

Responses to Congressional Arguments in Favor of Changes to Oxygen Policy

A document circulating in Congress says, in effect, there is nothing to worry about regarding the proposed changes to oxygen policy in S. 1932, the budget reconciliation bill, or the Deficit Reduction Act. The text below responds to each of the points made in that document, which has been sent to some providers and beneficiaries.

Claim: *The Deficit Reduction Act changes oxygen payment from perpetual rental to a rent-to-own payment program after 36 months. The Medicare program will pay for service and repairs to beneficiary's oxygen equipment as well as continue to pay for deliveries of oxygen.*

Homecare Response: While there is some ambiguous language in S. 1932 regarding “payments for oxygen” and “maintenance and service” after the purchase and transfer of title for the equipment to the beneficiary, there is no specific assurance or directive for payment detailed in this bill. The bill suggests such payments “may” be available and will be determined by the Secretary of U.S. Department of Health and Human Services. In the Medicare system today, there are no Healthcare Common Procedures Coding System (HCPCS) codes or policies governing the maintenance and services of oxygen technologies. In addition, the bill provides no guidance for the many service components currently required and incorporated into the Medicare oxygen rules and payment, including all patient training, deliveries, disposable accessories, billing, clinical professional support, 24-hour emergency service and equipment replacement.

It is important to note that S. 1932 will require *all* oxygen related equipment (stationary and portable) to be purchased after 36 months. Once the patient owns items such as oxygen cylinders, the delivery and filling of such will become the beneficiary’s responsibility. There are numerous state and federal regulations governing the safe handling, filling and transport of medical oxygen that will be complicated with this change in ownership.

Claim: *Here Are The Reasons Why Oxygen Payments Need Reform TODAY....Medicare Pays Significantly More Than the Retail Price to Buy Oxygen Equipment*
According to CMS, nearly 93 percent of Medicare payments for oxygen and oxygen equipment are for concentrators. An easy search on the Internet (froogle.google.com) shows that the average price for an oxygen concentrator is about \$1,000.

Homecare Response: Modern oxygen concentrators are clinically effective, technically sound, simple for the patient and caregiver to use and the most cost-effective home oxygen therapy technology available today, which demonstrates why they are the primary home oxygen delivery system used in the provision of home oxygen therapy. The cost of the basic oxygen concentrator technology has fallen over the last few years as technology and competition have influenced the market. It is important to note that the oxygen concentrator is only one small component associated with providing home oxygen therapy. Like many other medical therapies performed in conjunction with technology, the device cost is only a small fraction of

the overall cost associated with the provision of home oxygen therapy. New oxygen concentrator technologies that are billed to Medicare under the same oxygen concentrator HCPCS code (E1390, which include concentrators that fill cylinders and portable concentrators used in the home and approved by the FAA for air travel), have retail prices in excess of \$5,000.

***[Claim]:** Under current law, however, Medicare pays indefinitely for the rental of oxygen equipment at a rate of approximately \$200 per month (CMS). So after 5 months, Medicare has paid for the piece of equipment. Yet the program continues to make payments for the equipment – and beneficiaries continue to pay coinsurance. Medicare beneficiaries who need oxygen rent the equipment and use it for an average of 30 months, according to CMS. This means that Medicare and beneficiaries will pay several times the cost of the equipment over the course of the rental period.*

Homecare Response: Again, equipment is only one element of home oxygen therapy. Medical oxygen is a prescription drug, and the oxygen equipment is classified by CMS as frequent and substantially serviced because of the complex nature of the technologies and the necessary associated services. (The *Social Security Act* defines frequent and substantial as “covered items for which there must be frequent and substantial servicing in order to avoid risk to the patient’s health”.) When the Six Point Plan defined oxygen as modality neutral, the stationary payment (i.e., payment of the concentrator) was developed to include not only the cost of the device but also the ongoing maintenance and service, clinical and professional support, delivery of the gas and portables, emergency support, replacement of faulty equipment, consumable supplies and upgrades and replacement of the equipment as medical need determines.

Oxygen is one of the most cost-effective therapies used in the management of chronic obstructive pulmonary disease (COPD). Medicare oxygen patients are provided this life extending therapy for about \$7.50 per day. If responsible for the entire 20 percent co-pay, the cost to the patient is less than \$1.50 per day or about \$547 per year, which is a fraction of the annual out-of-pocket expense patients pay for most of their prescriptions. Oxygen is the only treatment or drug scientifically proven to extend the life of patients with chronic lung disease.

***[Claim]:** The Deficit Reduction Act changes this system by transferring ownership of the equipment to the beneficiary after 36 months of rental, so that neither Medicare nor beneficiaries continue to pay for equipment that has been more than paid for.*

Homecare Response: Medical oxygen is a prescription drug and the oxygen equipment classified as frequent and substantially serviced because of the complex nature of the technologies and the necessary associated services. Again, like many other medical therapies performed in conjunction with medical devices, the equipment cost is only a small fraction of the overall cost associated with the provision of home oxygen. To draw an analogy, it would be unwise to stop the payments to a hospital or laboratory for blood tests or x-rays simply because the payments for these procedures have exceeded the original price of the equipment used in the testing.

[Claim]: TODAY...Medicare Seniors Barred from Purchasing Equipment

Homecare Response: This is not true. Medicare beneficiaries can and do regularly purchase many home medical devices for personal use, including oxygen technologies. In many cases, Medicare beneficiaries elect to purchase items considered premium or items not routinely covered by Medicare. In addition, some beneficiaries choose to purchase duplicate or additional oxygen equipment.

[Claim]: Today, beneficiaries are prohibited from using his/her Medicare coverage to purchase an oxygen concentrator and must instead “rent” without any possible benefit from future ownership.

Homecare Response: Again, the Social Security Act defines “frequent and substantial” as “covered items for which there must be frequent and substantial servicing in order to avoid risk to the patient’s health.” This category ensures patients have access to technically sound, safe and clinically appropriate home medical equipment. The appropriate establishment of this payment category was based on the fact that the clinical and safety benefits of this payment methodology far outweigh any perceived short-term benefit of ownership of sophisticated medical devices that require ongoing professional monitoring, periodic maintenance and regular replacement.

[Claim]: In fact, a beneficiary on average pays more coinsurance for oxygen equipment than the retail price for the equipment.

- *Currently a Medicare beneficiary pays 20 percent coinsurance for each rental month or about \$40 per month (CMS).*
- *A beneficiary using oxygen equipment for the average of 30 months currently pays \$1,200 in coinsurance payments during this period. Some beneficiaries pay much more because they use the equipment for longer than 30 months.*
- *Thus, a beneficiary currently pays more in coinsurance for oxygen concentrators than the price that the equipment is widely available.*
- *Under the Deficit Reduction Act, beneficiaries will be permitted to purchase the equipment after three years of continuous use, which limits their maximum liability to \$1,440 for the equipment.*

Homecare Response: Medicare and its beneficiaries are NOT merely paying for oxygen equipment. They are paying for ongoing home oxygen therapy 24 hours per day, 7 days per week, 365 days per year. Oxygen is a Federal legend drug, and the devices are dispensed by prescription only. The oxygen technologies used to produce and/or deliver the drug are merely the technical components associated with the overall provision home oxygen therapy. The average annual cost for home oxygen under the current payment model is \$2,784. In 2002, there were 673,000 hospitalizations for COPD – their average length of stay was 5.2 days. The average Medicare cost for one day in the hospital is \$3,606, so the average admission for COPD costs more than \$18,000. Home oxygen therapy is the most cost-effective and clinically effective treatment available to those with COPD and low blood oxygen. Home oxygen therapy

can be provided to a patient for *one year* at less than the average cost for one day in the hospital.

[Claim:] *The DRA [Deficit Reduction Act] begins the process of reducing Medicare payments for oxygen and reducing beneficiary coinsurance payments by ending the requirement to rent oxygen equipment indefinitely. BOTTOM LINE: This reform is long overdue, will reduce waste in the system, and will reduce costs for beneficiaries.*

Homecare Response: Home oxygen payments have been drastically reduced over the last decade. The Balanced Budget Act of 1997 produced a 30 percent cut in the home oxygen payment in conjunction with CPI freezes that are still in place today. The Federal Employees Health Benefits plan cuts effective in 2005, as required in the Medicare Modernization Act of 2003, further cut another 12 percent in the home oxygen therapy payment. Home oxygen therapy is a both a clinically effective and cost-effective therapy. Focusing attention on the relationship between the overall cost of providing this therapy and the cost of a single component of this therapy provision is an apples-to-oranges comparison. The unplanned effect of the new oxygen policy proposed in S. 1932 would be a transfer of the burden for maintenance and repair for sophisticated oxygen technologies and therefore the total management of the oxygen therapy regimen to the oxygen beneficiary. This will clearly produce the undesired effect of unmonitored and unregulated dispensing and distribution of a prescription drug. This presents a serious risk to patient safety and care and will result in higher costs to the patient and the national healthcare financing system.

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