# OXYGEN AND OXYGEN EQUIPMENT PAYMENT SYSTEM

*payment***basics**

*Revised: October 2010*

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, over one million patients now receive oxygen therapy with Medicare allowed charges of almost $2.2 billion in 2009. These charges are lower than the nearly $3 billion level reached in 2008 because of two recent changes: a 9.5 percent reduction in 2009 rates mandated in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), and the 36-month time limit on rental payments mandated by the Deficit Reduction Act of 2005 (DRA). (Both of these mandates are discussed in more detail below.) Monthly rental payments had been 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 DRA limited rental of oxygen equipment to a period of 36 months of continuous usage. After 36 months, Medicare only pays for contents and non-routine maintenance. The clock started in January 2006; thus the first beneficiaries reached the rental cap three years later in 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.

Although the DRA transferred title for the equipment to the beneficiaries after 36 months, MIPPA repealed the transfer of ownership and leaves title with the suppliers. Beneficiaries do not pay the 20 percent coinsurance on the equipment after 36 months.

## 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 rates to encourage the use of newer, cost effective technologies. CMS stated: "The goals of this proposal are to implement the DRA payment changes for oxygen in a way that does not eliminate

*This document does not reflect proposed legislation or regulatory actions.*

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the incentive for suppliers to provide new cost-effective oxygen equipment technology and to ensure beneficiary access to portable oxygen contents in the event that they are still using traditional portable oxygen systems." Payments were designed to be budget neutral to the prior fee schedule; hence, to increase payments for newer technologies other payments were reduced.

The 2010 fee schedule rates are:

- stationary equipment: $173.17,
- portable add-on: $28.77,
- oxygen generating portable equipment add-on: $51.63, and
- oxygen contents $77.45.

### 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.

As mandated by the MMA, a competitive bidding process for DME was to be phased in nationwide, starting with 10 metropolitan statistical areas (MSAs) in 2008 and expanding to 80 MSAs by 2009. The first round started July 1, 2008. Weighted average savings for oxygen were 27 percent across all ten areas, ranging from 32 percent in Orlando, FL to 22 percent in Riverside, CA.

MIPPA terminated the contracts awarded in round one, delayed the competitive bidding process, and made several other changes to the program. To offset the cost of delaying the program, the fee schedule amount for any item selected for competitive acquisition before July 1, 2008, was not increased by the scheduled amount and was instead reduced by 9.5 percent nationwide in 2009. The new first round of competition started in 2009 with the competitively determined rates going into effect January 2011. CMS estimates the new rates are about 32 percent lower than the current allowed amount. The second round of competition will begin in 2011. Competition in additional areas will occur after 2011. ■