



**Morrison
Informatics, Inc.**

STRATEGIC DIRECTION THROUGH INFORMATION MANAGEMENT

**Comments on “Medicare Home Oxygen Equipment:
Cost and Servicing”**

**Department of Health and Human Services
Office of Inspector General
September, 2006, OEI-09-04-00420**

October 13, 2006

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Executive Summary

The September 2006 Department of Health and Human Services, Office of Inspector General (OIG) Report, “Medicare Home Oxygen Equipment: Cost and Servicing”, was submitted to the Centers for Medicare and Medicaid Services (CMS), to provide information and recommendations concerning payment policy for home oxygen. However, the analyses and recommendations in this OIG Report are based on limited and inadequate data about the actual costs of providing home oxygen for Medicare beneficiaries. The Report does not provide data on the costs for all home oxygen equipment or for all services provided to home oxygen beneficiaries but instead considers only the costs of oxygen concentrators, which understates the actual costs of providing oxygen for Medicare beneficiaries. The narrow scope of the Report results in information that is neither accurate nor complete, and its findings should not be used for determining Medicare home oxygen reimbursement policy. CMS must collect comprehensive data on the total costs of providing home oxygen so that reimbursement policies will reflect accurate costs and assure high-quality oxygen services for oxygen patients in the Medicare program.

1) Methodological Concerns

- The OIG report only examined selected costs associated with home oxygen therapy and therefore cannot justify a recommendation to reduce the payment period from 36 months to 13 months. The costs of oxygen equipment, including, but not limited to, oxygen concentrators, comprise only 28 percent of home oxygen providers’ total costs, while the remaining 72 percent of costs include patient intake and insurance verification, in-home patient education and delivery, clinical and administrative support services, Medicare billing/collection functions, regulatory compliance, licensing and accreditation, facility and other overhead costs. It is not appropriate to compare the cost of only one item of oxygen equipment, oxygen concentrators, to total Medicare reimbursement for oxygen provision which is intended to cover the cost of the entire group of services (including equipment) required for home oxygen.

- The report did not study a statistically valid sample of beneficiaries in order to project the results over the entire Medicare population.
- Also, the full cost of traditional portable oxygen modalities or increased up-front capital costs of new technology such as transfilling oxygen systems, were not included, although the OIG recommended increases in the Medicare allowable cost for providing portable oxygen.
- The OIG's savings estimate using a 13-month capped rental period is not accurate, since it does not reflect payments Medicare would have to make to reimburse providers for services currently covered in the monthly, bundled payment rate, and it includes savings that would not be scored by the CBO and CMS Office of the Actuary (OACT) as cost savings to Medicare. Finally, the Report stated that most non-equipment service costs were not studied by the OIG, and CMS acknowledged the same in its comment letter to the OIG. Therefore the OIG savings estimates do not account for costs which Medicare will incur and the estimates require adjustment as recommended by CMS and as indicated above.

2) Invalid Comparative Data

- The OIG's repeated use of 36 months of total reimbursement is inappropriate because this represents only 22 percent of all patients, not the average patient length of stay of 18 months, and therefore does not provide a valid comparison of Medicare reimbursement to the average cost of oxygen concentrators that was cited. Once providers' total costs are accounted for appropriately, Medicare's total payments are reasonable in comparison to total oxygen costs, when compared to other healthcare industry segments.
- The Veterans Administration's (VA) model is completely different than the Medicare model. Once all comparative costs incurred by the VA are accounted for, its payment levels for home oxygen therapy approach an acceptable range of Medicare's payment levels.
- Another data problem is evident in the Report's conclusion regarding delivery frequency for portable oxygen cylinders. The OIG reports that these are delivered to patients quarterly, when in fact a formal independent survey of providers proves that the average is 1.6 times per patient per month.

3) Statutory and Administrative Reimbursement Cuts Are Already Underway, with Savings Yet to be Realized

- The OIG Report did not account for the financial savings attributable to the Medicare Modernization Act of 2003 (MMA), which mandated two reimbursement reductions for oxygen (FEHB median pricing, adopted in 2005,

resulting in an 8.6 percent savings, and competitive bidding, scheduled to begin in 2007, for which CMS projects 10 percent savings).

- Nor did OIG account for savings attributable to the Deficit Reduction Act of 2005, which will begin to be realized in 2009.
- Establishing a 13-month maximum reimbursement/rental period for home oxygen, when added on top of a series of statutory and administrative reimbursement cuts already undertaken or contemplated, would harm vulnerable beneficiaries, especially since the effects of these policies have not yet been studied by the Administration.

It is worth noting that government studies have shown that long-term use of oxygen can reduce patient hospitalizations and the length of acute care stays. A 2004 study conducted by the federal Agency for Healthcare Research and Quality (AHRQ), showed that long-term oxygen therapy reduces the frequency of hospitalization and the number of hospital days. This study supports the fact that home oxygen therapy has been part of the solution to controlling Medicare costs (“Long-Term Oxygen Therapy for Severe COPD, Final Report,” June 11, 2004, Lau, et al. Tufts-New England Medical Center Evidence based Practice Center, under contract to AHRQ).

Introduction

In September 2006, the Department of Health and Human Services, Office of Inspector General published a report, “Medicare Home Oxygen Equipment: Cost and Servicing”, which was submitted to the Centers for Medicare and Medicaid Services (CMS), to provide some information and recommendations concerning the cost and servicing of Medicare home oxygen equipment as related to CMS oxygen payment policies.

Under the Medicare program, oxygen therapy is provided to approximately 1 million Americans who have respiratory illnesses and who require oxygen. Most of these illnesses, such as chronic obstructive pulmonary disease, are progressive and incurable, resulting in continuous loss of lung function. Home oxygen therapy, when properly prescribed and maintained can slow or stop lung degeneration. The use of medical oxygen and oxygen systems, require a physician’s prescription and the provision of oxygen is regulated by CMS, the Food and Drug Administration and the U.S. Department of Transportation. The provision of oxygen therapy requires equipment, oxygen contents and the delivery, maintenance, replacement and provision of patient instruction and education, related to proper use of oxygen. Home oxygen equipment and services are provided by home oxygen suppliers who are responsible for providing oxygen to Medicare beneficiaries, following all regulatory requirements, delivering, maintaining and servicing oxygen equipment and providing information and training for beneficiaries. These functions have costs which are required to provide oxygen to Medicare beneficiaries.¹ These costs need to be identified and documented accurately and completely in order to determine appropriate payment for home oxygen, which reflects the costs of this important treatment for Medicare beneficiaries.

Review of the OIG Report

OIG Report Findings

1. OIG Report data show that only 22 percent of Medicare beneficiaries rent oxygen for 36 months or longer. This means and the data demonstrate that 78 percent receive oxygen for less than 36 months. In fact, approximately 13 percent of beneficiaries receive oxygen for less than six months. It is therefore not appropriate or reasonable to use a 36-month calculation for comparing costs of oxygen concentrators with Medicare payments, when almost 80 percent of beneficiaries do not receive oxygen for this period of time, even where the actual complete costs of oxygen services are not included in the calculation.

The average length of oxygen provision for beneficiaries is 18 months and the average allowed charges are approximately \$3,900. Using data from the Morrison Informatics, Inc. study,¹ 28 percent of providers’ monthly cost of \$202 is for equipment and accessories and this amounts to \$1,018 over 18 months. The remaining 72 percent of the costs or \$2,618 over 18 months, are for all other services and administrative overhead required to provide oxygen to beneficiaries. Therefore,

providers operating income over 18 months is \$264 per average patient or just 6.8 percent before taxes.

The OIG report comparison of the cost of oxygen concentrators compared to the Medicare payment received is very misleading because it is based on a 36-month period of oxygen use that nearly 80 percent of oxygen beneficiaries do not have and because it omits most of the costs of providing home oxygen.

2. Similarly, the OIG Report uses a 36-month rental period to suggest that beneficiary co-payments far exceed the cost of oxygen concentrators. However, since beneficiaries, on average, receive oxygen for 18 months, their actual co-payment on average is \$780 and this payment also supports all the services used in providing oxygen for them. Using 36-months for calculating beneficiary co-payments is not appropriate and leads to inaccurate conclusions about beneficiary costs.
3. The OIG savings estimate using a 13-month capped rental period is not accurate. First, the estimate does not include any payments that Medicare would have to make for non-routine services and maintenance or other costs now included in the monthly payment rate. Second, the estimate includes the 20 percent beneficiary co-payment amount (about \$640 million) which CBO and the CMS Office of the Actuary (OACT) will not score as cost savings to Medicare. Third, the estimate also apparently includes beneficiary Part B premium costs which represent an additional 20 percent of the calculated savings and would not be counted by CBO or OACT. And fourth, the estimated savings did not include the 8.6 percent reduction in Medicare payments for stationary oxygen equipment enacted in 2005. These factors will dramatically reduce the estimated savings suggested in the OIG Report.
4. Suppliers' costs for providing oxygen services do not consist solely of the cost of concentrators. The OIG Report focuses on concentrators alone and fails to document other identifiable costs of oxygen provision as identified and documented in the Morrison report.¹ In addition, the use of a 36-month rental period for calculating Medicare payments is not representative of the actual average rental period for oxygen which is 18 months. The difference between costs and payments presented in the OIG Report is therefore inaccurate and should not be used to evaluate Medicare oxygen payment policy.
5. In addition, the Report provides extremely limited and incomplete data on the extent of maintenance and services required for home oxygen concentrators and does not provide any data or information on the regular overall repair and maintenance requirements and costs for oxygen equipment used by beneficiaries. Further, the Report does not recognize (or provide data on) the services provided by suppliers for beneficiaries, including assistance with the multiple modalities of oxygen equipment that they use, arrangements for beneficiaries when they travel away from home, emergency calls that are serviced 24 hours a day, seven days a week and meeting other beneficiary requests for assistance.
6. For portable oxygen, the Report does not recognize or provide information on provider costs related to the fact that the Food and Drug Administration, the Department of Transportation, the Department of Homeland Security and State agencies, regulate medical oxygen and providers incur significant operations costs to

comply with these regulations. In addition, accredited providers must offer 24/7 emergency on-call services and include emergency back-up oxygen systems for patients in the event of power outages or disasters. Also, the OIG Report did not collect any data on the costs of oxygen transfilling services or on the filling, delivery or servicing of patients requiring portable oxygen. While the Report documents the current \$21.41 monthly payment for portable oxygen cylinders and suggests that this may not be adequate to cover the costs of this service, the Report provides no data on provider costs for maintaining oxygen delivery and portable delivery services. Therefore, there is no data in the Report which can be used to support a payment rate for these services.

7. The Report states that suppliers provide training for beneficiaries so that they can perform certain maintenance on their oxygen equipment, but the Report does not provide data on the costs for these services. And, the Report does not provide any data on beneficiaries who are not able to perform these services and what providers then do to service beneficiary oxygen equipment. The Report does not in any way recognize that when providers perform routine maintenance services, it is because patients cannot do so. This is usually the case as a result of memory loss, dexterity and other functional challenges. The frequency of providing these services indicates that they are needed by beneficiaries. The Report provides neither data on the medical and safety risks that beneficiaries assume if these services are not provided, nor any data on provider requirements and costs for maintaining equipment in working order, monitoring the equipment, and providing the needed maintenance services. Accredited providers follow a strict policy and procedure for retrieving, cleaning and sanitizing, testing, and conducting preventive maintenance on rental equipment. This procedure is surveyed by JCAHO and other accrediting organizations. Providers also follow a strict procedure for determining when a medical device must be removed from service as a result of not meeting the required performance standards or becoming obsolete. Patient safety goals are mandated by JCAHO and are incorporated in accredited policies and procedures.
8. The Report suggested that only 6 percent of oxygen concentrators used by the sampled beneficiaries malfunctioned during their rental period. But, because providers retain title to the equipment, there is frequently a simple equipment exchange taking place without extensive documentation of malfunctioning of the equipment. (The OIG Report data in fact indicates a malfunction rate of more than 8 percent of concentrators rented by beneficiaries.) The OIG Report's use of anecdotal examples that cite the costs of oxygen concentrators and compare these limited costs (over various time periods), which do not include the actual complete costs of oxygen services, cannot be accepted as reliable data. The use of oxygen concentrators and equipment, the services necessary for Medicare beneficiaries and the costs of these services need to be documented by accurate and reliable data collection studies. The OIG Report also relies on similar anecdotal reports concerning the amount of time that providers spend in servicing beneficiary equipment and the percentage of provider visits with patient education services. This type of information is not based on representative, reliable, and comprehensive data collection and it is not reasonable to suggest that this information is accurate or representative.

9. The Report also suggests that providers deliver oxygen cylinders to beneficiaries once every three months. This is not accurate because many beneficiaries on constant oxygen receive at least one or two deliveries per month, which is documented in the Morrison Informatics, Inc. study.¹

OIG Report Recommendations

1. Further Reduce Rental Period for Oxygen Equipment

The OIG Report recommended that CMS further reduce the rental period for oxygen equipment, which would mean that beneficiaries would have to begin owning their equipment even earlier than current law dictates. This recommendation is made despite the fact that there has been no opportunity to review the effects of the new 36-month policy which is just beginning, no experience with the proposed new CMS modality specific oxygen payment policy and no experience with the upcoming initial implementation of competitive bidding in 2007.

In addition, the recommendation is based on the Report's inaccurate and limited analysis of the costs of oxygen equipment compared to Medicare reimbursement. Further, the Report does not present any data or information on the effects of a further reduced rental period on oxygen beneficiaries. Proceeding to make additional changes to the rental period for home oxygen before having any knowledge about the effects and results of the new 36-month rental policy, proposed new payment rates and new arrangements for covering the costs of maintenance and services, is not reasonable or prudent.

2. Necessity and Frequency of Non-routine Maintenance and Servicing of Concentrators

The Report recommends that CMS determine the necessity and need for non-routine maintenance and services for oxygen concentrators. The Report suggests that all beneficiaries are capable of performing routine maintenance of oxygen equipment but provides no data to support or verify this conclusion. The Report did not provide data on the frequency of non-routine maintenance and servicing of oxygen concentrators. Therefore, its recommendation that CMS determine the need for these services and their costs is reasonable. Before deciding on coverage and reimbursement for routine and non-routine maintenance and services for oxygen concentrators and other equipment requiring these services, CMS needs to collect comprehensive data on these requirements, actual needs of beneficiaries and the costs for these services. Once beneficiaries own oxygen equipment, it is essential that all needed maintenance and services be arranged and provided to assure proper functioning of oxygen equipment, needed maintenance and replacement of equipment as necessary. The costs for these maintenance and service requirements need to be fully documented and appropriately reimbursed by Medicare.

3. Determine If a New Payment Methodology is Appropriate for Portable Oxygen

Portable oxygen systems require refills and providers complete these refills by delivering full oxygen cylinders and picking up empty ones. While Medicare currently pays an add-on amount for portable systems, payment for the cost of refills for cylinders is bundled into the monthly rental amount for the patient's oxygen concentrator. When beneficiaries reach the 36-month rental limit, Medicare will no longer pay for concentrators or portable systems, but will pay for cylinder contents, delivery and pick-up and should also pay for other needed services related to assuring the correct operation of cylinders and portable oxygen equipment. The OIG Report points out that the current monthly payment for portable oxygen contents (\$21.41), does not vary based on the amount of oxygen that is required. Therefore, the payment may not adequately reimburse suppliers for providing portable refills and related services once a beneficiary reaches the 36-month rental limit. For this reason, the Report recommends that CMS determine if a new payment methodology is needed for portable oxygen. In proceeding with this recommendation, CMS needs to collect data on all provider costs for providing portable oxygen refills and related maintenance and services costs, so as to be able to determine an appropriate reimbursement policy that covers the actual costs of providing portable oxygen for beneficiaries.

OIG Report Objectives Were Limited

The OIG Report had the limited objectives of: (1) comparing Medicare spending for oxygen concentrators with suppliers average purchase price for this equipment; and (2) determining the nature and frequency of servicing for concentrators and portable oxygen equipment.

It is important to recognize that the review of data for these two limited objectives does not provide accurate and complete information on the cost and servicing of home oxygen equipment. The OIG Report, in fact, points out that the monthly Medicare allowance for stationary oxygen equipment covers the oxygen equipment and services; oxygen contents including all refills for stationary and portable systems; liquid and transfilling systems; patient education and other services associated with furnishing home oxygen including delivery and pick-up of equipment, equipment maintenance outside the home, billing, processing physician orders, regulatory compliance and overhead expenses. The report also identifies that Medicare pays an additional amount for portable equipment that a beneficiary rents to provide mobility in the home and that typically, beneficiaries rent both stationary and portable units. The report acknowledges that it does not provide data and information on the costs of these areas and instead focuses only on stationary oxygen concentrators and only on certain maintenance and service costs related to concentrators. The report therefore does not provide any data or information on the non-equipment services and costs that are continuously incurred by suppliers in providing home oxygen to Medicare beneficiaries. The OIG Report therefore is not a thorough and comprehensive study or review of the costs and services for home oxygen provision under the Medicare program, but represents only limited information which is incomplete

and should not be used to reach conclusions about the costs of home oxygen services or for decisions about Medicare payment for these services.

Methodology

The OIG Report was based on a sample of Medicare beneficiaries who rented home oxygen equipment in calendar year 2004 and information on the cost and rental history of the oxygen concentrators that these beneficiaries used. OIG reported that its review was national in scope and focused on the cost of concentrators that beneficiaries rented and the types and frequency of services for concentrators that oxygen equipment suppliers provided to beneficiaries in their homes. The report specifically states that it does not address either the overall costs of providing oxygen services or ancillary expenses such as billing, processing or the physician order, regulating compliance and equipment maintenance outside the home. The Morrison Informatics, Inc., study, "A Comprehensive Cost Analysis of Medicare Home Oxygen Therapy - A Study for the American Association for Homecare"¹, demonstrates that for home oxygen provision the costs of all equipment are only 28 percent of the total costs of the services provided; all services and overhead represent the remaining 72 percent of the costs of providing home oxygen therapy. Therefore, the OIG review does not represent in any way a complete study of the costs of providing home oxygen. The limited data on oxygen concentrators and on services that oxygen equipment suppliers provide to beneficiaries in their homes is not representative of the costs of home oxygen provision. The scope of the OIG review is too limited to permit reasonable conclusions about the cost of providing home oxygen to more than 1 million Medicare beneficiaries.

Sample Selection

A sample of 150 Medicare beneficiaries from a universe of nearly 450,000 beneficiaries is not statistically reliable. In addition, the data collected related to only oxygen concentrators which the OIG stated were not by any means the only oxygen equipment and services provided to beneficiaries. Therefore, the cost and service data collected by the OIG were not and could not be complete, according to the definition of the study purposes. The use of incomplete data on the costs of home oxygen provision resulted in misleading information and conclusions about the costs of home oxygen and the relationship of costs to Medicare reimbursement.

For example: (1) the study did not provide cost data about oxygen modalities other than concentrators, yet CMS data suggests that 5 percent of beneficiaries have liquid systems and 69 percent have portable gaseous or liquid systems; (2) the study did not provide data on the costs of ongoing oxygen provision for patients; and (3) the survey instrument did not include a list of services provided to oxygen patients and therefore does not provide accurate and complete data on costs.

The OIG Report also mentioned a few site visits to suppliers of home oxygen services in California and Florida and site visits to the Veterans Administration Medical Center in Tampa, Florida, to interview staff about the VA oxygen services program. Anecdotal information from these site visits is not representative of home oxygen provision in the nation as a whole, and the OIG did not study home oxygen service delivery by a representative sample of suppliers in the nation. The Veterans Administration oxygen program was not thoroughly studied and the OIG did not present complete representative data on the entire costs of operating the program. There is no detailed information presented in the report concerning the site visits and the services that were observed being provided to beneficiaries and the costs of those services. The site visit information is very limited and is not detailed or complete enough to permit any reasonable conclusions about the scope, extent or costs of supplier services for beneficiaries.

Conclusion

The Department of Health and Human Services Office of Inspector General Report, "Medicare Home Oxygen Equipment: Cost and Servicing" provides very limited and incomplete information on the cost and servicing of home oxygen equipment used by one million Medicare beneficiaries. The Report provides data only for oxygen concentrators and does not provide any data on most of the costs for providing oxygen services to Medicare beneficiaries. In addition, the sample of beneficiaries used in the Report is not statistically reliable. Because data on the full costs of providing stationary or portable oxygen were not collected for the OIG Report, its analyses are inappropriate and result in misleading conclusions which should not be relied on in formulating reimbursement policy. In addition, the savings estimates provided in the Report are based on a policy which has not been proposed, and on inaccurate assumptions which CMS says are not used by either the Congressional Budget Office or by the CMS Office of the Actuary.

The primary difficulty with the OIG Report is the fact that the report contains analyses and makes recommendations based on limited and inadequate data on the actual costs of providing home oxygen for Medicare beneficiaries. The Report is therefore not accurate or complete and its findings should not be used for determining Medicare home oxygen reimbursement policy. It is therefore very important for CMS to proceed to collect comprehensive data on the total costs of home oxygen provision so that its reimbursement policies will reflect those costs and be appropriate to assure high quality oxygen services for all Medicare beneficiaries.

¹ "A Comprehensive Cost Analysis of Medicare Home Oxygen Therapy - A Study for the American Association for Homecare", Morrison Informatics, Inc., June 2006.

Appendix: Background Information Concerning Multiple Reductions in Medicare Home Oxygen Payments

The OIG Report points out that Medicare has reduced payment rates for home oxygen three times since 1981. These reductions were substantial: a 25 percent reduction effective January 1, 1998; a 5 percent reduction effective January 1, 1999 and an additional 8.6 percent reduction for stationary oxygen equipment and an additional 8.1 percent reduction for portable oxygen equipment, both in 2005. In 2006, the long standing Medicare rental payment policy for home oxygen equipment changed under the Deficit Reduction Act (P.L. 109-171). The new law limits Medicare rental payments for home oxygen equipment, supplies and services to 36 months of continuous use; after this point, suppliers must transfer ownership of oxygen equipment to the beneficiary, but under a proposed rule that CMS published in August, 2006, suppliers would receive some payment for certain “non-routine” maintenance and services for beneficiary owned oxygen equipment. Further, the FY 2007 budget proposes reducing the rental period for home oxygen to only 13 months.

These major payment reductions, rental period reductions, and ownership transfer provisions have been developed without CMS having detailed data on the costs of providing home oxygen for Medicare beneficiaries. The limited data and information in the OIG Report do not provide accurate and complete information on the costs of home oxygen provision. The OIG Report points out that Medicare rental payments for home oxygen are based on a monthly fee schedule originally established in 1986 and subsequently periodically adjusted by the CPI. However, the Medicare Modernization Act mandated a five-year freeze on CPI increases starting in 2004 and various CPI freezes have occurred for the past 15 years. Therefore, the fee schedule amounts have not been consistently adjusted using the CPI, although multiple reductions in Medicare payments have been made. There have been many changes in oxygen technology, processes of delivery, services and maintenance, patient education requirements, regulatory requirements, delivery and transportation costs and overhead costs since 1986. However, there has not been a CMS study of the detailed costs of providing home oxygen and Medicare reimbursement policy changes have been developed and implemented with only limited and inadequate data on these costs.

The only major national study of the detailed costs of providing home oxygen is the Morrison Informatics, Inc. study completed in June 2006.¹ The Morrison study collected detailed cost data from 74 home oxygen suppliers providing services to 600,000 Medicare beneficiaries. The data demonstrated that only 28 percent of suppliers’ actual monthly costs for providing oxygen were for all equipment provided in the home (not only oxygen concentrators) and that the remaining 72 percent of costs were for all the other required services necessary for providing oxygen.

The OIG Report does not provide data on the costs for all home oxygen equipment or for all services provided to home oxygen beneficiaries. The report uses the costs of

concentrators alone (which are not the actual total costs of providing oxygen for Medicare beneficiaries), and compares these limited costs to the payment provided by Medicare for all oxygen services. This is not a correct or reasonable comparison because the costs for providing oxygen include far more than concentrator costs alone. Therefore, the oxygen equipment cost (for concentrator only) and the Medicare payment comparison made in the report is highly misleading and results in conclusions which are not accurate about the costs of oxygen provision and payments made by Medicare.

It is not reasonable for the OIG to use limited and incomplete analysis of the costs of providing home oxygen to support recommendations to further reduce the oxygen rental period and to further reduce reimbursement for maintenance and services provided to oxygen beneficiaries. The significant home oxygen reimbursement reductions in recent years have made it increasingly difficult for suppliers to continue all of the services required to provide oxygen for beneficiaries. Further reductions that do not take into consideration the actual costs for oxygen services can result in diminished services and additional risks for some of Medicare's most vulnerable beneficiaries. It is important that before creating these risks, CMS collect and analyze data on the actual costs for the provision of oxygen to Medicare beneficiaries.

Other background areas mentioned in the OIG Report include:

(1) Oxygen Concentrators

OIG specified that stationary oxygen concentrators weigh about 50 pounds and that beneficiaries usually have both stationary concentrators and portable cylinder systems which provide back-up in the event of power outages as well as for mobility in the home. Further, OIG stated that when suppliers deliver stationary and portable oxygen systems (which include delivery and set-up of concentrators and patient education and servicing of this equipment as required), they also provide accessories including oxygen tubing and nasal cannulas. While not identifying the substantial number of other services that are required to provide home oxygen, OIG has, at least in part, recognized that these services are necessary for providing home oxygen. But, the OIG report fails to identify the costs for these essential services, focuses only on the cost of oxygen concentrators and provides an analysis which does not include the total costs for oxygen provision.

(2) New CMS Variable Rate Structure

The OIG Report discusses the CMS proposed rule for implementing the Deficit Reduction Act of 2005 provisions regarding Medicare payment for oxygen equipment. The report points out that CMS has proposed "a new variable rate structure for different classes of oxygen and oxygen equipment with monthly payments tied more closely to the costs of each class" (pg 4-5). In fact, the "costs" being used by CMS are not based on any study or data of actual detailed costs for home oxygen provision and represent merely estimates based on original average payments in 1986 (as periodically adjusted and as significantly reduced by payment adjustments in 1998, 1999 and 2005).

(3) Routine Maintenance

Further, the OIG points out that Medicare would cover non-routine maintenance that an authorized technician would need to perform but would not cover routine maintenance including testing, cleaning and changing filters, after beneficiaries reach the 36-month rental cap and assume ownership of their equipment. At present, maintenance services are provided regularly by suppliers to beneficiaries who are renting oxygen equipment. These services have costs and are provided under the current rental program. Large numbers of beneficiaries receive these maintenance services regularly and many beneficiaries require these services because they are not able to perform the services themselves. The OIG does not have sufficient data to support a conclusion that routine maintenance can be easily performed by all beneficiaries who will own their oxygen equipment after 36 months. It remains completely unclear how beneficiaries who own their oxygen equipment after 36 months and who are not able to perform routine maintenance will be able to have these services performed since the Medicare program will not provide reimbursement for such services.

(4) Veterans Administration Program

The OIG Report refers to alternative payment methodologies used by Veterans Administration Medical Centers. The programs referred to by OIG were not studied in detail and there is no data provided in the Report on the total costs of all services provided by these programs, including all services provided for veterans receiving oxygen. It is therefore not possible to compare the costs of these programs to the Medicare home oxygen program. In addition, the Veterans Administration oxygen services program is totally different than the Medicare program: (1) the VA program does not require physicians to complete an oxygen Certificate of Medical Necessity, have providers verify VA benefits or provide clinical assessments and tolerance testing for devices; these services are provided by the Veterans Administration, whereas in the Medicare program the home oxygen provider has to coordinate these services under the monthly payment rate; (2) the VA program involves competitive bidding which guarantees winning providers volume and exclusive contracts, whereas the Medicare program does not provide these guarantees; (3) the VA program uses line item pricing for most services including liquid oxygen and portable cylinders, in-home clinical assessments and emergency and/or after-hours assistance requiring home visits; this type of pricing is not used in the Medicare program, (4) the VA program pays contract providers immediately based on all services rendered in the previous month; this is not the case for the Medicare program, (5) there are no patient co-payments to collect in the VA program as there are under the Medicare program; (6) the VA contract includes an approximately 10 percent automatic price increase each year the contract is retained; this is not the case for the Medicare program, (7) when all VA oxygen services are included as reimbursed, the monthly payment amount allowed by the VA is within 10 percent of the current monthly Medicare allowable payment (including depreciation and amortization for oxygen concentrators purchased directly from manufacturers); (8) the VA program does not have any cap on monthly oxygen services as long as medical need can be demonstrated; this is not the situation under Medicare; (9) in prior reports, the

GAO has acknowledged that the oxygen Certificate of Medical Necessity process, billing and collection costs are 30 percent higher for Medicare than in the VA program model; (10) in prior reports, the OIG has acknowledged other differences between the Medicare and VA oxygen programs; and (11) the current OIG report did not provide these previous findings, which is a significant omission.
