

Why GAO Did This Study

Studies have found that Medicare payment rates for home oxygen exceeded other payers' rates. Congress has reduced home oxygen payment rates, capped rental payments after 36 months, and directed the Centers for Medicare & Medicaid Services (CMS), which administers Medicare, to use competitive bidding. GAO was asked to examine Medicare home oxygen payment policy. GAO describes how Medicare pays for home oxygen; the effect on Medicare's payments of using other methodologies and rates; and changes in beneficiary access. GAO reviewed federal laws and regulations, industry-reported costs, Medicare claims data and payment data from selected private insurers, the Department of Veterans Affairs (VA), and CMS's competitive bidding program.

What GAO Recommends

Congress should consider reducing home oxygen payment rates. GAO recommends that CMS remove payment for portable oxygen refills from the payment for stationary equipment.

The Department of Health and Human Services (HHS) commented that payments for home oxygen are "excessive," but disagreed with the recommendation because HHS believed it would not yield immediate savings. GAO's recommendation was not intended to generate savings but to help ensure beneficiary access to oxygen.

MEDICARE HOME OXYGEN

Refining Payment Methodology Has Potential to Lower Program and Beneficiary Spending

What GAO Found

For beneficiaries who qualify for home oxygen benefits, Medicare pays suppliers a monthly rate that covers rental of a stationary, home-based unit and all related services and supplies; these payments were substantially higher than estimated suppliers' costs. Medicare pays a separate rate for rental of a portable unit if one is supplied. Medicare combines, or bundles, payment for stationary equipment with payment for oxygen refills, which are required only for certain equipment types. Thus, when a supplier furnishes oxygen equipment that does not require refills, it may still receive payment for them. As of January 1, 2006, Medicare capped suppliers' rental payments for home oxygen equipment after 36 months of continuous use by a beneficiary. At that point, the supplier may experience diminished payments and more coverage requirements. In some cases, suppliers may have to subcontract with another supplier if a beneficiary moves out of the supplier's service area.

The eight private insurers GAO interviewed used payment methodologies similar to Medicare's, but seven did not use a rental cap. If Medicare had used the methodologies and payment rates of the lowest-paying private insurer, it could have saved about \$670 million of the estimated \$2.15 billion it spent on home oxygen in 2009. Using the VA's payment methodology, savings could have been approximately \$410 million to \$810 million. Basing Medicare's national rates on data from CMS's competitive bidding program 2011 rates could have saved \$700 million. Since beneficiaries pay 20 percent of the payment, lower rates could have reduced beneficiary spending.

Utilization trends show overall beneficiary access to home oxygen has not diminished, despite reductions in payment rates and in the number of suppliers from 2001 through 2008. In that period, the proportion of Medicare Part B beneficiaries using home oxygen rose from less than 3 percent to almost 5 percent. But the relative mix of equipment changed—use of more service-intensive portable equipment decreased and use of only stationary oxygen concentrators increased. Medicare's rental payment for stationary concentrators, which includes payment for portable oxygen refills although they are not provided to about one-third of home oxygen beneficiaries, may discourage provision of portable equipment. The equipment might not always be accessible to beneficiaries who would benefit from using it as well as a stationary concentrator. Although the majority of home oxygen suppliers GAO spoke with said they were reluctant to or would not accept new beneficiaries who were approaching the 36-month cap, according to CMS, the agency has ensured that all beneficiaries who relocated found suppliers. Further, CMS stated that if in the future access to home oxygen becomes a problem after a beneficiary relocates; it may consider requiring the supplier that provides home oxygen for month 18 or later to provide oxygen for the remainder of the rental period or make arrangements with another supplier to do so.