments and are not indexed for inflation.

APPENDIX A

ENTITIES INCLUDED IN THE SAMPLE

PRIVATE INDEMNITY COMPANIES

Name	State	Response Received
Aetna Life and Casualty Co	CT	Y
Blue Cross & Blue Shield of Florida	FL	Y
Blue Cross & Blue Shield of Michigan	MI	Y
Blue Cross & Blue Shield of Texas, Inc.	TX	Y
Empire Blue Cross Blue Shield	NY	N
Metropolitan Life Insurance Company	FL	Dropped (sold to United Health Care)
Mutual of Omaha	NE	Y
New York Life Insurance Company	NE	Y
Prudential Insurance Company of America	PA	N
United Health Care (formerly Travelers)	CT	Y
Total Companies: 10	**Total Responders: 7**	

MEDICAID STATE AGENCIES

Name	State	Response Received
Arizona Health Care Cost Containment System [1]	AZ	Y [2]
Department of Human Services [1]	HI	Y
Department of Human Services	ID	Y
Department of Health & Mental Hygiene	MD	Y
Division of Medicaid	MS	Y
Department of Human Services	ND	Y
New Mexico Human Services Department	NM	Y
Department of Social Services	NY	Y
Department of Human Services [1]	OH	Y
Department of Human Services	WI	Y
Total States: 10	**Total Responders: 10**	

[1] Medicaid § 1115 Waiver State

[2] The Arizona Health Care Cost Containment System (the Medicaid State Agency) has seven subcontractors who provide Medicaid Coverage. Ventana Health Systems, provided the only response. This contractor furnishes Medicaid health care to 7 of 15 Arizona Counties.

FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM--LOCAL PLANS

Name	State	Response Received
Foundation Health	CA	Y
CIGNA Healthcare of Colorado	CO	N
Health New England	CT	N
Suburban Health Plan, Inc.	CT	Y
Exclusive Health Care	IA	Y
BCI HMO, Inc	IL	Y
Personal Care Blue Shield HMO	IL	Y
Advantage Care, Inc.	KY	Dropped--No longer participating in FEHB Plans.
HMO Maine	ME	Y
AETNA Health Plans of the Mid-Atlantic States	MD	Y
Health Alliance	MI	N
Prudential Health Care HMO	MO	N
United Health Care Select	MO	Y
Exclusive Health Care	NE	Y
FHP New Mexico	NM	Y
Presbyterian Health Plan	NM	N
GHI Health Plan	NY	Y
Healthsource HMO of New York	NY	Y
Independent Health Association	NY	Y
Personal Care Plan of North Carolina	NC	Y
PHP, Inc.	NC	Y
HMO Health Ohio	OH	Dropped--No longer participating in FEHB Plans.
Prudential Northern Ohio	OH	Y
Pacific Care of Oregon	OR	N
United Health Plans of New England	RI	Y
Harris Methodist	TX	Y
HMO Blue	TX	Y
Total Companies Contacted: 25 [3]	**Total Responders: 19**	

[3] Total does not include the two companies that no longer participate in the Federal Employees Health Benefits Program.

FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM--NATIONAL PLANS

Name	Response Received
Alliance	Y
American Postal Workers Union (APWU)	Y
Blue Cross & Blue Shield	Y
Government Employees Hospital Association (GEHA)	Y
Mail Handlers	Y
National Association of Letter Carriers (NALC)	Y
Postmasters	Y
Association Benefit Plan	Y
BACE	Y
Foreign Service	N
Panama Canal Area	Y
Rural Carrier Benefit Plan	Y
Special Agents' Mutual Benefit Association (SAMBA)	Y
Secret Service	N
Total Companies: 14	**Total Responders: 12**

MEDICARE RISK HEALTH MAINTENANCE ORGANIZATIONS

Name	State	Response Received
Health Partners of Alabama	AL	Y
Blue Cross of Arizona	AZ	Y
Blue Cross of California	CA	N
FHP, Inc.	CA	N
Foundation Health, A California Plan	CA	Y
Kaiser Foundation HP, Inc.	CA	Y
Kaiser Foundation HP of Colorado	CO	Y
Kaiser Foundation HP of NY	CT	Y
AV-Med Health Plan, Inc.	FL	Y
U.S. Healthcare Delaware	DL	Y
Health Alliance Plan of Michigan	MI	N
Partners National Health Plans of North Carolina, Inc.	NC	Y
First Option Health Plan of New Jersey, Inc.	NJ	Y
CIGNA Healthcare of New York	NY	Y
Independent Health Plan, Inc	NY	N
NYLCARE Health Plans, Inc.	NY	Y
Family Health Plan, Inc.	OH	Y
Community Care HMO, Inc.	OK	Y
Kaiser Foundation of the Northwest	OR	Y
Geisinger Health Plan	PA	Y
Keystone Health Plan Central, Inc.	PA	Y
Qualmed Plans for Health, Inc.	PA	Y
U.S. Healthcare, Inc. - Delaware	PA	Y
U.S. Healthcare Systems of Pennsylvania	PA	Y
IHC Care, Inc.	UT	Y
Total Companies: 25	**Total Responders: 21**	

OTHER FEDERAL GOVERNMENT HEALTH INSURANCE PROGRAMS

Name	Response Received
Indian Health Service (Department of Health & Human Services	Y
Tri-Care (Department of Defense) [4]	Y
Railroad Retirement Board (RRB)	Dropped [5]
Department of Veteran's Affairs (VA)	Y
Total Government Programs in Sample: 6 [4]	**Total Responders: 5 [4]**

[4] Tri-Care (formerly CHAMPUS) contracts with several insurance companies to administer the rate and method of reimbursement for claims filed under their program. Three of these contractors responded to our survey. Each was coded as a separate response, since payment rates are State specific. Comparisons were performed against Medicare's rates for those States.

[5] We dropped the Railroad Retirement Board (RRB) from the sample. Contact with them confirmed that retirees' health claims are covered by Medicare and are processed by the DME Regional Carriers (DMERC). Therefore, HCFA policies for payment are followed and the reimbursement rates are the same as for non RRB Medicare clients.

APPENDIX B

SAMPLE RESPONSE RATE

Type of Health Insurer	Number in Sample	Number Responding	Response Rate
Private Indemnity Insurance	10	7	70%
Medicaid State Agencies	10	10[1]	100%[1]
Federal Employee Local Insurance Plans	25	19	76%
Federal Employee National Insurance Plans	14	12	86%
Medicare Risk Health Maintenance Plans	25	21	84%
Other Government Health Insurers	6	5	83%
Total:	**90**	**74**	**82%**

[1] The Arizona Health Care Cost Containment System (the Medicaid State Agency) has seven subcontractors who provide Medicaid Coverage. Ventana Health Systems, provided the only response. This contractor furnishes Medicaid health care to 7 of 15 Arizona Counties.

A P P E N D I X C

CALCULATION OF SAVINGS

Breakout of DMERC 1996 Payments for the Hospital Bed Codes Surveyed

Procedure Code	DMERC Payments 1996	Total Payments for Rentals of only 1 Month Duration	Total Payments for Rentals of Only 2 Months Duration	Total Payments for Rentals of Only 3 Months Duration	Total Payments Rentals of 4 - 15 Months Duration
E0250	$7,085,989	$2,437,580	$836,147	$559,793	$3,252,469
E0255	$30,720,446	$11,428,006	$3,102,765	$2,150,431	$14,039,244
E0260	$233,607,390	$80,828,157	$28,266,494	$18,454,984	$106,057,755
E0265	$1,084,068	$576,724	$106,239	$82,389	$318,716
Total	**$272,497,893**	**$95,270,467**	**$32,311,645**	**$21,247,597**	**$123,668,184**

Estimated Savings if Rental Reimbursement for Months 1 - 3 were Reduced From 10 Percent of Purchase Price to 7.5 Percent of Purchase Price

Procedure Code	Rentals of only 1 Month Duration-- Savings [1]	Rentals of only 2 Months Duration-- Savings [2]	Rentals of only 3 Months Duration-- Savings [3]	Rentals of 4 - 15 Months Duration Savings [4]	Total Savings [5]
E0250	$60,940	$41,807	$41,984	$243,935	$388,666
E0255	$285,700	$155,138	$161,282	$1,052,943	$1,655,064
E0260	$2,020,704	$1,413,325	$1,384,124	$7,954,332	$12,772,484
E0265	$14,418	$5,312	$6,179	$23,904	$49,813
Total	**$2,381,762**	**$1,615,582**	**$1,593,569**	**$9,275,114**	**$14,866,027**

[1] The amount in this column reflect the 2.5 percent savings for beneficiaries who rented these DME items for only 1 month.
[2] The amount in this column reflect the 5 percent savings for beneficiaries who rented these DME items for only 2 months.
[3] The amount in this column reflect the 7.5 percent savings for beneficiaries who rented these DME items for only 3 months.
[4] The amount in this column reflect the 7.5 percent savings for beneficiaries who rented these DME items from 4 - 15 months.
[5] These savings estimates are based on calendar year 1996 payments and are not indexed for inflation.

A P P E N D I X D

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: OCT 2 1 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle NMD
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Medicare Reimbursement for Hospital Beds in the Home--Prices," (OEI-07-96-00221) and "Medicare Reimbursement for Hospital Beds in the Home--Payment Methodology," (OEI-07-96-00222)

We reviewed the above-referenced reports that examine Medicare rates paid for four categories of in-home hospital beds against the rates paid by other agencies and private insurance payers. Findings of this report indicate that Medicare rates are substantially higher than rates paid by most other payers. In particular, Medicare was the only insurer that allows a higher rate of reimbursement for rental periods lasting less than 4 months.

The Health Care Financing Administration (HCFA) concurs with the intent of the OIG recommendations. Our detailed comments follow:

OIG Recommendation - Prices (OEI-07-96-00221)
HCFA should take immediate steps to reduce Medicare payments for in-home hospital beds.

HCFA Response
We concur, and intend to take steps to do this, but we must follow the law governing the "inherent reasonableness" authority that permits HCFA to reduce Medicare payments by up to 15 percent a year only when HCFA has made a determination that current payment allowances are grossly excessive.

We have begun this process of examining Medicare's payment allowances for hospital beds by requesting payment amounts and methodologies from other purchasers of hospital beds, such as the Department of Veterans Affairs and state Medicaid agencies.
We intend to propose a payment adjustment when these data are received and a comparison is made between Medicare's payment amounts and those of the other payers.
We are also conducting a competitive bidding demonstration project in Polk County,

Florida which includes hospital beds. Based on these data, and data collected by OIG as part of its study, we will then make a determination. If it is determined that Medicare payment allowances are grossly excessive, we will begin the process of making an adjustment using our inherent reasonableness authority.

OIG Recommendation - Payment Methodology (OEI-07-96-00222)
HCFA should seek legislation to eliminate the 2.5 percent enhanced rate for the first 3 months of rental. We realize that legislative action could take some time. Therefore, in the interim, we recommend that HCFA use the authority under the Balanced Budget Act of 1997 to reduce rates overall.

HCFA Response
We concur with the intent of the recommendation. Should our requested data on hospital bed pricing indicate that Medicare's allowances are excessive, we will consider Medicare's payment methodology regarding "enhanced payments" during the first 3 rental months. However, it is not clear that the approach recommended in this report (eliminating the enhanced payment methodology) is preferable to using our inherent reasonableness authority or conducting competitive bidding to address pricing issues. There are a number of factors that should be considered in determining the best approach. For example, if almost half of the Medicare beneficiaries rent beds for a period of 3 months or less, then the current policy of enhanced payment might be justified to allow suppliers to recoup their costs of transporting hospital beds to and from beneficiaries' homes. We want to work with the OIG to determine the best approach to achieve a fair price for hospital beds if the data does support that Medicare's payments are excessive.