OXYGEN AND OXYGEN EQUIPMENT PAYMENT SYSTEM

*payment***basics**

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Oxygen equipment and supplies used at home by beneficiaries for whom they are medically necessary are covered by Medicare. Medicare pays 80 percent and beneficiaries are responsible for 20 percent coinsurance. According to CMS, almost one million patients now receive oxygen therapy with Medicare allowed charges of $2.78 billion in 2004. This represents a 71 percent increase since 1998. Monthly rental payments were reduced by 30 percent in the Balanced Budget Act of 1997 (BBA) and approximately 10 percent by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

The equipment Medicare pays for

Medicare covers both stationary and portable home oxygen equipment. Concentrators are the most common form of stationary equipment. These machines concentrate the oxygen in room air and therefore do not require any refilling with oxygen contents as do tanks of liquid or gaseous oxygen. Portable units are usually small tanks that require refilling with oxygen contents. Newer technologies include transfilling concentrators, which can be used to refill small portable tanks, and portable concentrators.

Currently, Medicare uses a fee schedule to set prices for rental of home oxygen equipment. Beginning in January 2006, section 510(b) of the Deficit Reduction Act of 2005 (DRA) limited rental of oxygen equipment to a period of 36 months of continuous usage. After 36 months, title to the equipment goes to the beneficiary and Medicare only pays for contents and non-routine maintenance. The clock started in January 2006; thus the first beneficiaries will not take title until three years later or January 2009. According to the Office of Inspector General (OIG), 22 percent of beneficiaries who started renting equipment in 2001 rented for 36 months or longer. CMS estimates 36 percent of Medicare beneficiaries use oxygen equipment for more than three years. The DRA also required that Medicare continue to make payments for delivery and refilling of oxygen contents for beneficiary-owned gaseous or liquid systems for as long as it is medically necessary.

Beneficiaries will no longer have to pay the 20 percent coinsurance on the equipment after 36 months because they will then own the equipment.

Setting the payment rates

Recent fees were taken from an OIG study of the median 2002 Federal Employee Health Benefit Plan (FEHBP) rates as required by the MMA. They varied by state and averaged $200 a month for stationary equipment and about $32 a month for portable equipment (paid as an add-on fee to the stationary amount). These fees represented a reduction from the prior fee schedule and went into effect in April 2005.

In its November 2006 final rule, CMS established separate payment classes and monthly payments for:

- stationary payment: $177.
- portable add-on: $32.
- oxygen generating portable equipment add-on (portable concentrators or transfilling systems): $64.
- stationary contents delivery: $101.
- portable contents delivery: $55.

CMS stated: "The goals of this proposal are to implement the DRA payment changes for oxygen in a way that does not eliminate the incentive for suppliers to provide new cost-effective oxygen equipment technology and to ensure beneficiary access to portable oxygen contents in the

This document does not reflect proposed legislation or regulatory actions.

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event that they are still using traditional portable oxygen systems." Payments were designed to be budget neutral to the prior fee schedule hence some oxygen payments were reduced.

Competitive bidding

Qualified suppliers were allowed to bid against one another to test a new method of pricing and purchasing durable medical equipment (DME) in a two-site, three-year demonstration between 2000 and 2002. As an incentive to compete, suppliers whose bids were chosen could gain market share from suppliers who were not chosen. Bidders who were not among the lowest priced were excluded from the market or not allowed to serve new clients. In that demonstration, competitive bidding lowered prices for home oxygen between 17 and 21 percent. Analyses of the demonstration did not find serious quality or access issues.

A competitive bidding process for DME will be phased in nationwide, starting with 10 metropolitan statistical areas (MSAs) in 2008 and expanding to 80 MSAs by 2009. In areas without competitive acquisition after 2009, Medicare may either apply competitive bidding payment rates from other areas or survey markets outside of the Medicare program and apply those prices if they are substantially different from Medicare's prices (using the "inherent reasonableness" authority). ■