



## **Background Paper: Legislation to Reform the Medicare Home Oxygen Therapy Benefit**

The American Association for Homecare (AAHomecare) urges the 111<sup>th</sup> Congress to reform the Medicare home oxygen benefit in order to improve quality of care and provide for appropriate reimbursement during the entire period of a patient's medical need. Budget-neutral oxygen reform legislation will ensure consistent and comprehensive services for Medicare beneficiaries while eliminating the current 36-month reimbursement cap and establishing a bundled payment for the duration of time in which home oxygen therapy is provided.

AAHomecare is focused on broad reform because it offers a comprehensive solution to a multitude of problems and shortcomings that currently undermine the Medicare home oxygen benefit. Providers of home oxygen, as well as Congress, CMS, and the Office of Inspector General within the Department of Health and Human Services, have all identified areas within the benefit that need to be improved. Comprehensive reform is the best way to achieve the necessary changes within the current political environment.

AAHomecare supports the objective sought by HR 2373 (the Home Oxygen Patient Protection Act) because it is important that reimbursement for oxygen equipment and services not be capped at an artificial point in time unrelated to the period of medical necessity. However, the Association thinks the goal of the HOPP Act is more likely ultimately to be accomplished by enacting broader reform of the entire oxygen benefit. Legislation that addresses the many concerns cited by providers, Congress, and HHS will achieve not only the goals of HR 2373 but also satisfy longstanding criticisms of oxygen payment policy by policymakers and those who administer Medicare. Oxygen reform will bring transparency to the home oxygen payment policy, and it will make home oxygen therapy a more patient-focused benefit by recognizing the importance of related services and not just the cost of the equipment. Finally, oxygen reform will also remove oxygen from the competitive bidding program.

Health care reform is one of the top priorities for both Congress and the Obama Administration in 2009. Because the health care debate is unfolding quickly this year, a legislative vehicle that overhauls the nation's health care system provides an ideal opportunity to include a reform of the home oxygen therapy benefit.

### **Timeframe for Reform**

The House and the Senate committees that have jurisdiction over health care issues have announced a goal to achieve passage of health care reform by August. This short timeframe makes it crucial that the homecare community push for oxygen reform now. Without a

meaningful reform effort, it is likely that Congress will continue to target additional cuts to home oxygen payments.

### **Need for Reform**

Despite numerous payment reductions over the past decade, home oxygen providers continue to be a target for additional cuts. Because the current oxygen payment system focuses (in accordance with the statute) on the oxygen equipment rather than the services provided, there is a deeply held belief that Medicare is overpaying for oxygen therapy. The HME sector has quantified in several studies the non-equipment costs associated with the provision of home oxygen therapy. Yet, Congress, CMS, and the OIG continue to focus on the overpayment issue leaving oxygen at risk to further cuts.

At least three times in 2009, the OIG has testified at Senate hearings on Medicare fraud and health reform that home oxygen is over-reimbursed, each time highlighting its recommendation that Congress reduce the oxygen rental cap to 13 months. The Senate Finance Committee's list of options for financing health care reform includes a provision that would draw on OIG reports to ensure "appropriate" payments for DME items, and a joint press release by Finance Committee Chairman Max Baucus (D-Mont.) and Ranking Member Charles Grassley (R-Iowa) cites oxygen in reference to this provision.

As the Senate looks to fund its health care reform proposal, which could top \$1 trillion in costs, home oxygen payments are at a risk for additional cuts unless the HME community is proactive in reforming the benefit and addressing the perception that oxygen is overpaid.

### **Development of Reform Proposal**

AAHomecare has spearheaded efforts in recent years to bring together oxygen stakeholders to discuss the structure of the home oxygen benefit. In 2006, AAHomecare convened an oxygen stakeholder summit that included both national and independent providers, manufacturers, physician and clinician organizations, and patient advocacy groups to develop principles for reforming the oxygen benefit. Following the summit, a workgroup of industry stakeholders developed these principles into a proposal for a reformed home oxygen benefit.

After numerous iterations and revisions, AAHomecare convened the New Oxygen Coalition (NOC), which included representatives of independent and national providers, manufacturers, state associations, and other DME organizations and associations. This group devoted considerable time to both examining the Medicare home oxygen benefit and exploring how its structure might be improved to better serve the needs of oxygen providers and their patients. The NOC scrutinized the oxygen reform proposal and made numerous refinements including: development of a revised payment system, refinement of the re-testing requirement, and refinement of the required services that oxygen providers must perform. State associations also offered comments on the reform proposal. AAHomecare's Board of Directors approved an oxygen reform plan in April 2009, and the Association is now working to have Congress include it in legislation this year.

## **Basics of Oxygen Reform**

The current structure of the home oxygen therapy benefit inappropriately focuses on the equipment provided rather than on the needs of beneficiaries and the necessary services provided to them. Congress should act quickly to reform this benefit in a manner that links reimbursement to beneficiary need. Not only would this structure mirror that applied to other Medicare providers, but it would also address many of the concerns historically raised about the benefit by requiring specific covered services and data collection through cost reports.

Home oxygen therapy reform would be budget neutral, and it would:

- Eliminate the oxygen rental cap;
- Exempt oxygen from competitive bidding;
- Mandate a minimum set of services tied to patient needs;
- Link patient need and reimbursement;
- Establish a new class of Medicare providers – home oxygen therapy providers;
- Provide for greater cost transparency;
- Establish a Home Oxygen Therapy Advisory Committee;
- Enhance anti-fraud, abuse, and waste efforts; and
- Establish strong patient protections.

## **Specifics of Oxygen Reform**

### **1. Elimination of Oxygen Cap**

The 36-month oxygen rental cap would be eliminated effective January 1, 2010.

### **2. Elimination of Competitive Bidding for Oxygen**

Oxygen would be eliminated from the DMEPOS competitive bidding program.

### **3. Covered Services**

The oxygen reform proposal would define *in law* what services are required under the Medicare home oxygen benefit. These services are already being provided by home oxygen suppliers, but because they are not defined under a legislative mandate, Congress, CMS and the OIG *do not* recognize their costs when they assess the appropriateness of oxygen payments. The services would be taken into account in future cost studies if they are recognized in legislation.

Establish a uniform level of beneficiary care coordination services that include:

- Routine evaluation of the beneficiary's ability to operate the oxygen equipment safely and appropriately;
- Patient and caregiver education about home oxygen therapy, equipment, safety and infection control;
- Equipment delivery, set-up, and maintenance, including checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of alarms and back-up systems;
- Monitoring visits by trained personnel to evaluate patient compliance with physician's plan of care;

- Reports to physicians when changes occur in patients' compliance with the plan of care;
- Provision of a 24-hour on-call coverage as well as supplies and equipment (including back-up systems);
- Assistance with coordination of equipment, services, and providers associated with beneficiary travel; and
- No additional mandate for a federal requirement for the provision of clinical services. Oxygen providers would still be required to comply with state law requirements.

#### 4. **Re-testing**

Providers would have a re-testing requirement for a limited segment of patients who do not have a chronic diagnosis to ensure that only those who need oxygen therapy receive it.

- Home oxygen providers would be required to facilitate re-testing of patients between 60 and 120 days when those patients had an acute diagnosis where oxygen was prescribed for the first time.
- Patients with a diagnosis of the following would be exempt from the retesting requirement: Chronic Obstructive Pulmonary Disease (COPD), emphysema, obstructive chronic bronchitis, bronchiectasis, congestive heart failure, pulmonary fibrosis, obstructive sleep apnea, and Alpha-1 Antitrypsin Deficiency (A1AD), since these chronic conditions typically require oxygen therapy for an extended period of time.

#### 5. **Establishing Provider Status**

Today's home oxygen therapy suppliers are actually more like Medicare providers than other durable medical equipment suppliers because of the service-intensive nature of home oxygen therapy. The oxygen reform proposal would remove oxygen from the DMEPOS supplier category under Medicare law and create a new, separate category for qualified home oxygen providers. Under current law, providers that meet the appropriate Medicare requirements are protected by "any willing provider" law from being competitively bid, so a move to a provider status would permanently keep home oxygen providers out of competitive bidding.

The reform proposal would recognize this distinction and in doing so establish strong criteria that entities must meet to qualify as home oxygen therapy providers. These criteria would include:

- Requiring a standardized set of patient services linked to individual patient need;
- Meeting accreditation requirements;
- Meeting supplier enrollment safeguards including supplier standards and quality standards; and
- No additional requirement for the provision of clinical services.

#### 6. **Technical Clarifications related to Provider Status**

In addition to the basic requirements for qualified home oxygen providers, the oxygen proposal would also specify the following technical aspects related to the move from DMEPOS supplier status to the provider category:

- No additional accreditation would be required -- all current CMS-deemed accrediting bodies for DMEPOS suppliers would qualify as accreditors for oxygen providers;

- Maintain compliance with Medicare Supplier Enrollment Safeguards and the Medicare Quality Standards regulations;
- No additional NPI would be required. A provider's DME NPI would be used as the NPI for oxygen providers;
- No additional surety bond would be required beyond the current requirement for DMEPOS suppliers;
- No requirement that oxygen providers accept assignment for Medicare oxygen claims;
- No requirement that oxygen providers participate in the Medicare program; and
- Oxygen providers would bill claims for home oxygen therapy through the DME MACs.

## 7. **Bundled Payment Structure**

The reform proposal would link Medicare payment with beneficiary need by establishing a new payment system that would:

- Establish patient categories based on number of liter hours a beneficiary needs per week based upon ambulation status:
  - i) Category 1- Patient who lacks mobility or is prescribed oxygen for nocturnal use only;
  - ii) Category 2- Patient with standard portability needs; and
  - iii) Category 3- Patient with high portability needs.
- “Portability needs” will be defined as-
  - i) Standard- use of portable oxygen estimated at less than or equal to 40 “liter hours” per week.
  - ii) High- use of portable oxygen estimated at more than 40 “liter hours” per week.
  - iii) “Liter hours” is defined as prescribed LPM multiplied by estimated number of hours of use per week.
- Require physicians to classify beneficiaries into one of three categories based on ambulatory status – the physician would indicate the patient category on an expanded Certificate of Medical Necessity (CMN).
- Require providers to report to the physician observed changes in a beneficiary’s condition that might warrant reclassification by the physician.
- Payment for services and supplies would be included (bundled) in a monthly allowable.
- Require providers to submit annual cost reports to CMS, with a streamlined system for small providers
- There would be an initial one-year transition period for existing patients.

## 8. **Allowable Charges & Annual Updates**

Home oxygen providers would continue to be paid based on the bundle of services provided. Payments would:

- Be made on a per-patient per-month basis;
- Correspond to the period of medical necessity (there would be no payment cap on the monthly payments); and

- Receive an annual update each year that corresponds with the Consumer Price Index for Urban Consumers (CPI-U).

#### 9. **Transition Period**

Home oxygen reform would include a transition period to allow providers and patients proper time to adapt to the new payment system. Transition elements include:

- Patients currently receiving oxygen as of January 1, 2010, would be grandfathered for up to one year, at which time all patients should have new prescriptions that reflect the patient's classification in the new payment structure.
- Initial payment rates would be locked in for three years to allow providers and patients time to properly adapt to the new system before adjusting the allowables.

#### 10. **Cost Transparency**

Home oxygen providers would be required to submit an annual cost report to CMS. These reports would quantify all aspects of the costs of providing home oxygen therapy and services to Medicare beneficiaries. This is essential to ensuring that HME providers are reimbursed for oxygen services.

- CMS could require a maximum of one cost report per year;
- Small providers (defined as \$1 million or less in Medicare oxygen revenue) would be subject to shorter or streamlined report; and
- The cost reporting requirement would be delayed at least two years to give providers an opportunity to transition to the new payment system.

#### 11. **Home Oxygen Therapy Advisory Committee**

The reform proposal would require HHS to create a Home Oxygen Therapy Advisory Committee to advise the Secretary on the development and implementation of home oxygen payment policy. The advisory committee would include representatives from all stakeholders in the home oxygen therapy community (including patients and providers) to, among other things, provide advice and recommendations on:

- The development of a quality improvement program;
- Defining the payment categories;
- Refining patient services; and
- Evaluating comparative effectiveness for home oxygen therapies.

#### 12. **Anti-fraud & Abuse Protections**

The proposal strengthens existing efforts to curb fraud, abuse, and waste in the program by:

- Mandating site inspections for all new home medical equipment providers;
- Requiring site inspections for all provider renewals;
- Improving validation of new homecare providers;
- Requiring two additional random, unannounced site visits for all new providers;
- Requiring a six-month trial period for new providers;
- Establishing an Anti-Fraud Office at Medicare;
- Ensuring proper federal funding for fraud prevention;
- Requiring post-payment audit reviews for all new providers;
- Conducting real-time claims analysis;

- Ensuring all providers are qualified to offer the services they bill;
- Establishing due process procedures for providers;
- Increasing penalties and fines for fraud; and
- Establishing more rigorous quality standards.

13. **Beneficiary Protections:** The proposal would specify rights of the beneficiary to, among other things:

- Choose or change providers;
- Be informed about and participate in all aspects of the oxygen therapy services being provided;
- Be informed about all treatment modalities and categories of equipment offered by the provider;
- Be informed of the right to consult with his or her physician about changes to equipment or services; and
- Be informed of the provider's internal and external grievance processes, including how to contact Medicare through the hotline or Ombudsman and how to file grievances.