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GAO

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General Accounting Office
Washington, D.C. 20548

Health, Education and Human Services Division

B-272723

May 15, 1997

The Honorable William V. Roth, Jr.
Chairman, Committee on Finance
United States Senate

Subject: Medicare: Comparison of Medicare and VA Payment Rates for Home Oxygen

Dear Mr. Chairman:

In fiscal year 1996, almost 480,000 Medicare beneficiaries received home oxygen at a cost of about $1.7 billion. Studies within the Department of Health and Human Services (HHS) and legislation introduced previously in the Congress proposed reductions in the Medicare payment levels for home oxygen, but to date no rate reductions have been implemented through the regulatory processes of HHS' Health Care Financing Administration (HCFA) or through legislation. Therefore, you asked that we review the appropriateness of the payment rates and policies for Medicare's home oxygen benefit.

On March 25, 1997, we met with your office to discuss our ongoing review of Medicare payment rates and policies. Since the Committee may shortly consider legislation on Medicare payment rates, your office requested that, pending completion of our full report, we provide you with our preliminary analysis comparing the rates paid for oxygen by Medicare with the rates paid by the Department of Veterans Affairs (VA). This letter provides that analysis and also includes background on the Medicare home oxygen benefit, a discussion of why we chose the VA payment rates for comparison with Medicare's rates, and an explanation of how we adjusted the VA rates to take into account differences between the VA and Medicare programs.

RESULTS IN BRIEF

Medicare's fee schedule allowances for home oxygen are significantly higher than the rates paid by VA, which uses competitive contracting arrangements.

As shown in table 1, Medicare's monthly rate, including allowances for portable units, was about $320 for each home oxygen patient for the first quarter of fiscal year 1996. During that same period, VA paid about $155 per month for each patient, according to our analysis of all oxygen supplies, services, and portable units provided to a nationwide sample of 5,000 VA patients.

We analyzed differences between the Medicare and VA oxygen programs that could make servicing a Medicare patient more costly than servicing a VA patient. Our analysis included consideration of the administrative burden associated with filing Medicare claims. On the basis of this analysis, we concluded that adding a 30-percent adjustment to VA's payment rates adequately reflects the higher costs suppliers incur when servicing Medicare beneficiaries.

The VA payment rate, after the 30-percent adjustment, was about $200 per month, or $120 less than Medicare. If Medicare had paid oxygen suppliers at the adjusted VA rates, the Medicare program would have saved over $500 million in fiscal year 1996.

Table 1: Comparison of Medicare and VA Payment Rates for Home Oxygen Supplies and Services (First Quarter, Fiscal Year 1996)

	Monthly payment per patient
Medicare	
Basic fee schedule allowance[a]	$285
Additional allowance for portable unit[b]	35
Total Medicare allowance	**$320**
Department of Veterans Affairs	
Average monthly payment[c]	155
Plus adjustments for comparability with Medicare[d]	45
Total adjusted VA payment	**$200**
Difference between Medicare and adjusted VA rates	**$120**

[a]The Medicare basic monthly fee schedule allowance for oxygen varies by state. During the first quarter of fiscal year 1996, the fee was subject to a floor of $262.40 and a ceiling of $308.71. This analysis uses $285, the approximate midpoint of the floor and ceiling.

[b]The Medicare monthly fee schedule allowance for a portable unit also varies by state. During the first quarter of fiscal year 1996, the fee was subject to a floor of $41.23 and a ceiling of $48.51. We determined that Medicare paid for portable units for about 75 percent of oxygen patients; therefore, in this analysis we used a per-patient allowance for portable units of $35, which is about 75 percent of the approximate midpoint of the floor and ceiling.

[c]The VA payment rates are based on VA competitive contracts with oxygen suppliers. The average monthly payment used in this analysis is a "bundled" rate, including all supplies, services, oxygen contents, and portable units provided to a nationwide sample of 5,000 patients. The average VA monthly payment for patients using oxygen concentrators was about $125, and the average monthly payment for patients using stationary liquid systems was $315. The combined average, weighted by the number of patients using each type of system, was $155.

[d]This is GAO's estimate of the additional costs that a VA supplier would incur to provide home oxygen to a Medicare patient. This estimate includes the cost of oxygen supplies and services provided to new patients subsequently determined not to be medically eligible; the administrative costs associated with preparing and processing claims, including obtaining a physician's certificate of medical necessity; the administrative costs associated with collecting the Medicare copayment; and the lack of a guaranteed patient pool.

BACKGROUND

Many individuals suffering from chronic obstructive pulmonary disease or similar conditions are unable to meet their bodies' oxygen needs through normal breathing. Supplemental oxygen has been clinically shown to assist many of these patients. Currently, there are three primary methods or modalities through which these patients can obtain supplemental oxygen:

- compressed gas, which is available in various-sized tanks, from large stationary cylinders to small, portable cylinders;

- oxygen concentrators, which are electrically operated machines, about the size of a dehumidifier, that extract oxygen from room air; and

- liquid oxygen, which is available in large stationary reservoirs and portable units.

Each of the three modalities is equally effective at delivering supplemental oxygen. However, liquid oxygen is most often prescribed for patients that require a very high liter flow. Physicians also order portable units for about 75 percent of their Medicare patients to enable them to perform activities away from their stationary unit and outside the home. The most common portable system is a gas cylinder set on a small cart that can be pulled by the patient. Highly active patients can be equipped with a portable liquid oxygen system or a lightweight gas cylinder. These systems may be used with an oxygen-conserving device to increase the time a portable unit can be used before a refill is required.

Medicare's eligibility criteria for the home oxygen benefit are quite specific. Patients must have an appropriate diagnosis, such as chronic obstructive pulmonary disease, and clinical tests of arterial blood gases and oxygen saturation levels that document the need for supplemental oxygen. Medical experts told us that most patients that meet the Medicare eligibility criteria for oxygen remain on oxygen for the rest of their lives. However, for some patients the need for supplemental oxygen may be temporary, such as during an episode of pneumonia.

Medicare pays a fixed monthly fee to cover all of a patient's primary needs, regardless of the type of oxygen system supplied.[1] If a physician determines that a patient also needs a portable unit, Medicare pays a supplemental, fixed monthly fee for the portable unit. At the time of our review, the primary Medicare fee was about $285 per month, and the fee for a portable unit was about $45 per month.

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[1]This fee is increased by 50 percent for those beneficiaries whose prescribed liter flow is over 4 liters per minute and decreased by 50 percent for those with a prescribed liter flow of less than 1 liter per minute. Our analysis of claims data indicated that these modifiers were used in less than 2 percent of the claims approved for each modality.

SCOPE AND METHODOLOGY

In conducting our work, we reviewed the laws, regulations, and fee schedules pertaining to Medicare's home oxygen benefit. Our payment comparison analysis is based on data we gathered on Medicare and VA home oxygen payments made from October 1, 1995, through December 31, 1995. We obtained data on Medicare home oxygen payments from each of the four Durable Medical Equipment Regional Carriers[2] and the nationwide Statistical Analysis Durable Medical Equipment Regional Carrier.[3] We obtained data on VA payments for home oxygen from invoices for a nationwide sample of about 5,000 VA patients, drawn from 46 of the 161 VA medical centers that have home oxygen contracts. We included at least 1 medical center from each of VA's 22 Veterans' Integrated Service Networks in our sample to ensure complete geographic coverage.

We also visited at least three oxygen suppliers in each of the areas serviced by the four Durable Medical Equipment Regional Carriers to directly obtain the suppliers' views and insights. We selected these suppliers to include some who serviced both VA and Medicare patients and some who provided liquid systems as well as oxygen concentrators. During these visits, we reviewed a sample of 550 Medicare patient records to learn about patient services, Medicare claims paperwork, and copayment collection. We did not attempt to evaluate the quality of care provided to Medicare or VA patients by home oxygen suppliers, and we did not examine the clinical outcomes for either VA or Medicare home oxygen patients.

Our fieldwork did include discussions with HCFA and VA officials; groups representing oxygen suppliers, respiratory therapists, and physicians; selected state Medicaid officials; and various private insurers. We did this work and analysis between May 1996 and April 1997 in accordance with generally accepted government auditing standards, except that we did not examine the internal and data processing controls of the Medicare claims databases maintained by HCFA's contractors.

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[2]These carriers process Medicare claims for durable medical equipment, orthotics, prosthetics, and supplies within designated geographic areas for HCFA.

[3]The Statistical Analysis Durable Medical Equipment Regional Carrier performs a variety of statistical reporting and analysis functions relating to the Durable Medical Equipment benefit under contract with HCFA.

WHY WE COMPARED MEDICARE'S PAYMENT RATES WITH VA'S RATES

To evaluate the appropriateness of Medicare's reimbursement rates for home oxygen, we considered comparing Medicare's rates with those paid by Medicaid, private insurance companies, managed care plans, and VA. All such comparisons have some inherent limitations. For the reasons discussed in the following paragraphs, we decided to use VA's competitive contracting rates, with some adjustments, for our rate comparisons.

We did not use Medicaid payment rates for our comparisons because each state has wide latitude in determining the benefits covered and their reimbursement rates. Also, since Medicare is the largest single payer of home oxygen benefits, many states base their payment levels on Medicare's fee schedule.

We found that individual private insurance companies have limited numbers of beneficiaries receiving home oxygen benefits and have a wide range of payment rates. Some firms simply base their fees on Medicare's reimbursement levels while others pay submitted charges or negotiate rates on a case-by-case basis. We found that some private insurers pay more than Medicare and others pay less. We were not able to identify any insurance company with a sufficiently large number of beneficiaries on long-term home oxygen therapy to serve as the basis for a nationwide comparison with Medicare's rates. We also could not identify any private insurer that had done a study to determine the appropriate reimbursement level for home oxygen services.

Medicare managed care plans that we contacted were unwilling to provide us information on the rates they negotiate with oxygen suppliers because they consider that information to be proprietary. However, during our patient file reviews at oxygen suppliers, we noted two Medicare managed care plans that pay about $200 a month for services comparable to those provided to fee-for-service Medicare beneficiaries. Because the availability of these data was very limited, we could not use them for our analysis.

We concluded that the VA home oxygen program is the best available data source for comparison with Medicare reimbursement rates. Both are federally funded, nationwide programs with a significant patient population using home oxygen. In fiscal year 1995, VA provided oxygen benefits to over 23,000 patients at a cost of almost $26.5 million. VA's eligibility guidelines are the same as Medicare's, and clinical experts and suppliers told us that the home oxygen service needs of the VA and Medicare patient populations are essentially the same. We were able to obtain access to original invoices to gather cost data for a nationwide sample of about 5,000 VA patients.

After excluding the relatively small number of patients using stationary compressed gas systems from both patient groups, we found that the ratio of stationary liquid systems to concentrators was remarkably similar among Medicare beneficiaries and our VA patient sample. About 84 percent of the VA patients in our study used an oxygen concentrator and 16 percent used a stationary liquid oxygen system. Among Medicare beneficiaries nationwide, 86 percent used oxygen concentrators and 14 percent used stationary liquid oxygen systems.

VA PAYMENTS FOR OXYGEN

VA medical centers structure their contracts with oxygen suppliers in various ways. Many centers pay flat monthly rates that cover equipment rental, setup visits, service visits, and supplies, and pay separately for gas and liquid refills on the basis of patient use. Other medical centers may incur additional charges for setup visits, for example, or for various types of supplies. Since Medicare pays one fee for everything, we "rebundled" the costs incurred by each VA center to compare the total per-patient cost with Medicare reimbursement rates.

For the approximately 5,000 VA patients in our sample, we used the data from contractor invoices submitted to each VA medical center for equipment rental, oxygen refills, supplies, and services, including the cost of any portable systems and contents provided to the patient. We excluded from our analysis cases in which the VA medical center provided the supplier with the equipment to be used and only paid the supplier a fee to maintain the VA equipment. Furthermore, we excluded the small number of patients using only compressed gas because we found that some VA medical centers provided compressed gas to patients for conditions such as cluster headaches, which would not qualify for the Medicare benefit.

To determine whether there were any significant geographic differences in costs, we grouped each of the VA medical centers by the geographic areas served by each of Medicare's four Durable Medical Equipment Regional Carriers. We found that the average weighted cost for the VA medical centers in three of the four geographic areas was within 10 percent of the $155 nationwide average. The average weighted cost for the VA medical centers in the fourth geographic area was 17 percent higher than the nationwide average. This region also had the highest percentage of patients on liquid oxygen of the four geographic areas, while the region with the lowest average cost had the highest percentage of patients on concentrators. We concluded that the modality mix within a region affected the average price more than geography.

For the medical centers we reviewed, VA paid an average of about $125 per month for a beneficiary using a concentrator system and $315 per month for the use of a stationary liquid oxygen system. VA's average monthly payment for a patient on home oxygen, weighted by the number of patients on each type of system, was $155. This payment rate includes all charges for the rental of stationary, backup, and portable equipment; maintenance; supplies; services; and liquid or compressed oxygen.

Before comparing the Medicare and VA payment rates, we addressed some differences between the two programs. Those differences, and the adjustments we made to account for them, are discussed in the following section.

DIFFERENCES BETWEEN MEDICARE AND VA

There are significant differences between the Medicare and VA programs that may account for some of the differences between the rates VA and Medicare pay for home oxygen. Most significantly, VA competitively procures oxygen supplies and services. In contrast, Medicare, like a fee-for-service insurer, simply reimburses suppliers for services provided to beneficiaries--it does not directly contract for services with specific suppliers; therefore, it cannot guarantee a fixed number of patients to any supplier.[4]

Other differences between the Medicare and VA programs can place a greater administrative burden on suppliers when they service Medicare patients. For example, VA preapproves each patient for home oxygen services, while Medicare requires that oxygen suppliers furnish a certificate of medical necessity completed by a physician before paying the suppliers' claims. Also, VA patients are not responsible for a 20-percent copayment; therefore, VA suppliers do not have to bill VA patients for the copayment, as they do for Medicare patients.

In our meetings with home oxygen suppliers and industry representatives, we solicited their views and any data they could provide to quantify the differences in costs between servicing VA and Medicare patients. One 1995 industry study[5]

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[4]HCFA is currently planning a demonstration project for nonexclusive competitive pricing for some medical supplies and services, including home oxygen.

[5]"HME Industry Findings: The Health Care Financing Administration's Initiative on Medicare Payment for Home Oxygen," Home Oxygen Services Coalition, (Washington, D.C.: Sept. 7, 1995).

estimated that the differences are the equivalent of a 15-percent differential between the cost of serving a VA patient and a Medicare beneficiary. In other words, the industry study estimated that the rates obtained by VA for home oxygen should be increased by 15 percent before they are compared with Medicare's rates.

The following sections address each of the factors we identified that could affect a comparison of the Medicare and VA payment rates.

VA Use of Competitive Contracting and Specific Supplier Requirements

Each VA medical center is responsible for procuring its home oxygen through competitive bidding. This competitive procurement process is a significant factor in the difference between Medicare and VA payment rates for oxygen. Critics of competitive bidding claim that firms will compete on the basis of price at the expense of service and quality. However, VA central office policy encourages the medical centers to contract with suppliers that are either accredited by the Joint Commission on Accreditation of Healthcare Organizations or comply with its standards. Within certain guidelines, each center can structure its contract to reflect its own operating philosophy in terms of financial management and patient care as well as the local market for home oxygen.

We reviewed the contracts of the 46 VA medical centers from which we received patient cost data. We found that the contract requirements defined the qualifications of the bidder, the type of equipment desired--often specifying brand name or its equivalent--and the type and frequency of service visits and patient evaluations. Many VA contracts were quite specific regarding the professional qualifications of supplier staff and the frequency of patient assessments. The local VA medical center staff can monitor vendor compliance. In contrast, HCFA has never established standards for the home oxygen benefit to define what services it expects suppliers to provide Medicare patients.

The VA competitive contracting process is attractive to some suppliers because the volume of patients it can ensure allows for economies of scale. Suppliers have said there are other advantages associated with the local VA contract. For example, winning a VA contract enhances a firm's reputation and visibility in the local market. In addition, some firms hope to retain their VA patients if they become eligible for Medicare.

VA's Preapproval Process

When a supplier under VA contract is told by the VA medical center to provide home oxygen for a patient, the supplier knows that it will be paid for those services. For Medicare patients, the supplier is told by the prescribing doctor to provide oxygen services. However, it is only after the service is provided that the supplier will know for sure whether Medicare will pay for this service. The industry study previously noted quantifies this risk as adding 5 percent to VA's payment rate to make it comparable to Medicare's payment rate.

Our analysis of Medicare claims data showed that the denial rate for this benefit for the first quarter of fiscal year 1996 was 18.7 percent. However, most of these denials were for administrative reasons such as duplicate claims or missing information. The actual denial rate for medical ineligibility was 2 percent. Medicare's criteria for eligibility are specific and clear cut, and suppliers told us they know whether patients are going to qualify for coverage.

We concluded that the risk of medically based claims denial is not a major factor in explaining the cost differential between the VA and Medicare. However, because this factor represents the different ways home oxygen is authorized in the two programs, we considered it as part of our overall adjustment of the VA payment rates.

VA's Less Cumbersome Administrative Process

Industry representatives stated that the administrative burden of complying with Medicare requirements is onerous and accounts for a major portion of the difference between VA and Medicare payment rates. One major burden they cited is the certificate of medical necessity that must be completed by the prescribing physician before the claim can be submitted to Medicare for payment. Every supplier we interviewed complained about the difficulty in quickly obtaining this document. The industry study estimated that the cost of complying with Medicare's administrative requirements, including documenting patient eligibility, is equivalent to adding 4 percent to VA's payment rate to make it comparable to Medicare's payment rate.

HCFA officials acknowledged the suppliers' dilemma. They realize that a supplier provides services to patients immediately upon referral by a doctor and that there may be a significant delay between the start of service and the completion of the certificate of medical necessity. However, they pointed out that the establishment of eligibility for the home oxygen benefit usually results in continuous Medicare coverage of this benefit for the life of the patient.

HCFA officials believe that the documentation requirements for this expensive, often lifelong benefit should be fairly stringent. Recent changes have reduced the administrative burden by allowing many patients to receive lifetime certification. Also, HCFA recently issued a draft revision of the certificate of medical necessity in an attempt to simplify the form and make it easier for doctors to complete. For example, in the revised certificate, doctors no longer need to write out a justification for the portable unit.

Our review of patient case records showed that, while most certificates are completed within 30 days of service setup, there is documentary support for the suppliers' contention that there are significant problems with this process. We found several examples of long delays and one case in which a patient died and the doctor refused to fill out the certificate, so the firm was not paid at all for its services. Many suppliers we talked with had developed strategies to facilitate the completion of certificates of medical necessity. These strategies involved extra staff time and costs. For the records we reviewed, we found that 64 percent of the certificates were completed within 30 days of the supplier's starting service, and 88 percent were completed within 90 days.

While obtaining the certificate of medical necessity represents a major start-up cost, the impact on the difference between the monthly VA and Medicare payment rates is less when that cost is amortized over the length of time that the certificate is valid. For most patients, eligibility must be renewed after the first year.[6] At that time, the doctor may certify the patient for lifetime eligibility, and the patient will never have to be recertified again. Once a patient's eligibility is established, Medicare billing is usually electronic and fairly straightforward. One VA contractor we visited noted that the electronic billing process for Medicare is far less cumbersome than submitting paper invoices each month to the local VA medical center. This indicates that the VA system is not entirely without processing costs, although when the medical eligibility documentation is included, Medicare's overall administrative burden on suppliers is greater.

We concluded that the administrative burden for documenting medical eligibility and obtaining Medicare reimbursement is significantly greater than that associated with providing services under a VA medical center contract.

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[6]Those patients whose partial pressure of oxygen in the arteries is between 56 and 59 as measured in millimeters of mercury must be recertified within 90 days in order to maintain eligibility.

Therefore, an adjustment to the VA rate is appropriate for comparison with the Medicare rate.

VA Does Not Require a Copayment

The Medicare home oxygen benefit requires that beneficiaries pay an annual deductible and 20 percent of the allowed reimbursement amount every month. Industry representatives contend that the cost of billing and collecting this copayment adds to the cost of providing services to Medicare beneficiaries. In addition, they point out that a portion of the copayment owed to them may never be collected. Under the VA program, in contrast, VA pays 100 percent of the contract price. The industry estimate states that this accounts for 6 percent of the difference between the cost of the VA program and Medicare.

Noncollection of copayments does represent a cost differential between VA and Medicare but can only justify a small amount of the difference in payment rates. Our review of case records at the suppliers we visited showed that 86 percent of the Medicare beneficiaries whose records we saw either had supplemental insurance or were covered by Medicaid.[7] Of the 14 percent of beneficiaries with neither private supplemental insurance nor Medicaid coverage, we found that only 3 percent had financial hardship waivers in their records. Even if suppliers were not able to collect copayments from three times the number of patients with hardship waivers, the uncollected amount would only represent 2 percent of the total revenue suppliers receive for Medicare home oxygen.

POTENTIAL SAVINGS IF MEDICARE USED ADJUSTED VA RATES

On the basis of our analysis of the differences between the VA and Medicare programs, we concluded that adding a 30-percent adjustment to VA's payment rates adequately reflects the higher costs suppliers incur when servicing Medicare beneficiaries. As noted in table 1, after the 30-percent adjustment the VA payment rate was about $200 per month, or $120 less than Medicare. If Medicare's monthly allowances of $320 for oxygen had been reduced by $120, the Medicare program would have saved over $500 million of the $1.7 billion in fiscal year 1996 costs.

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[7]While some state Medicaid programs such as Oregon's do not cover the Medicare copayment for their clients on home oxygen, others do.

AGENCY AND INDUSTRY COMMENTS AND OUR EVALUATION

We made draft copies of this correspondence available for review by officials at the Health Care Financing Administration and VA, representatives of the home oxygen industry, and officials of associations representing respiratory care specialists and physicians that treat patients with chronic lung disease.

HCFA officials agreed with our analysis of the Medicare and VA payment rates for home oxygen. More specifically, HCFA agreed that (1) the VA payments are the most appropriate rates available for comparison with the Medicare fee schedule rates and (2) the methodology we used to compare the Medicare and VA payment rates was appropriate. Regarding our adjustments to account for differences between the Medicare and VA programs, HCFA officials noted that the administrative burden on oxygen suppliers associated with processing Medicare claims may be partially offset by the VA requirement that its suppliers adhere to the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations–a requirement that HCFA does not impose on Medicare home oxygen suppliers.

HCFA officials also noted that they have three initiatives under way that are intended to bring some Medicare payment rates, including those for home oxygen, more into line with marketplace rates. First, within a few weeks, HCFA expects to publish a Notice of Proposed Rulemaking to adjust the Medicare fee schedule allowances for oxygen. Second, the administration is requesting legislative authority to streamline the regulatory process for adjusting some Medicare payment rates, including those for oxygen, by allowing either the Secretary of HHS or Medicare's Durable Medical Equipment Regional Carriers to periodically review and adjust those rates. Under the revised process, HCFA would not have to publish a Notice of Proposed Rulemaking in the Federal Register for comment. Finally, HCFA is planning a competitive pricing demonstration project for various medical equipment and supplies, including home oxygen. Specific quality standards are being developed for use in the demonstration project.

Regarding HCFA's initiatives, it should be noted that HHS and HCFA have been working on the Notice of Proposed Rulemaking for at least 2 years, and even after publication of a proposed rule, additional time will be required to obtain comments from interested parties, address those comments, and finalize the proposed rule. Also, HCFA has repeatedly revised its plans to conduct a competitive pricing demonstration project, and the revisions to the plans have caused repeated delays in the start of the project.

VA officials stated that they were satisfied that the draft of this correspondence accurately described the VA home oxygen program.

Representatives of the home oxygen industry and respiratory care specialists and physicians raised questions or concerns regarding (1) the scope of our work; (2) differences between the Medicare and VA patient populations, such as the proportion of each group that is highly ambulatory; (3) the rates paid by other insurers; (4) the range of VA costs per patient; (5) the effect of a Medicare payment reduction on the willingness of oxygen suppliers to meet the needs of patients who are highly ambulatory; and (6) the potential problems that might arise should Medicare use competitive procurement or competitive pricing for home oxygen. Each of these matters is addressed in the following paragraphs.

To clarify the scope of our work, we added a statement that we did not attempt to evaluate the quality of care provided to Medicare or VA patients by home oxygen suppliers and that we did not examine the clinical outcomes for either VA or Medicare home oxygen patients.

Regarding potential differences between VA and Medicare patients receiving home oxygen, we have noted that clinical experts and suppliers told us that the home oxygen needs of VA and Medicare patients are essentially the same. The commenters did not provide us with any evidence that there are differences between the two groups that would affect their home oxygen needs.

Regarding the rates paid by private insurers, we did not include information on those rates because we were not able to identify any insurance company with a large number of beneficiaries on long-term home oxygen therapy that could serve as the basis for a nationwide comparison with Medicare's rates.

Regarding the range of VA home oxygen costs per patient, the oxygen needs, service requirements, and costs vary among VA patients, as they do among Medicare patients. We believe that the weighted average cost representing all the patients in our sample is the most relevant statistic to compare with Medicare payment rates.

Patients who are highly ambulatory may require frequent refills of portable oxygen equipment; consequently, they may be more expensive to service than patients with limited mobility. The adjusted VA rate we compared with the Medicare rate includes all the costs associated with a broad mix of VA patients, including some who are highly ambulatory and obtain frequent gas and liquid refills. Therefore, if adjustments to the Medicare payment rate are similarly

based on the costs to service a broad patient mix, suppliers should still be able to meet the needs of highly active patients.

We did not evaluate the potential use of competitive procurement or competitive pricing for the Medicare home oxygen benefit because such an evaluation was outside the scope of our analysis. As we noted, HCFA is planning a demonstration project to evaluate the potential use of competitive pricing for the Medicare home oxygen benefit.

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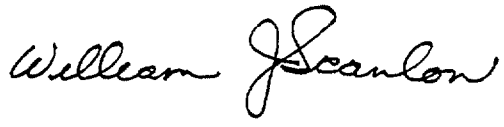
As agreed with your office, unless you release its contents earlier, we plan no further distribution of this letter for 30 days. At that time we will make copies available to other congressional committees and Members of Congress with an interest in this matter, the Secretary of Health and Human Services, and the Secretary of Veterans Affairs.

Please call William Reis at (617) 565-7488 or me at (202) 512-7114 if you or your staff have any questions about the information in this letter. Other contributors to this analysis were Frank Putallaz and Suzanne Rubins.

Sincerely yours,



William J. Scanlon
Director, Health Financing
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