

NAMES

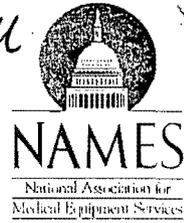
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William D. Coughlan, CAE *Bill*

President & CEO

National Association for
Medical Equipment Services
625 Slaters Lane, Suite 200
Alexandria, VA 22314-1176



THE WHITE HOUSE

WASHINGTON

December 15, 1995

William D. Coughlan, CAE
President & CEO
National Association for
Medical Equipment Services
625 Slaters Lane, Suite 200
Alexandria, VA 22314

Dear Bill:

Thank you for taking the time to come and visit with me and Diana today. I appreciated your presentation and the materials you brought. We look forward to a continued dialogue with you on these critical matters.

Best wishes during this holiday season and as we move into the new year.

Sincerely,



Carol H. Rasco
Assistant to the President
for Domestic Policy

THE WHITE HOUSE

WASHINGTON

December 15, 1995

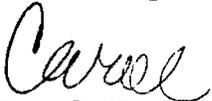
Walt Patterson
President
Patco Services, Inc.
Stephens Building
Suite 1430
111 Center Street
Little Rock, AR 72201

Dear Walt:

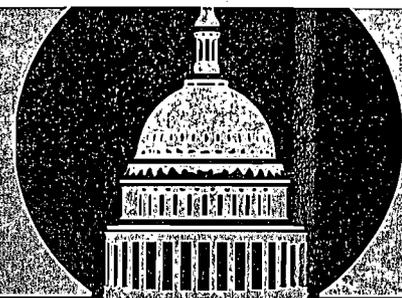
As always it was so good to see you.
Thanks so much for bringing Bill Coughlan
in to see Diana and me. We will continue
to plug away working with you on these
matters!

Have a good holiday, I will hope to see
you again soon.

Sincerely,



Carol H. Rasco
Assistant to the President
for Domestic Policy

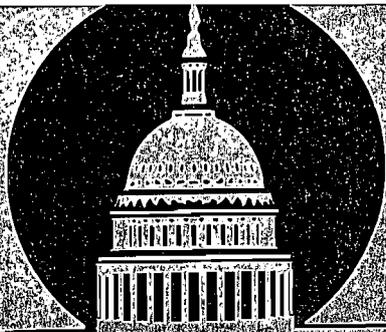


NAMES

National Association for
Medical Equipment Services

Carol Rasco

Promoting access to quality home
medical equipment services and
rehabilitation/assistive technology



NAMES

National Association for
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**Meeting with Carol Rasco/Walt Patterson
The White House
December 15, 1995**

Legislative

1. Oxygen Cuts
2. Competitive Bidding
3. Freeze on CPI

Regulatory

1. Inherent Reasonableness of Oxygen and HME
2. Competitive Bidding
3. Certificates of Medical Necessity
4. Fraud and Abuse
5. Business and Services Standard



Budget Reconciliation

*We have offered Congress
our proportionate dollar
share in Medicare cuts.*

Congress recently passed the 1995 Budget Reconciliation Act, which contains several provisions which would greatly affect the HME services industry. The home medical equipment (HME) services and rehab/assistive technology industry has worked with Congress throughout the budget process to offer our fair share of cuts.

- **The proposed Medicare cuts would devastate the HME services industry as well as reap undue harm on Medicare beneficiaries!**
- The home oxygen therapy industry is one of the **most cost-effective** Medicare benefits. Oxygen therapy has **strict utilization controls** including a 20 percent co-pay, a physician prescription and an arterial blood gas test. Oxygen therapy allows beneficiaries to stay in the home where they prefer to be.
- We understand the difficult challenge facing Congress. For this reason, the HME services industry has presented a proportionate cuts proposal for Medicare for our industry. The industry wants to work with Congress. However, the magnitude of the **proposed cuts** would be **devastating** and would result in severe losses to the HME services industry and to the Medicare beneficiaries who receive our services, 24 hours a day, 7 days a week.
- NAMES has expressed to Congress the following concerns:
 - The proposed 20 percent reduction in the Medicare reimbursement for home oxygen therapy must be reduced to the industry's proportionate share. The industry is prepared to **accept up to a 10 percent cut** for the home oxygen benefit.
 - Any future **competitive bidding** proposal for HME should be **rejected** by Congress.
 - The **seven-year CPI freeze for all HME is excessive** on top of the proposed oxygen reimbursement cut, since this industry has received 18 Medicare reimbursement cuts in the past nine years.
 - Congress should adopt performance standards for home oxygen therapy, as suggested in testimony last year by the HHS Inspector General.
- NAMES wants to work with Congress to provide savings for Medicare. We also have **designed**, through our Coalition of Health Associations United Against Fraud & Abuse, a **proposal to help rid the health care industry of any fraud**. This additional proposal will also save our country billions of dollars. Some provisions have already been included in the budget package.

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December 1995

**Payments for Home Oxygen Equipment and Supplies
by
the Medicare Program and Veterans Administration**

Prepared by:
Roland E. King, FSA, MAAA

Background and Overview:

Proposed legislation to reform the Medicare program includes substantial reductions in Medicare payments for home oxygen equipment and supplies. Legislation proposed in the Senate provides for a 40 percent reduction in Medicare payment rates and legislation proposed in the House of Representatives provides for a 20 percent reduction in Medicare payment rates. In addition, the Health Care Financing Administration (HCFA) has proposed reductions in Medicare payment rates ranging from 7 percent to 43 percent based on the inherent reasonableness provisions of the Medicare statute.

These proposed reductions in payment rates appear to be based on two factors: (1) data published by the Veterans Administration (VA) indicating that payment for home oxygen by the VA is substantially lower than payments by the Medicare Program, and (2) a shift in modality observed by HCFA in the provision of home oxygen services and supplies that has occurred since the payment rates were determined under the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). King Associates was engaged by the Davidson Colling Group to review and comment on the technical soundness of these findings.

Executive Summary:

To estimate monthly VA payments for home oxygen, I examined twelve VA home oxygen contracts (previously selected by the Office of the Inspector General) and used the itemized schedule of payment rates in these contracts to construct the monthly cost to the VA for a patient using either a concentrator or liquid oxygen equipment. These estimates were constructed under low utilization and high utilization assumptions, described in more detail in the section describing the analysis of the VA home oxygen contracts.

Using the Medicare based distribution, contained in HCFA's 1994 BMAD file, of 84 percent concentrator patients and 16 percent liquid oxygen patients, under the high utilization assumption, the 75th percentile of monthly costs was \$370.79 and the 25th percentile of monthly costs was \$214.50. The median monthly cost for the twelve contracts was \$336.81. Under the low utilization assumption, the 75th percentile of monthly costs was \$298.19 and the 25th percentile of monthly costs was \$176.90. The median monthly cost for the twelve contracts was \$270.10.

Data published by the VA is much lower than the figures indicated above, but I have determined that the VA data is not credible based on a lack of face validity and simple spot checks. These

spot checks are described in more detail in the section discussing the consistency of the VA data with the results of this study.

I understand that the average monthly Medicare payment for oxygen and the associated equipment and supplies is approximately \$280 for stationary equipment and \$45 for portable equipment, for a total of \$325 for a patient using both stationary and portable equipment. While it is possible that the twelve contracts selected by the OIG may not be representative of all VA home oxygen contracts, this analysis suggests that the VA and Medicare payments for home oxygen therapy are substantially similar.

I also examined HCFA's analysis of the modality shift that had occurred since the payment rates for home oxygen had been established in 1987. HCFA's analysis of the modality shift was flawed. It only examined the change in the percent of patients using concentrators, thereby concluding that a shift to a less expensive modality had occurred. When all three modalities are examined, the percent of patients using the least expensive modality (gaseous oxygen) has declined and the percent of patients using the most expensive modality (liquid oxygen) has increased. Home oxygen contractors have absorbed the cost of this shift under HCFA's modality neutral payment method.

Different VA and HCFA Payment Methods for Oxygen Equipment and Supplies:

HCFA and the VA use substantially different payment methods for oxygen equipment and supplies which make direct comparisons difficult.

Summary of HCFA Payment Method:

HCFA pays a flat monthly rate for stationary oxygen equipment which includes payment for all of the ancillary supplies and oxygen consumed with that equipment. This payment is the same regardless of the type of stationary equipment used and regardless of the amount of oxygen supplied. If portable equipment is needed in addition to the stationary equipment, an additional flat monthly rate is paid for the portable equipment. Payment for the cost of oxygen consumed by the portable equipment is included in the stationary equipment payment amount.

Summary of VA Payment Method:

The VA pays for oxygen equipment and supplies on the basis of an itemized payment schedule established by contract at each local site. The VA establishes separate payment rates for each different type of stationary equipment, each different type of portable equipment, and each separate piece of ancillary equipment. In addition the VA pays separately for oxygen by the contents, with different payment rates for gaseous (per cylinder) and liquid (per pound) oxygen.

Comparison of VA and Medicare Payments for Home Oxygen:

VA payments for home oxygen services and supplies cannot be directly compared to Medicare payments for home oxygen equipment and supplies because of the differences in the two payment methods. Moreover, estimation of the total monthly VA payments for oxygen and oxygen supplies and equipment is extremely complex because of the fragmented way that VA pays for oxygen and associated supplies and equipment.

For example, a comparison of the VA's monthly payments for oxygen concentrators with HCFA's flat monthly payment for fixed equipment would not be valid because the VA monthly rate covers only the oxygen concentrator itself, while HCFA's monthly rate covers the oxygen concentrator and all the ancillary supplies and equipment. If liquid oxygen (a much more expensive piece of stationary equipment than an oxygen concentrator) is used as the stationary equipment, HCFA's monthly rate covers not only the equipment but all of the liquid oxygen consumed through that equipment.

Analysis of VA Home Oxygen Contracts:

Twelve VA home oxygen contracts were analyzed to determine the monthly payments made by the VA for home oxygen. The twelve VA contracts used in this analysis were selected for study by the Office of the Inspector General (OIG). I understand the OIG did not pursue this study to its conclusion when its preliminary findings suggested that VA and Medicare payments for home oxygen equipment and supplies were substantially the same.

In order to convert the VA itemized payment schedule costs to monthly costs, it was necessary to make assumptions regarding the monthly utilization of oxygen. The low assumption is ten portable cylinders per month for those patients using concentrators and 300 pounds of oxygen per month for those patients using liquid oxygen. The high utilization assumption is 15 portable cylinders of oxygen per month for those patients using concentrators and 350 pounds of oxygen per month for those patients using liquid oxygen. The high utilization assumption represents about 56 hours per month (slightly less than two hours per day) of portable oxygen utilization and the low utilization assumption represents about 37 hours per month (slightly more than one hour per day) of portable oxygen utilization for the average patient.

Using the Medicare based distribution of 84 percent concentrator patients and 16 percent liquid oxygen patients, under the high utilization assumption, the 75th percentile of monthly costs was \$370.79 and the 25th percentile of monthly costs was \$214.50. The median monthly cost for the twelve contracts was \$336.81. Under the low utilization assumption, the 75th percentile of monthly costs was \$298.19 and the 25th percentile of monthly costs was \$176.90. The median monthly cost for the twelve contracts was \$270.10. The table below summarizes the development of these estimates under the low utilization and high utilization scenarios.

Monthly VA Home Oxygen Costs

Percent	<u>Low Utilization</u>			<u>High Utilization</u>		
	<u>Concentrator</u>	<u>Liquid</u>	<u>Weighted</u>	<u>Concentrator</u>	<u>Liquid</u>	<u>Weighted</u>
25th	\$175.83	\$182.50	\$176.90	\$215.83	\$207.50	\$214.50
50th	262.50	310.00	270.10	335.25	345.00	336.81
75th	280.50	391.08	298.19	357.50	440.58	370.79

Explanation for Discrepancy with VA Data:

The monthly payment amounts displayed in the table above are significantly higher than the data displayed in the "NATIONAL HOME OXYGEN PROGRAM FY94 Cost Review" published May 1995 by the National Center for Cost Containment, Department of Veteran Affairs, Milwaukee, WI. What is the explanation for this large discrepancy?

An examination of the summary cost data on page VII of this document reveals such great variation that it does not appear to be plausible on its face. For example, the reported monthly cost for patients using rented concentrators varies from a minimum of \$14.24 to a maximum of \$465.00; the monthly cost for patients using rented cylinders varies from a minimum of \$6.00 to a maximum of \$252.00; the monthly cost for rented liquid varies from a minimum of \$20.00 to a maximum of \$1,392. It does not seem plausible, even with market differences, that the variation in payment can be this great.

In order to ascertain if this questionable data was flawed, I performed a rudimentary spot check of the data. I obtained copies of the contracts for two of the sites reporting low costs and compared the provisions of the actual contracts with the data reported. The results of this spot check are as follows:

For the Buffalo, NY site, the VA report (page 35) indicates that the total monthly payment for a full range of oxygen supplies and services for a concentrator patient is \$14.24. However, the contract for the Buffalo site indicates a monthly fee of \$51.24 for concentrator rental alone. Additional monthly fees include \$13.45 for each portable E-cylinder or \$12.75 for D-cylinders.

For the Cheyenne, WY site, the VA report (page 49) indicates that the total monthly payment for a full range of oxygen supplies and services for a concentrator patient is \$85.00. However, the contract indicates a monthly rental fee of \$85.00 for concentrator rental alone. Additional costs itemized in the contract include a \$14.00 delivery and set-up fee, a \$16.00 monthly fee for service visits, a \$4.25 fee for each portable E-tank refill, and a \$9.25 fee for each H-tank refill.

Given the lack of face validity of the data and its failure to pass even a rudimentary spot check, I have concluded that the VA data is not credible. In fact, the VA's own report states on page VII that the VA "recognizes that some facilities may have had difficulty determining their costs."

Analysis of Modality Shift:

I examined HCFA's analysis of the modality shift that had occurred since the payment rates for home oxygen had been established in 1987. I used the same BMAD data that HCFA used in its analysis. Since the percent of fixed equipment using oxygen concentrators (a less expensive modality) had increased, HCFA had conjectured that the percent of liquid oxygen (the most expensive modality) had decreased.

A more careful analysis which examines all three modalities (concentrators, gaseous oxygen, and liquid oxygen) reveals that the percentage of liquid oxygen has increased, even as the percent of concentrators has increased. These increases in the use of concentrators and liquid oxygen have taken place at the expense of gaseous oxygen (the least expensive modality). Thus, an analysis of the modality shift shows that there has been a shift to the higher cost modalities rather than to the lower cost modality. Under HCFA's modality neutral payment system, oxygen suppliers absorbed the increased cost of this shift in technology.

The table below indicates how HCFA arrived at the erroneous conclusion that a shift to a less costly modality had occurred. The table also shows that HCFA's modality shift, though incomplete, is consistent with a complete analysis, but the HCFA analysis does not capture the shift to liquid oxygen, the most expensive of the three modalities.

Comparison of Modality Shift

Year	<u>HCFA Analysis</u>		<u>Complete Analysis</u>	
	<u>1987</u>	<u>1993</u>	<u>1986</u>	<u>1994</u>
Concentrator	68.2%	87.13%	66.4%	83.2%
Total, liquid & gaseous	31.8	12.87	33.6	16.8
Gaseous Oxygen	NA	NA	22.1	1.2
Liquid Oxygen	NA	NA	11.5	15.6

Conclusion:

My analysis of the twelve VA contracts selected by the OIG, review of the VA's published report "NATIONAL HOME OXYGEN PROGRAM FY94 Cost Review" and analysis of the modality shift suggest that (1) the VA monthly payment for home oxygen is essentially the same as the monthly payment by Medicare for home oxygen and oxygen equipment and supplies, (2) the VA data which seems to contradict this conclusion is not credible and (3) since the Medicare monthly payment rates for home oxygen were determined in 1987, there has been a shift to the more expensive modalities (oxygen concentrators and liquid oxygen), and away from the least expensive modality (gaseous oxygen).



Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access to HME for Americans.

Competitive Bidding

Background

Competitive bidding has been proposed over the past several years as a helpful solution to problems in the Medicare program.

In 1993, the Clinton Administration submitted to Congress proposed legislation to reform the nation's health care system which included a provision that would have implemented competitive bidding.

In 1994, Congress decided that competitive bidding was not a good solution and did not provide quality health care for consumers.

In 1995, the House Budget Committee in its draft budget recommendations proposed competitive bidding for oxygen therapy and parenteral and enteral therapy.

Status

Competitive bidding under the Medicare program

Competitive bidding is a process whereby a home medical equipment (HME) service provider or rehab/assistive technology provider in a designated area submits a bid in hopes of winning all of the business in that designated area. Competitive bidding is synonymous with a "winner takes all" scenario.

Competitive bidding is anti-small business

It is difficult to design and administer any competitive bidding process without damaging the market. A winning bid awarded solely to one provider within a given service area would drive many small companies out of business, creating a considerably reduced level of competition.

Competitive bidding has been tried with the Medicaid program

Competitive bidding for certain selected HME items has been tried or considered and subsequently abandoned in a number of states. States found competitive bidding to impair freedom of choice for recipients, to render the States incapable of utilizing the expertise of all vendors, and to impede competition and access. For example:

- Ohio Medicaid officials concluded that competitive bidding was unworkable after issuing a request for purchase.

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Competitive Bidding – page 2

- Montana abandoned competitive bidding in its Medicaid program because the program was found to deny access to beneficiaries and impair the ability of the State to tap the expertise of all providers. Abandoning competitive bidding has resulted in greater access to care and freedom of choice for recipients.
- South Dakota backed away from a decision to implement competitive bidding in 1993 after deciding it could reduce Medicaid costs in other, more effective, ways.

Competitive bidding also has worked poorly for both the Defense Department and the Veterans Administration (VA), where it has been employed on a large scale similar to what Medicare may require. VA hospitals have experienced deficiencies documented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) due to the poor quality of home care provided by VA contract winners. The Medicare program should expect similar, if not greater, problems in access and quality given the lack of standards for HME services under Medicare. In monitoring the provision of services under competitive bidding contracts in a number of states, the VA has found many providers to have limited knowledge or expertise in home oxygen and other HME items. Areas where such limitations exist include: quality of equipment, appropriateness of equipment, differences between various types of equipment, safety features and current pricing schemes.

Position

Competitive bidding hurts consumers

Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access to HME for Americans. Such a radical restructuring of how HME is provided would jeopardize the quality of HME services. In fact, in instances where competitive bidding has already been attempted, some providers have submitted unreasonably low bids to win the contract, only to find they could not cover the costs of providing the services. They thus have been forced to cut corners, with devastating results.

Recommendation

Competitive bidding for HME services of any type must not be included in any legislation. It has been tried and found not to provide the quality and scope of expected services or the anticipated program savings.

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June 1995

MEMORANDUM - December 14, 1995

RE: Certificates of Medical Necessity for Durable Medical Equipment - Revision Update

Background: Certificates of Medical Necessity (CMNs) are documents for collecting information to determine if the beneficiary's condition meets the Medicare policy for "medically necessary" equipment when a physician orders a covered item of home medical equipment (HME). The document also serves the program as part of the utilization control process and as the memorialization of the physician-supplier-carrier interaction.

Beginning in 1993 and extending through 1995, due to statutory changes, HCFA and the newly created Durable Medical Equipment Regional Carriers (DMERCs) have been in the process of revising and updating the CMNs. The revisions proposed as final in mid-1995 were not acceptable to the HME industry or physicians due to the increased paperwork burden and undefined rationale for the collection of non-medical necessity information on the forms. The National Association for Medical Equipment Services (NAMES), the American Society for Internal Medicine (ASIM) and the American Medical Association (AMA) met with the Office of Management and Budget (OMB) on September 29, 1995, and requested the OMB intervene and require HCFA to submit the forms to a Paperwork Reduction Act (PRA) Review. This request was subsequently supported by a coalition of HME industry and physician representatives. OMB directed HCFA to submit the forms as per the PRA requirements. Comments were submitted by the HME industry and physician groups and a meeting to exchange comments was conducted on November 29, 1995.

Current Status: NAMES and other industry and physician groups met again on December 8, 1995, with HCFA and OMB to receive HCFA's responses to the questions left with the agency and to obtain some insight into the agency's intentions regarding CMN revisions. HCFA has been given until December 19, 1995, to complete its final revisions and submit them to OMB for that agency's review and approval. HCFA has indicated significant adjustments its original positions on the CMNs and has indicated that the final revised CMNs will reflect positive responses to the HME industry's and physicians' concerns. **An evaluation of the revised CMNs as submitted by HCFA to the OMB on December 19 will be necessary to confirm these indications of genuine responses to the expressed concerns.**

With regard to the CMN issues, HCFA indicated the following:

Creating a "one-page" CMN - HCFA is experimenting with each of the CMNs in an attempt to turn as many of the forms as possible into one page forms. There are possibly one or two items with significant accessories to be listed that would not make the form amenable to a one page format. One such item identified during the meeting was non-standard wheel chairs.

Warranty information - HCFA said that request for warranty information will be removed from the CMNs. HCFA will develop a separate collection process to obtain the warranty information as necessary to protect Medicare from paying for repairs and maintenance that should be covered by warranties.

MEMORANDUM CMN Status Update

December 14, 1995

Page Two

HME Services Provider Completion of the Physician Phone Number and UPIN - HCFA indicated that the physician name, address, phone number and UPIN information will be moved from section B to another part of the form and therefore will be allowed to be completed by the HME services provider.

Definition of "financial relationship" - HCFA has decided to forgo using the term "financial relationship" and return to the previous statement on the form that "The supplier may not fill out information in Section B." HCFA may require the person actually filling out the form provide their name, title and affiliation, if other than the physician.

Cover letter contents - Though an issue peripheral to the "form", HCFA addressed provider questions regarding clarification of the content of the CMN cover letter. HCFA has decided to return to the clarifications of the content of the cover letter contained in a memorandum issued by the agency several years ago, i.e., an HME provider is permitted to use a cover letter as a review and confirmation of the physician's instructions in ordering the item, provided that the cover letter does not change the physician's order and does not provide answers to the questions in Section B of the CMN. Potential conflicts as to when recorded information could be construed as providing answers to the questions was discussed, without resolution except for a statement by the agency that a "common sense" approach should be used in audits of cover letters by the DMERCs. Follow-up with the agency for clarification on this issue is necessary.

Physician attestation statement - Responding to the physicians' concerns, HCFA will change the attestation statement to say that the physician has received the information completed by the HME services provider and that the information the physician has completed is true and correct.

Potential Problem:

Automation of the Forms - Currently, computer software vendors provide the HME industry with programs that permit the HME providers' computer printers to print on blank paper the entire form and/or pertinent questions of each form related to the equipment ordered. HCFA appears to be leaning toward the position that once these forms are "approved by OMB as government forms," these types of computer software capabilities will no longer be allowed. This will be a serious inconvenience for fully automated billing operations and catastrophic to the various software companies serving the industry. NAMES is disappointed with HCFA's disregard of the current investment in automation hopeful that the OMB will allow maximum flexibility for the reproduction of the approved forms by computer automation by allowing for the appropriate variations in the final approval of the CMN formats.

EXHIBIT #1

Examples of Industry Developed One-Page CMNs

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 01.02A

Certificate of Medical Necessity: Hospital Beds

Section A Supplier Completion Section Certification Type/Date: Initial ___/___/___ Revised ___/___/___

PATIENT NAME, ADDRESS and HIC NUMBER SUPPLIER NAME, TELEPHONE and NSC NUMBER

TELEPHONE () ___ - ___ HICN TELEPHONE () ___ - ___ NSC#

Description of All Equipment HCPCS Code Supplier Price Medicare Allowable

PLACE OF SERVICE ___ Home ___ Nursing Facility ___ Other Patient Sex ___ F ___ M Patient DOB ___/___/___

Estimated Length of Need (In Months): ___ 1-99 (99=Lifetime) Diagnosis Codes (ICD-9):

PHYSICIAN NAME, ADDRESS, UPIN AND TELEPHONE (Printed or Typed)

Telephone: _____

UPIN: _____

Section B Information below may not be completed by the supplier, or an employee of the supplier, of the items/services.

ANSWERS Answer Questions as follows: Manual Hospital Bed Questions 1 and 3 thru 5
Manual Hospital Bed with Height Adjustment Questions 1 and 3 thru 6
Electric Hospital Bed with Height Adjustment Questions 1 and 3 thru 5 and 7

Yes ___ No ___ Does not apply ___ 1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?

Yes ___ No ___ Does not apply ___ 3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?

Yes ___ No ___ Does not apply ___ 4. Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?

Yes ___ No ___ Does not apply ___ 5. Does the patient require traction which can only be attached to a hospital bed?

Yes ___ No ___ Does not apply ___ 6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?

Yes ___ No ___ Does not apply ___ 7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Printed to Typed)

Name: _____ Title: _____

PHYSICIAN ATTESTATION, SIGNATURE and DATE:

I, the patient's physician, certify that I have received Sections A and B of this Certificate of Medical Necessity (including charges for items ordered). I certify the medical necessity of these items for this patient. I have reviewed the answers in Section B of this form. Any statement on my letterhead attached hereto, has been reviewed and signed by me. The foregoing information is true, accurate and complete, to the best of my knowledge, and I understand that may falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____
(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

DATE ___/___/___

Certificate of Medical Necessity: Hospital Beds/Support Surfaces

Section A (THE SUPPLIER MAY FILL IN INFORMATION IN SECTION A)

Certification: <input type="checkbox"/> Initial <input type="checkbox"/> recertification <input type="checkbox"/> revised Effective date: _____ <input type="checkbox"/> this is a replacement item		Supplier name Address: _____ Telephone #: _____ NSC #: _____	
Patient name: PIC #: _____			
Diagnosis (ICD-9)	Description		
ICPCS	Description		

Section B (UNLESS OTHERWISE INDICATED ONLY THE PRESCRIBING PHYSICIAN OR A PHYSICIAN EMPLOYEE MAY FILL IN INFORMATION BELOW THIS LINE)

Estimate the length of need in number of months from 1-99 (99 = lifetime): _____

Answer for ALL HOSPITAL BEDS: (check one: Y = yes; N = no; D = does not apply unless otherwise noted)	supplier completion permitted	physician completion ONLY												
1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?		[Y] [N] [D]												
2. (reserved)														
3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?		[Y] [N] [D]												
4. Does the patient require the head of the bed to be elevated more than 30° most of the time due to congestive heart failure, chronic pulmonary disease or aspiration?		[Y] [N] [D]												
5. Does the patient require traction which can only be attached to a hospital bed?		[Y] [N] [D]												
Answer for VARIABLE HEIGHT BEDS (manual height, head and leg elevation adjustments):														
6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position?		[Y] [N] [D]												
Answer for SEMI-ELECTRIC BEDS (manual height and electric head and leg elevation adjustments):														
7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?		[Y] [N] [D]												
8, 9, 10, 11 (reserved)														
Answer for ALTERNATING PRESSURE PADS/MATTRESSES:														
12. Is the patient highly susceptible to decubitus ulcers?		[Y] [N] [D]												
13. Are you directing the home treatment regimen for this item?		[Y] [N] [D]												
Answer for AIR-FLUIDIZED BEDS (warm air passed through ceramic beads to simulate fluid movement):														
13. Are you directing the home treatment regimen for this item?		[Y] [N] [D]												
14. Does the patient have coexisting pulmonary disease? (Note: An AFB cannot be elevated/is contraindicated if head elevation is required.)		[Y] [N] [D]												
15. Has a conservative treatment program been tried without success?		[Y] [N] [D]												
16. Was a comprehensive assessment performed after failure of conservative treatment?		[Y] [N] [D]												
17. Is the home electric system sufficient for the anticipated increase in energy consumption?	[Y] [N] [D]													
18. Is structural support adequate to support the air-fluidized bed?	[Y] [N] [D]													
19. Are open, moist dressings used for the treatment of the patients? (Note: An AFB will dry out a moist dressing.)		[Y] [N] [D]												
20. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?	[Y] [N] [D]													
21. Provide the stage and size of each pressure area/ulcer necessitating the use of the overlay mattress or bed. (Note: If the AFB is being prescribed for preventive reasons — prior to the manifestation of a pressure area/ulcer — enter "0" in the size, length, width columns.) Patient must exhibit an appropriate combination of risk factors, i.e. blood or circulatory deficiencies, weight and/or nutrition problems, chronic illness, past history of decubiti, incontinence and/or immobility. (See reverse.)		<table border="1"> <tr> <td>Stage:</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>Max length (cm):</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Max width (cm):</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	Stage:	1	2	3	Max length (cm):	_____	_____	_____	Max width (cm):	_____	_____	_____
Stage:	1	2	3											
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Risk factors:														
22. Over the past month, the patient's ulcer(s) has/have: 1) improved; 2) remained the same; 3) worsened														

Physician name, address and telephone #: _____ UPIN: _____	I certify the medical necessity of these items for this patient. Section B of this form and any statement over my signature attached hereto has been completed by me, or by my employee and reviewed by me. I certify that I examined this patient prior to ordering the medical equipment. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. _____ physician's signature (a stamped signature is not acceptable) date (required)
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NAMES

National Association for
Medical Equipment Services

**Statement
of the
National Association for
Equipment Services
on
Fraud and Abuse
in the Medicare System
Before
the
Health Care Financing
Administration
Tuesday, August 29, 1995
Washington, DC**



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Good Morning. I am William D. Coughlan, President and CEO of the National Association for Medical Equipment Services (NAMES), the only national association exclusively representing the home medical equipment (HME) services industry. NAMES welcomes this opportunity to present our comments about improving and preserving the solvency of the Medicare program by ending fraud and abuse.

NAMES members comprise approximately 1800 HME companies which provide quality, cost-effective services and rehabilitative/assistive technology to patients in their homes. According to physician prescription, HME providers furnish a vast array of HME and related services, ranging from "traditional" HME items such as standard wheelchairs and hospital beds, to highly advanced services such as oxygen, nutrition, and intravenous antibiotic therapies; apnea monitors and ventilators; and state of the art rehabilitation equipment customized for the unique needs of people with disabilities. Many of these consumers are Medicare beneficiaries.

NAMES takes pride in its mission to promote access to quality HME services and rehab/assistive technology and has devoted significant resources for several years to combat fraud and abuse. The industry has worked diligently with the Administration and Congress to help eliminate the few unethical providers who damage the reputation of an otherwise upstanding industry.



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Recently, NAMES took a serious look at the specific problems with the provision of HME services and rehab/assistive technology in the Medicare program. The following reflects our solutions to those problems, which we believe will potentially save the Medicare program millions of dollars by changing the inherent system weaknesses that encourage fraud and abuse.

- **Accountability Measures--The Need for Standards.** We have advocated for years that there must be stronger accreditation, certification and/or licensure requirements for HME service providers, including on-site inspections. Despite the work of NAMES and HME providers to create a higher level of service for individuals in need of care, formal Medicare certification standards for the provision of HME services still do not exist today. HCFA has no detailed specific requirements for beneficiaries receiving HME services. There are no provisions regarding the type or frequency of services that should be rendered, record-keeping practices, emergency care, patient education, home safety assessments or infection control practices.
- **Consistent Monitoring of the HCFA Common Procedure Coding System (HCPCS) Codes.** The HCPCS codes are currently updated only on a yearly basis. One of the abusive areas in HME is rooted in questionable coding practices, made possible by the inadequacy of codes to reflect technological advances. HCFA should change the coding



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system and establish appropriate fees for new codes on a quarterly basis. Increased agency vigilance could eliminate problems that have occurred, such as the situations with support surfaces and lymphedema pumps. Provider and manufacturer input will be necessary to make these quarterly coding adjustments meaningful. We believe HCFA has the authority to undertake this project now, for HME, at the Durable Medical Equipment Regional Carrier (DMERC) level. The quarterly carrier coding and new fee adjustments could still be ratified on an annual basis by HCFA.

NAMES would also advocate that HCFA create a **Manufacturer and Provider Advisory Committee** to assist in adjusting the HCPCS Codes and to recommend appropriate descriptors to help identify emerging technology.

- **Optional Electronic Preauthorization.** Assistive technology and special wheelchair systems require building and delivery prior to claims submittal. HCFA has no set time period for claim adjudication and guaranteed payment. We have received information which suggests that some providers may be submitting claims and paperwork indicating the equipment has been delivered, when in fact they have not even begun constructing the equipment. Providers are unfortunately forced into this otherwise abusive practice in order to get advanced assurance of Medicare coverage and payment for costly,



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complex equipment that has been prescribed by the physician. Otherwise, these providers run the risk of serious financial commitment to equipment construction with no guarantee of any, much less adequate, reimbursement.

HCFA is under a statutory mandate to create a prior authorization system for customized assistive technology, but to date, has not issued specifications on how that preauthorization will operate. As long as HCFA and the DMERCs lack the technical expertise to evaluate individual patient need for assistive technology, the risk of serving such Medicare beneficiaries will continue to be unacceptably high for HME assistive technology providers.

- **Equipment Upgrades.** Under the current system, a Medicare beneficiary with a prescription who wishes to purchase certain pieces of equipment may be unable to do so. For instance, a beneficiary who has a prescription for a full-electric hospital bed to meet his/her physical needs is prohibited by Medicare from purchasing the bed. Although Medicare will pay for the rental of a semi-electric bed, a full-electric bed has been deemed by the DMERCs to be medically unnecessary under any circumstances, even as originally prescribed by the physician. In essence, regardless of the patient's medical needs or a physician's prescription, Medicare makes the final medical need and payment



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decisions.

Often, when a beneficiary needs an item of medical equipment the provider will bill Medicare for the item and Medicare may deny payment and instead substitute another item that costs Medicare less. This is referred to as "down coding". In addition, Medicare denies the beneficiary the ability to "upgrade" and receive his/her equipment of choice. NAMES strongly supports legislative efforts to allow equipment upgrades for Medicare beneficiaries. In the interim, NAMES recommends that HCFA halt the practice of "down coding" equipment and issue the appropriate and honest claim denials for non-covered equipment, rather than second-guessing the physician, beneficiary, and HME services provider regarding the equipment choice.

In closing, NAMES recognizes the difficulties faced by this Administration and Congress in developing a responsible legislative and regulatory package that will reduce Medicare fraud and abuse while addressing America's critical health care needs. By enacting the suggested provisions, the solvency and integrity of the Medicare program could be preserved while achieving significant savings.

We also call for the GAO to score the issue of Medicare fraud and abuse. For example, at a "Medicare University" held earlier this month in Washington, DC, sponsored by the



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Citizens Against Government Waste (CAGW) and the Coalition to Save Medicare, CAGW President Thomas Schatz estimated the amount of Medicare fraud and abuse at \$17 billion per year; \$46 million per day. He also pointed out that there are no HHS OIG investigators in 25 states where Medicare spent more than \$26 billion covering 7 million beneficiaries. Why won't HHS hire additional investigators on the state level who can then perform on-site evaluations of providers.

We will be pleased to answer any questions you may have. Thank you for inviting us to submit our comments.



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EXTENDED COMMENTS

*August 29, 1995
HCFA Listening Session
Washington, DC*

In addition to suggested program changes, NAMES is currently working with the Coalition of Associations United Against Fraud and Abuse to assist the Administration and Congress in creating an environment that discourages fraudulent providers from participating in the health care system and encourages quality and cost-effective health care.

NAMES has also been a member since 1993 of the Advisory/Liaison Committee of the National Health Care Anti-Fraud Association (NHCAA), whose mission is to enhance the identification prevention, detection and prosecution of health care fraud. In addition to NAMES, the other members of this committee include: the AMA, the ADA, Health Insurance Association of America, the NAHC, and the Coalition Against Insurance Fraud.

The Coalition of Associations United Against Fraud and Abuse is made up of organizations that represent health care providers and suppliers who believe that existing fraud and abuse statutes must:

- Increase tools of enforcement against willful and criminal violations by giving regulators budgetary recognition and sufficient resources to enforce the law;
- Provide adequate and thorough education for providers, consumers, and payers to prevent violations;
- Protect Federal health care programs from unnecessary cost, utilization, and the failure to deliver appropriate levels of care;
- Be appropriate for the changing health care market; and
- Separate willful from technical violations.



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In addition, the Coalition is urging Congress to adopt the following proposals to help eliminate health care fraud and abuse. Most of the following items require changes to the Medicare statute, however, some could be implemented by HCFA within its current administrative authority. NAMES is hopeful that the Agency will evaluate and implement these suggestions as appropriate.

I. Tools of Enforcement

Federal Regulators should have the ability to prosecute fraudulent health care providers and suppliers.

- A. **Establish a new health care fraud statute in the criminal code.** Providing penalties of up to ten years in prison, or fines, or both for willfully and knowingly executing a scheme to defraud a health plan in connection with the delivery of health care benefits, as well as for obtaining money or property under false pretenses from a health plan will help as a deterrent to fraud.
- B. **Provide for the creation of an Anti-fraud and Abuse Collection Account.** An account subject to the congressional appropriations process will provide the Office of the Inspector General and the Federal Bureau of Investigation with the resources necessary to prosecute fraudulent providers and suppliers, and to provide guidance to those who seek to comply with the law.
- C. **Clarify Antikickback Statute.** The current antikickback statute is vague and not focused on fraudulent activity. This provision would ensure that the antikickback law applies to those who intentionally defraud the government by codifying the Hanlester Network vs. Shalala decision. In this case, the court ruled that "knowingly and willfully" committing a fraudulent act should be the basis of federal prosecution. In addition, there is a clarification to the longstanding issue that an action is illegal, if a "significant or substantial reason" for making a payment is to induce referrals.
- D. **Additional Enforcement Tools.** In addition to criminal prosecution, regulators are given the following enforcement tools to punish those found to commit a health care fraud offense:



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1. **Exclusion from Federal and State Health Care Programs.** Mandatory exclusion from Medicare and state health care programs to those convicted of a health care felony. Increase existing permissive exclusion and apply it to an officer in an entity that has been convicted of a health care offense, if that officer is found to have a "reason to know" that the crime was committed; and
2. **Expansion and increase in civil monetary penalties.** Expanding penalties will serve as an appropriate deterrent.

II. Health Care Fraud and Abuse Guidance

It is the belief of the coalition that the vast majority of providers and suppliers seek to comply with the complex laws of Medicare and Medicaid. We further believe that much of the "noncompliance" can be resolved with education and guidance. The following provides mechanisms for further guidance to health care providers on the scope and applicability of the anti-fraud statutes.

- A. **Safe Harbors.** Updates existing safe harbors and creates new ones.
- B. **Fraud Alerts.** Establishes a formal process for the request and issuance of special fraud alerts.
- C. **Advisory Opinions.** Advisory opinions assist providers and others engaged in the delivery of health care to ensure that they remain in compliance with health care statutes and regulations.

III. Medicare Claims Process

The General Accounting Office (GAO) in its report entitled "Medicare Claims Commercial Technology Could Save Billions Lost to Billing Abuse" (May 1995) stated "Flawed payment policies, weak billing controls, and inconsistent program management have all contributed to Medicare's vulnerability to waste, fraud, and abuse." The following provisions will improve that process.



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- A. **Medicare Transaction System (MTS).** Downgrade the priority or terminate the development of the Medicare Transaction System.
- B. **Commercial Automatic Data Processing Equipment (ADPE).** Require Medicare carriers to acquire commercially made Commercial Automatic Data Processing Equipment.
- C. **Reduce number of Medicare Carriers to ten.** Upon implementation of the ADPE, HCFA should be required to study and report to Congress on reducing its 32 Medicare Part B carriers to 10 such as the Durable Medical Equipment Regional Carriers (DMERCs) that were reduced to four. This will help to foster better communication between HCFA and the Regional Carriers.
- D. **Contractor/Provider Relationships.** Prohibit Medicare carriers and intermediaries from reviewing claims of provider organizations when the Medicare contractor has an investment in that organization;
- E. **Study Fraud and Abuse Under Managed Care.** The rise in managed care brings new forms of fraud and abuse. For example, the government and beneficiaries may be defrauded through withholding necessary services. The Institute of Medicine should undertake a study on the types of fraud that it may encounter under managed care and to begin ways to detect and combat such fraud.

MAR 10 REC'D



March 9, 1994

Ms. Carol Rasco
Domestic Policy Advisor
The White House
2nd Floor West Wing
Washington, D.C. 20500

Dear Ms. Rasco:

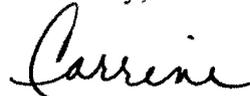
I very much appreciate your meeting with Walt Patterson, Becky Ogle and myself yesterday to discuss the Health Security Act. The following reiterates some of our concerns regarding competitive bidding (Section 4118 of the Act). NAMES members believe that, under a competitive bidding system for home medical equipment (HME):

- o Quality of care and services will deteriorate and decline;
- o Access to care, particularly in rural and inner city areas will be adversely affected;
- o Reasonable coverage for delivery of the full spectrum of home medical equipment items and services will decline;
- o Emergency services (24 hours a day, 7 days a week) will be compromised because of longer travel and delivery distances and fewer providers;
- o Earlier hospital discharges also will be compromised; and
- o Hospital readmissions due to delays in services and decrease in quality likely will be exacerbated.

I fully understand the Administrations position on not wanting to come forward at this time with various "compromising" positions on health care, particularly as we are all pushing for universal coverage. Nevertheless, I would ask that, if you are approached by a Member of Congress regarding deletion of competitive bidding for HME, you could support NAMES efforts.

Again, many thanks for your kind attention to this significant matter.

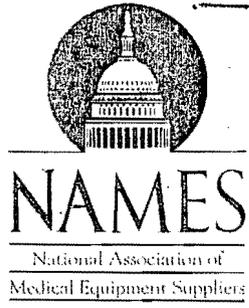
Sincerely,


Corrine Parver
President & CEO

P.S. Enclosed are our "universal coverage" stickers.

Enclosure

CP/tlj



Corrine Propas Parver
President and
Chief Executive Officer

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Alexandria, VA 22314
(703) 836-6263
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National Association of
Medical Equipment Suppliers

**Home Medical Equipment and Services:
Providing Preferred, Cost-Effective
Health Care in the Home**

A Paper Prepared for

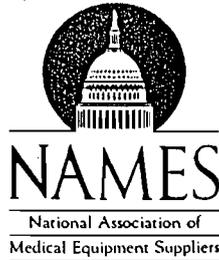
The Clinton Administration

by the

National Association of Medical Equipment Suppliers

January 1993

"Promoting access to quality home medical equipment services"



Home Medical Equipment and Services: Providing Preferred, Cost-Effective Health Care in the Home

I. Introduction

One of the most pressing issues to be faced by the Clinton Administration as it takes office will be how to set the direction for our nation's health care reform — a precarious balance of maintaining quality of care and expanding its access, while reducing costs. Toward that goal, this paper addresses the potential role of home care in ensuring quality, affordable health care for all Americans. Home care using home medical equipment (HME) services can ensure the continued provision of high quality health care in a setting that the vast majority of patients and their families prefer. And, that care can save our nation's health care system billions of dollars. But it will not happen unless the new Administration appreciates the policy issues that will ensure growing access to home care.

As America addresses the difficult issue of health care reform, one potential part of the solution routinely has been overlooked: home care using HME services. Currently, there are approximately 5,000 to 8,000 HME suppliers, about 11,000 home health agencies and some 1,200 freestanding hospices providing home care services to millions of Americans. Home care services come in many forms, from life-saving equipment to specialized nursing care and financial management assistance for patients and their families. These services often can be more cost-effective than certain institutional care while providing as high a level of quality of care as hospitals, nursing homes and other facilities. *Recent studies have found that a large majority of Americans believe that receiving treatment in the comfort of their own home when recuperating from an illness or injury would be vastly preferable to some form of institutional care. As such, when reforming the health care system, home care and HME services should be included in any basic set of uniform benefits package that eventually is developed.*

The future growth of home care services is being fueled, in part, by a powerful convergence of demographic, technological, economic and consumer trends. Each trend or "imperative" provides a unique contribution to creating an increased demand for home care services:

- The "Demographic" Imperative — creating the growing need for home care;
- The "Technological" Imperative — created by scientific and technological innovations that are enabling more Americans to choose home care options;
- The "Economic" Imperative — created by home care's fulfillment of the need for cost-effective health care services; and
- The "Consumer" Imperative — created by the public's preference for home care.

Taken together, these imperatives for growth present a compelling case for the overarching theme that home care services can and must play a key role in responding to the emerging health care needs of Americans and solving the current health care costs dilemma.

Manufacturers of HME are continuing to invest significant research and development resources in equipment designed to help the millions of Americans who have some type of condition that requires home care or “assistive” technology. In the recent past, similar efforts have led to the introduction of such devices as oxygen concentrators, portable oxygen cylinders, home infusion therapy equipment, lighter and stronger manual wheelchairs and state-of-the-art prosthetic devices. The Clinton Administration should address these issues to ensure that home care makes the fullest possible contribution to guaranteeing health care quality, accessibility and affordability for all Americans.

II. The Provision of Home Medical Equipment and Services

A. HME Suppliers: Home Care Professionals

Home care services are provided by many different professionals and volunteers. Many patients seeking home care services for the first time may not be sure where to turn; they also may be unsure of how the home care process works. In addition to providing consumers with a clear understanding of the “who” and the “how” of their services, HME suppliers make concerted efforts to educate and support “caregivers.” Demographic and life-style trends (e.g., increasing geographic diversity and a growth in the number of working couple households) make it more and more difficult for traditional caregivers — who represent an absolutely vital link in the home care process — to care for loved ones.

HME suppliers provide the equipment, services, education and caregiver training necessary for the successful use of HME. They also provide follow-up service, repair and maintenance for HME. Patients or their families often choose the home care provider or supplier they prefer. In the case of immediate post-hospital care, however, that choice often is made by a discharge planner. In the case of non-hospital-related care, the choice of a home care provider or supplier may be made by the attending physician. Suppliers also train family members in the proper use of HME and provide 24-hour emergency service when needed. Many HME suppliers have nurses or therapists on staff who make home visits to monitor patients and equipment. HME suppliers also aid families in completing and submitting necessary paperwork to ensure appropriate insurance reimbursement.

The role of HME suppliers in the overall health care system has been misunderstood. For example, some consumers and health professionals mistakenly believe that, aside from follow-up maintenance calls, the responsibilities of an HME supplier begin when equipment is ordered and end when it reaches the patient’s doorstep. In fact, that is only the beginning of a complicated, yet crucial process.

In many cases, “the HME company is actually bringing the hospital care home to the patient” — HME helps make homecomings possible. For that reason, the people who deliver HME must be highly trained in its operation, as well as the medical conditions being treated, to ensure that caregivers and patients operate equipment safely and effectively. These requirements complicate the HME process and often force the supplier to incur operating expenses that people outside the HME services industry may not recognize or acknowledge.

B. The HME Process

What follows is a step-by-step explanation of the HME prescription, delivery, maintenance and billing process:

Under the Medicare program, HME always must be prescribed by a physician. Once a physician determines that a patient can be treated at home, he or she may order appropriate equipment directly, but more often that duty falls to a discharge planner or social worker. The hospital discharge planner or social worker discusses specific needs with the patient and caregiver and makes them aware of the different HME suppliers in the area. *Once chosen, the HME supplier works closely with the discharge planner or physician’s office to identify equipment that best meets the requirements of the patient.* Often, variables

besides specific medical needs must be addressed. For example, a patient living on the third floor of a walk-up apartment building may need special or customized HME. Once these special needs are determined, equipment can be ordered. Phone orders are common, but all orders also must be verified in writing through a certificate of medical necessity (CMN) form that is completed and signed by the attending physician.

After the order for equipment is placed, *the HME supplier carefully checks insurance guidelines* to make sure that the prescribed equipment is covered, that the patient qualifies for home care benefits and that the patient meets all documentation requirements. In many cases, HME suppliers are required to contact the insurer prior to the beginning of treatment. After consultation with the physician and discharge planner, the supplier arranges a delivery time with the patient.

Delivery of HME is much more involved than delivery of other types of equipment for the home. Complicated or large pieces of equipment often cannot be carried en masse into a patient's home. Instead they may have to be assembled on site. This means *a delivery person must have extensive knowledge of the mechanical operation of the HME and the medical purpose it fulfills*. Furthermore, employees who deliver equipment are required to train patients and caregivers to ensure that they know how to operate the HME safely and effectively. Following installation and verbal training, *HME suppliers must provide detailed, written instructions for patients and caregivers* to refer to in the future. Suppliers also must carefully explain all paperwork related to the equipment, including warranty, patient rights and responsibilities and maintenance procedures.

Once delivery and installation are complete, *the supplier must provide all maintenance and service*. Through answering services and pocket pagers, suppliers and their professional staff are available 24 hours per day, 365 days per year to support patient and equipment care in the home, as repairs or replacement of equipment are needed. In cases where equipment cannot be serviced in the patient's home, temporary equipment must be provided at no extra cost. In some rural areas, suppliers routinely provide extra back-up equipment in case the primary equipment fails. This back-up equipment also is provided at no cost. This means two items actually are dedicated to one patient. However, the supplier only is reimbursed for the cost of providing one item. Billing and insurance-related paperwork during the time a patient needs HME may drive up administrative costs incurred by a supplier. For instance, it may be necessary to issue two bills each month: one to the insurer and one to the patient for his or her copayment. Finally, after an individual no longer needs HME, the retrieval process may be as complicated and costly as delivery. *The supplier must disassemble the equipment, carefully disinfect it and pay the cost of storage until it is rented again*.

III. Issues to Consider in Reform

Assessing the successes and failures under Medicare and Medicaid is an instructive starting point in charting the nation's health policy well into the 21st Century, whether these programs are retained in whole or in part, or abandoned in favor of something new. Medicare's authors envisioned in essence a "triage" system, with the hospital as the primary point of entry for most patients. For that expected group of individuals who might require further care incident to their hospitalization, the drafters created two very limited benefits: a restricted number of days of care in a skilled nursing facility; and a similarly restrictive home care package consisting of two separate components to be used either together or in the alternative: (a) skilled nursing and aide care provided by home health agencies; and (b) durable medical equipment provided by suppliers.

Implicit in this scenario is the assumption that the preponderance of patient needs are either acute or immediately incident to an acute episode. Thus, the program provides for the 70 year old stroke patient who requires immediate hospitalization followed by post-acute rehabilitation leading to complete or near-complete restoration. And in 1965, perhaps stroke victims, or individuals with fractured hips and the like indeed accounted for the preponderance of Medicare patients. But this concept of health care as

synonymous with acuity is not in harmony with today's emerging cohort of patients whose needs are chronic and for whom the acute care model is clinically inappropriate and financially costly. In view of the services and technology now available in the home, the acute model is also unnecessary in all respects save one, but that one is too frequently determinative of where care today is rendered; payer policies biased against patients with chronic conditions and unrecognizing of home care as an alternative to (rather than incident to) hospitalization.

Thus, as the work on creating a national health insurance program progresses from conceptual to operational issues, the following preliminary views are presented on the interrelationship and policy implications of three broad trends or principles that are appropriate to the current debate with respect to home care and the HME services industry: (A) technology; (B) chronicity; and (C) home medical equipment.

A. Technology

Trend: Technological advances are making possible high levels of quality care in the home that, in prior years, was available only in institutions.

Home care generally was a relatively unexplored concept in 1965, and, as envisioned by Medicare's authors, the home (durable) medical equipment benefit consisted primarily of standard wheelchairs, walkers, commodes and hospital beds — items often used for post-acute convalescence. This was the current state of technology, and the drafters aptly termed it the "durable medical equipment" (DME) benefit.

But as patients' needs have evolved, so too has home care technology. While traditional post-acute capability remains in place and available, an increasing array of new home care services and equipment is available to post-acute and chronic patients who, in prior years, would have required hospitalization: apnea monitors for infants; insulin pumps for the long-term diabetic; oxygen therapy for chronic obstructive pulmonary disease; power mobility devices for injuries and degenerative diseases (e.g., spinal cord damage, muscular dystrophy, multiple sclerosis, amyotrophic lateral sclerosis); parenteral and enteral administration of nutrition; oxygen ventilator equipment for the ventilator-dependent child or adult; and intravenous administration of chemotherapy or antibiotics for AIDS and cancer patients, to name but a few. In view of this evolution, the medical equipment supplier industry has dropped the out-moded term "DME" in favor of the more accurate phrase "HME."

Home care providers and suppliers of all types have been affected by the "sicker and quicker" phenomenon under the DRG hospital payment program. This was expected and, while challenging, is consistent with Medicare's original notion that home care is always incident to a prior acute episode. Less known and more unexpected is the fact that HME suppliers confirm an increasing number of their Medicare patients present with chronic needs also requiring recently available home equipment technology. Nor is the chronicity/technology trend restricted to Medicare's elderly. For example, low income Medicaid-eligible mothers are more likely to produce premature infants prone to Sudden Infant Death Syndrome. In prior years they remained in hospital nurseries for purely observational purposes until they developed past the SIDS threshold. With home apnea monitors, these Medicaid infants can be discharged earlier with no loss in necessary observation.

In short, technology and services are available to serve traditional post-acute patients as well as the emerging population with chronic needs, and in so doing forestall or shorten hospitalization. But public and private payer policy is lagging. To give but two examples: Medicare has virtually no home benefit for infusion chemo- or antibiotic therapy and many Medicaid programs do not cover home apnea monitors. As a result, unnecessary institutionalizations are still the norm because of physician convenience and the fact that current programs will cover certain equipment and services provided in an institution, but not in the home setting. With the continuing devastating rise in the number of individuals with the HIV virus, it is

unfortunate that more people cannot receive the care they require in the home, a setting certainly more compassionate and cost-effective. During the development stages of national health reform, policymakers must be encouraged by our industry to reflect on how these advances in technology should be factored into any future coverage and payment program.

B. Chronicity

Trend: A large and growing number of current Medicare and Medicaid eligible beneficiaries have chronic rather than acute health needs.

In America, health care needs traditionally have arisen and been treated as a series of acute interventions provided sporadically in a physician's office or an institution. But current data indicate that, increasingly, patients are experiencing needs which are more chronic than episodic. Improved nutrition, healthier lifestyles, better and earlier medical attention and a host of other factors contribute to the fact that people are living longer and not succumbing to acute illnesses. In conquering many acute health problems, however, we are surviving longer, thereby experiencing a greater incidence of chronicity.

In an important "humanistic" sense, this is a success. However, if the trend continues — as seems likely — the policy implications for health care costs are considerable. As embodied in governmental and commercial third party payer programs, current American health reimbursement policy has a pronounced tilt toward episodic and costly acute institutional interventions. To cite but one example: Medicare is still premised largely on the original authors' notion that necessary care will in the first instance be provided in the hospital with only very restricted benefits for that presumed minority of individuals who might require a period of post-acute convalescence at home or in a nursing facility.

This is not to fault Medicare's original drafters. Their work 25 years ago rested on an accurate reading of admissions and clinical data and experience from the 1950's and early 1960's. But more recent data available suggest strongly that to be responsive to the population served, health policy for the future must address a greater incidence of chronicity. Accommodating this fact within available funding likely will require policymakers to reconsider the bias toward institutionalization inherent in current public and private programs. *Turning to home care as a more cost-effective alternative thus becomes logical from a financial standpoint and humane from a purely societal view.*

C. Home Medical Equipment

Trend: HME is harnessing the technology and chronicity trends to produce a cost-effective alternative to institutionalization for many patients, while continuing to serve traditional post-acute patients.

The fact is that, increasingly, HME is being called on as a safe and less costly means of caring for both post-acute and chronic patients in their homes. The challenge for physicians, patients and HME suppliers is to continue caring for patients in the context of antiquated public and private programs that were designed with virtually sole emphasis on acute care in institutions. And as the chronicity/technology trends continue through the 90's and into the next century, such programs will be increasingly "out of synch" with public policy fashioned 25 years ago or more at a time when patient needs were in the main acute in nature.

The tension is obvious and benefits no one. The opportunity for the future is to capitalize on the cost, clinical and social advantages of maintaining chronic and post-acute patients in their homes through neutralizing the present policy tilt toward acute institutional care. In this way, home care (including HME), is not disadvantaged when patients and their physicians select a care setting. NAMES respectfully suggests that the policy goals of the Clinton Administration should be to make public and private payer policy setting neutral at the very least and, to the extent politically feasible, to create some incentives for home care. The result would be the maintenance of existing acute capability where appropriate, but an increased flexibility

to serve both post-acute and the emerging chronic patient with technology and services in the less costly non-institutional environment.

At the conceptual level, accomplishing this goal is relatively easy, requiring only that policymakers adopt a limited number of guiding principles, as described in the following recommendations:

- *Retain and preserve both the current Medicare and Medicaid existing HME benefit;*
- *Facilitate patient access to HME services independent of institutionalization or an acute care episode, where appropriate ;*
- *Identify HME services as a required (rather than optional) benefit under any new health reform legislation;*
- *In the alternative, where home care and HME services are not included in the standard or minimum benefit plan, allow actuarially-equivalent home care and equipment to be substituted at no additional premium cost, under a standard or minimum benefit plan; and*
- *Expedite recognition of new technology available in the home.*

If policymakers are prepared to enunciate these broad policy principles or recommendations, the HME services industry would welcome the opportunity to provide input on ways to implement them. The HME services industry's current efforts to provide quality patient care through ethical business practices, certification and accreditation should secure firmly its place at the table during this most crucial debate of health care reform.

IV. Conclusion

Home medical equipment suppliers are faced with issues that already have begun to affect the services they provide. How well these issues are addressed — ensuring access to quality home care, eliminating unethical business practices and coordinating and supporting the continued development of home care services — will determine the extent to which home care becomes a vital and cost-effective contributor in America, thereby fulfilling its great promise to the future of health care.

Three factors drive the growth of health care expenditures: (1) demographics, (2) price, and (3) utilization of services. Any reformed health care system must assure that incentives are appropriate to reduce utilization. Conflict of interest must be eliminated and patients must have an incentive to not use health care services unless they are required — that is, health care reform must promote the responsible use of health care services by all parties, providers and recipients alike.

Finally, home care is an important component in the delivery of both acute and long-term health care. Any reformed health care system must contain reimbursement for appropriate health care services in the lowest cost alternative setting, including the home.

* * * * *

The National Association of Medical Equipment Suppliers (NAMES) is a nonprofit trade association comprised of over 2,100 HME suppliers in over 4,500 sites across the country. Based upon individual patient needs and according to physicians' prescriptions, NAMES members furnish a wide variety of equipment, supplies and services for home use. These items may range from traditional medical equipment such as walkers, oxygen and hospital beds, to highly sophisticated items and services such as parenteral and enteral supplies for complete nutritional support for individuals who cannot digest food normally; apnea monitors, which allow parents to closely monitor high risk infants' breathing; and specialized wheelchairs and other technologically-advanced equipment, which are custom-designed for the needs of rehabilitation patients. A substantial portion of HME patients/clients are Medicare and Medicaid beneficiaries.

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Home Medical Equipment Services

**a quick guide for
Medicare beneficiaries**

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NAMES

National Association for
Medical Equipment Services