

CONFIDENTIAL

Outline of New Oxygen Coalition (NOC) Oxygen Reform Plan DRAFT 3-19-09

Introductory note: The American Association for Homecare is pleased to share with the HME state association executives the oxygen reform proposal that has been developed by New Oxygen Coalition (NOC) over the past 45 days. The proposal represents the collective work of a dedicated group of representatives from across the oxygen industry. Members of the NOC have 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 group has been meeting in person and by phone to develop a reform plan that addresses the problems with the current Medicare oxygen payment system. The goal is to put the final reform plan into legislation that would be considered by Congress this year.

The plan is based on a fee-for-service model that has three patient classifications that will be paid on a monthly basis with a bundled allowable. The allowables would include payment for related services and supplies. The plan calls for eliminating oxygen therapy from the Medicare competitive bidding program and for eliminating the 36-month cap on oxygen services.

While development work is continuing, the document below is meant to provide details to industry stakeholders of the main elements of the plan. As AAHomecare envisioned at the outset of the NOC process, an important step in finalizing the plan and creating consensus within the broader industry is for the state executives and their leadership to provide comments, recommendations and, hopefully, eventual endorsement of the proposal. In preparing this plan, everyone on the NOC wants to be responsive to the concerns of the state and regional associations.

* * * *

Note: The following represent the primary components of the NOC Oxygen Reform Plan. Upon industry endorsement, they will be translated into legislative language.

- 1.) **Elimination of Oxygen Cap and Competitive Bidding for Oxygen-** Legislative language would include elimination of oxygen cap and exclusion of oxygen from competitive bidding and state that payments will be made until the end of medical need. Legislative language would also provide for defined allowable charges for first two years and related budget neutral assumptions.
- 2.) **Recognition of Service Costs-** Legislative language would include specific (brief) statement at the outset that the service cost of providing home oxygen greatly exceeds the equipment cost (or other words to convey that acknowledgement).

- 3.) **Covered Services-** The term “home oxygen therapy services” means such services and supplies furnished by a qualified home oxygen therapy provider. The services and supplies furnished must be linked to specific patient need and include at a minimum:
- a. Conducting an initial evaluation of patients using a uniform Oxygen Patient Evaluation Form;
 - b. Providing written and verbal patient and caregiver education about home oxygen therapy, stationary and portable oxygen therapy options and oxygen safety (e.g., evaluating the home environment for safety risks or hazards, including home fire and fall prevention);
 - c. Providing appropriate delivery, set-up and coordination of services (e.g., delivery of oxygen technology to hospital prior to discharge, delivery and set-up of equipment in the home), as needed, in a timely manner as agreed upon by the beneficiary, and/or caregiver, provider, and prescribing physician;
 - d. Evaluating beneficiaries’ ability to operate the equipment safely and effectively;
 - e. Educating and, when necessary, providing assistance with infection control, focusing on keeping equipment from leading to infection;
 - f. Providing equipment-related services consistent with the manufacturer specifications and in accordance with all federal, state, and local laws and regulations. These may include but are not limited to: checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms and back-up systems;
 - g. Monitoring visits by appropriately trained personnel to evaluate all aspects of the oxygen therapy services being provided to the patient by the home oxygen provider, including ensuring that beneficiaries follow their prescribed plan of care;
 - h. Documenting exception reporting by the home oxygen therapy provider when changes occur in a patient’s compliance with his/her plan of care to the prescribing physician;
 - i. Providing, as needed, continued education regarding appropriate home oxygen equipment maintenance practices and performance by the patient and caregivers;
 - j. Implementing all home oxygen therapy services that are prescribed by the physician’s plan of care;
 - k. Providing as needed appropriate home oxygen equipment, supplies (including but not limited to supplemental supplies and emergency oxygen back-ups as appropriate);
 - l. Providing 24-hour on-call coverage to respond to patient needs with home oxygen therapy; and
 - m. Assisting the beneficiary with the coordination of oxygen equipment, services, and providers if the beneficiary travels outside of the provider’s service area. If the beneficiary relocates permanently, the new oxygen provider caring for him/her will assume responsibility for billing the Medicare program directly.
 - n. Nothing in this section should be interpreted to establish a federal requirement that a qualified home oxygen therapy provider employ or otherwise retain a licensed respiratory therapist to provide services for which state law does not require them to be provided by such a licensed respiratory therapist.
 - o. The Secretary, in consultation with the Home Oxygen Therapy Advisory Committee will develop a uniform patient evaluation instrument.

- 4.) **Patient Classification System-** The following system will be used to classify, document, and reclassify oxygen patients:
- a. Patients would be classified into one of three Patient Categories-
 - i. Category 1- Patient who lacks mobility or is prescribed oxygen for nocturnal use only;
 - ii. Category 2- Patient with standard portability needs;
 - iii. Category 3- Patient with high portability needs.
 - b. “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.
 - c. An Expanded CMN will be developed-
 - i. Physician would indicate the “patient category” on the CMN.
 - ii. For Category 2, the physician would check off a box indicating “standard portability needed”.
 - iii. For Category 3, the provider would supply the estimated hours of weekly portable use based on information from the Oxygen Patient Evaluation Form. The physician would enter the estimated weekly hours as supplied and the prescribed LPM to arrive at the required liter hours per week.
 - iv. The provider would be able to enter testing results on CMN.
 - v. Note- provider and physician committee to work jointly on proposing CMN to CMS.
 - d. Patient classification would be changed upon the physician’s determination of a change in the patient’s medical condition and/or need (such change would be documented with updated CMN).
- 5.) **Payment for Services and Supplies-** Payments for these would be included (bundled) in the monthly allowable.
- 6.) **Patient Retesting-** The Secretary will establish a retesting process that allows:
- a. Home oxygen providers to facilitate re-testing of patients between 60 and 120 days when those patients had an acute diagnosis for whom home oxygen therapy was prescribed for the first time.

- b. The re-testing policy does not apply to patients whose diagnosis includes chronic respiratory disease, including, but not limited to, Chronic Obstructive Pulmonary Disease, 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.
- c. Oxygen retesting will be performed in accordance with current standards of practice and CMS regulations.

7.) **New Coding and Estimated Patient Mix **-**

New Code	Description	Est. Patient Mix **
Hxxxx	Category 1- H.O.T. services for non-mobile or nocturnal-only patient	30 to 40%
Hxxxx	Category 2- H.O.T. services for patient with standard portability needs (\leq 40 Liter-Hours per week)	40 to 50%
Hxxxx	Category 3- H.O.T. services for patient with high portability needs ($>$ 40 Liter-Hours per week)	15 to 25%

** This is an initial estimate of the potential range of the breakdown of Medicare beneficiaries on home oxygen within the three categories. It will be researched further and refined as the proposal is developed.

- 8.) **Establishment of Allowable Charges-** Legislative language would provide for defined allowable charges for first two years and related budget neutral assumptions. The allowable charges for Categories 1 and 3 would be based on a % relationship to the allowable for Category 2.
- 9.) **Updates to Allowable Charges-** Annual updates will be made to the allowable amounts based on the Consumer Price Index for Urban Consumers (CPI-U).
- 10.) **Establishment of Advisory Committee-** The HHS Secretary must establish and convene a meeting of a Home Oxygen Therapy Advisory Committee (HOTAC) pursuant to section 222 of the Public Health Service Act (42 U.S.C. 217a) within 6 months of enactment of this legislation.
 - a. The Advisory Committee will be comprised of members of the home oxygen therapy community, including, but not limited to, qualified home oxygen providers representing urban/rural markets and members that represent the diverse provider

community, patients, nurses, respiratory therapists, pulmonary and primary care physicians, providers, public health organizations, patient advocates, and manufacturers. A public health organization is a private entity and the term does not include public health agencies.

- b. The Committee must provide a forum for expert discussion and deliberation and the formulation of advice and recommendations to the Secretary regarding Medicare coverage for beneficiaries in need of home oxygen therapy, including:
 - i. Designing an Oxygen Patient Evaluation Form to be developed with consensus from the Advisory Committee;
 - ii. Selecting, modifying, and updating quality measures;
 - iii. Developing the objective, evidence-based clinical criteria used to define each of the ambulatory payment categories;
 - iv. Refining the patient services provided under this benefit;
 - v. Establishing a quality improvement program;
 - vi. Establishing appropriate case mix adjustment factors for home oxygen therapy services; and
 - vii. Evaluating a comparative effectiveness program that also would also include chronic care management.
- 11.) **Cost transparency-** Legislative language would provide for the HOTAC to work with the GAO or CMS on an industry cost study every three years.
- 12.) **Placeholder for Anti-Fraud and Abuse.** Language would incorporate by reference the American Association for Homecare recommendations for anti-fraud and abuse.
- 13.) **Placeholder for Beneficiary Protections Language.** Still needs to be reviewed by the sub-group of the NOC and be finalized by the full NOC.