Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ENTERAL NUTRIENT PAYMENTS IN NURSING HOMES

JUNE GIBBS BROWN
Inspector General

MARCH 1996
OEI-06-92-00861

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EXECUTIVE SUMMARY

PURPOSE

To determine whether Medicare Part B is paying too much for enteral nutrition therapy for nursing home residents.

BACKGROUND

Enteral nutrition therapy provides nourishment directly to the digestive tract of a patient who cannot, for a variety of reasons, ingest an appropriate amount of calories to maintain an acceptable nutritional status.

For this inspection, we gathered data on the utilization of enteral nutrition in nursing homes from 1992 Medicare payment records, surveyed nursing homes about their methods and costs of securing enteral nutrients for residents, and randomly surveyed 200 hospitals for nutrient purchase costs and quantity purchased annually. Additionally, we obtained proprietary data from IMS America concerning purchase patterns of various enteral nutrient products obtained from its 1994 fiscal year audit of nursing home pharmacies.

To assess the extent of enteral nutrition billed to Part B for nursing home residents, a sample of nursing homes was drawn and payment history extracted for calendar year 1992. Our two-stage stratified sample consists of 150 nursing homes randomly selected from 10 States (15 nursing homes per State). Data from the sample were projected to the total nursing home population (residents in Medicare or Medicaid-certified nursing homes).

This inspection was conducted as a part of Operation Restore Trust. The initiative, focused on five States, involves multi-disciplinary teams of Federal and State personnel seeking to reduce fraud, waste, and abuse in nursing homes and home health agencies, and by durable medical equipment suppliers.

FINDINGS

Medicare Part B payments for enteral nutrition are excessive.

- Medicare reimbursement for nutrients substantially exceeds purchase prices commonly available to nursing homes through volume purchasing and other contractual relationships, often by about 42 percent. For example, while Medicare pays $0.61 per 100 calorie unit for the most commonly used enteral product, nursing homes report they can buy the same nutrients for an estimated average price as low as $0.43 per unit.

- An estimated $170 million was allowed for enteral nutrients provided to about 5 percent of nursing home residents in 1992. Of this, Medicare paid an estimated $136 million. The remaining $34 million was paid by (or on behalf of) beneficiaries.

- Although nursing homes often can buy enteral nutrients at substantially below Medicare reimbursement levels, no incentives exist for them to exert their buying power and pass the savings on to the taxpayer.

Most charges (estimated 75 percent) are for Category I nutrients, the simplest and most readily available type.

- The most common enteral nutrients used in nursing homes are Ensure, Jevity, and Osmolite, which are considered basic food (these three products are readily available in the marketplace, are often purchased for use as a food supplement, and are considered by the Food and Drug Administration to be food).

RECOMMENDATIONS

Medicare reimbursement policies fail to recognize the ability of a nursing home to purchase nutrients and supplies at costs less than those incurred by the average beneficiary through bulk purchasing and institutional buying power. Nor do these policies provide incentives for the nursing home to exert its buying power to save the taxpayer money.

Further, and possibly more critical, current coverage of enteral nutrients does not recognize enteral nutrients as "food." If recognized as food, payment for enteral nutrients would be made as a part of the facility payment, rather than separately billed to Medicare Part B. Thus, the current excessive Part B payments would be eliminated, along with Medicare's exposure to fraud involving enteral nutrients when they are used as a food supplement (not covered by Medicare) rather than as the primary source of nutrition (covered by Medicare).

To address excessive payments for enteral nutrients, we offer the following options ***(each requiring legislation to implement)*** and our recommendation for consideration:

Options

1) Exclude enteral nutrients from Part B reimbursement when the patient resides in a nursing home.

2) Continue Part B reimbursement, but lower enteral nutrient reimbursement levels when provided to residents of nursing homes.

Recommendation

We support either option. However, we believe ***Option 1*** is preferable for several reasons. First, enteral nutrients represent a resident's food or meal while in the nursing home. Second, this option provides an incentive to nursing homes to exert their buying power to get preferred pricing on enteral nutrients. Third, incentives to overutilize enteral feeding will be removed. Fourth, this option is supportive of the Health Care Financing Administration's efforts to require consolidated billing for services provided in skilled nursing facilities. Finally, most enteral nutrient costs are roughly comparable to general nursing home meal costs.[1]

AGENCY COMMENTS

Both the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE) provided comments on this report. Both concur that Medicare is paying too much for enteral nutrients and support the recommendation's first option on the grounds that enteral nutrients are "food" and, thus, should not be billed separately to Medicare Part B. Rather, the cost of enteral nutrients should be included in a facility's costs and covered as a part of payment to the facility for the nursing home stay. The HCFA emphasizes legislation would be required to change current payment rules for enteral nutrients to implement this payment option.

The ASPE does express reservations about the impact of this recommendation on the general nursing home population whose nursing home stay is paid by other payers (e.g., Medicaid). We appreciate ASPE's concerns and wish to emphasize that the cost of enteral nutrients is comparable to that of a meal. Since meals are provided by the nursing home and paid by whomever is paying for the nursing home stay, we do not believe a change in reimbursement policy for enteral nutrients would pose a financial hardship on the beneficiary. However, to ensure this, exceptions might be made for some categories of enteral nutrients where it can be shown that costs substantially exceed general food costs.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To determine whether Medicare Part B is paying too much for enteral nutrition therapy for nursing home residents.

BACKGROUND

Enteral nutrition therapy provides nourishment directly to the digestive tract of a patient who cannot, for a variety of reasons, ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition consists of a liquid nutrient formula which is administered by tubing inserted through 1) the nose, 2) an incision to the small intestine, or 3) an incision leading to the stomach.

Enteral nutrients are covered as a routine cost during a Part A covered skilled nursing facility (SNF) stay, or are included in the daily rate when provided to a Medicaid-eligible nursing home resident. Section 1861h of the Social Security Act specifies covered extended care services to an individual in a skilled nursing facility stay. These services include "bed and board in connection with the furnishing of nursing care" and are considered routine services. Routine services (e.g., dietary) are expected to be provided by the nursing home.

Medicare Part A and Medicaid coverage includes enteral nutrition products when they are used to satisfy dietary needs and are provided by a nursing home. In such a case, these products are considered food. However, enteral nutrients provided by an outside supplier are currently not considered as a cost to the nursing home. Instead, they are covered under the Part B prosthetic device benefit.

Medicare guidelines classify enteral nutrition under the prosthetic device benefit because coverage under Part B is only for therapy required due to an absent or malfunctioning body part which normally permits food to reach the digestive tract. Nutrients are classified by the Health Care Financing Administration (HCFA) into six categories, based on the composition and/or product. (See Table 1.)

TABLE 1

Category	*HCPCS Category*	*Medicare Reimbursement per unit** (1993-1995)*	*Content Description*	*Examples of Products*
I	B4150	$0.61	Semi-synthetic intact protein isolates*	Ensure, Osmolite, Isosource, Jevity
I	B4151	$1.43	Natural intact protein/protein isolates*	Compleat-B Vitaneed
II	B4152	$0.51	Intact protein/protein isolates*	Comply, Ensure Plus, Nutren, Sustacal, Sustacal HN
III	B4153	$1.75	Hydrolized protein/protein isolates	Criticare HN Precision HN Travasorb HN
IV	B4154	Varies with product	Defined formula for specific metabolic need	Citrotein, Fulfill, Promote, Vivonex Plus
V	B4155	Varies with product	Modular components	Advera, Sumacal, Isosource VHN
VI	B4156	Varies with product	Standardized nutrients	Prevision LR, Travasorb STD, Vivonex STD

**** require effective digestive and absorptive processes for utilization (suitable only for patients with sufficient gastrointestinal function). (See Appendix A for further information on product classification.)***
***** 1 unit = 100 calories***

The HCFA's decision to consider enteral nutrients as a prosthetic benefit was in direct response to 1980 Congressional deliberations in which the House Ways and Means Committee expressed its concern that Medicare did not cover enteral therapy for non-institutionalized patients; although, in the view of the Committee, such coverage was warranted. The Committee directed the Secretary to "fully explore" the possibility of Medicare coverage for enteral products. However, it is unclear whether committee members intended that institutionalized patients be provided enteral nutrition by anyone other than the institution providing the care.

In July 1981, HCFA issued instructions providing coverage under the Part B prosthetic device benefit, in addition to the parenteral coverage under this benefit. The coverage of enteral nutrients under this provision, rather than as a home health benefit, is based upon several reasons. First, the beneficiary does not have to be homebound, as required to receive home health benefits. Second, there is no authority to pay for "drugs and biologicals and food under home health." Finally, "it is these items that represent the most costly component of enteral and parenteral therapy."

METHODOLOGY

For this inspection, we gathered data on the utilization of enteral nutrition in nursing homes from Medicare payment records for 1992, surveyed nursing homes about their methods and costs of securing enteral nutrients for residents, and randomly surveyed 200 hospitals for nutrient purchase costs and quantity purchased annually.

Additionally, we obtained proprietary data from IMS America. IMS is a private corporation that conducts marketing research in such areas as the medical community. Specifically, IMS routinely surveys different sectors of the business community concerning purchase patterns of various products. One audit regularly conducted by IMS obtains data for oral supplements purchased through nursing home pharmacies, or purchased by pharmacies that conduct a majority of business with nursing homes. Results from the 1994 fiscal year audit were obtained.

To assess the extent of enteral nutrition billed to Part B for nursing home residents, a sample of nursing homes was drawn and payment history extracted for calendar year 1992. Our two-stage stratified sample consists of 150 nursing homes randomly selected from 10 States (15 nursing homes per State). Those States were California, Delaware, Florida, Indiana, Kansas, Louisiana, Maine, Michigan, Montana, and Wyoming. Stratification was based on facility size (large, medium, and small).

Each sample nursing home provided us with a list of all Medicare eligible beneficiaries residing in that nursing home during 1992, along with each resident's corresponding dates of stay. After verification of the beneficiary's health insurance claim number (HICN) with the Medicare enrollment database, all Medicare services provided during the nursing home stay were extracted from the Medicare National Claims History File for calendar year 1992. The Part B services, processed by both the carrier and the intermediary, were identified. Data from the sample were projected to the total nursing home population (residents in Medicare or Medicaid-certified nursing homes).

This inspection was conducted as a part of the Presidential initiative, Operation Restore Trust (ORT). The initiative involves multi-disciplinary teams of Federal and State personnel seeking to reduce fraud, waste, and abuse in nursing homes, home health agencies, and involving durable medical equipment supplies.

Our review was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

** ***Unless stated otherwise, figures in this report are national estimates projected from a random sample*** **

FINDINGS

Medicare allowed an estimated $170 million for enteral nutrients.

At the 95 percent confidence level, we estimate that during 1992, between $130 and $210 million was allowed for enteral nutrients to approximately 112,830 nursing home residents in more than 15,000 nursing homes. This represents an estimated average bed day cost of $7.20 per day for enteral nutrition. The overall average daily charge, spread across all nursing home residents, is small at $0.36 per day. This is because only an estimated 4.7 percent of nursing home residents receive enteral nutrition which is reimbursed by Part B.

An average daily caloric intake of 1,800 multiplied by the cost of the lowest Part B reimbursement for enteral formulae ($0.51 per 100 calories) yields an expected daily charge for enteral nutrients of $9.18 per day. However, our estimated daily cost was only $7.20. This disparity can be explained if 1) the enteral nutrients were not provided for the entire duration of the nursing home stay, 2) the person received a portion of nutrient intake from other sources, or 3) the person was simply receiving supplemental feeding with enteral (which is not covered by Medicare). Also, it is possible that enteral nutrition was paid partially by other sources (e.g., Medicaid, private insurance). Further investigation is needed to establish the extent to which these or other factors account for the disparity noted.

Most charges (75 percent) are for Category I nutrients, the simplest and most readily available type.

The majority of enteral nutrient charges are for Category I ($140 million). Over 90 percent of the Category I charges ($128 million) are for products that fall under the B4150 product code and are termed semi-synthetic nutrients. These include recognizable liquid food brand names such as Ensure, Jevity, Osmolyte, and Isocal. The remaining charges are distributed among four additional categories, as shown in Figure 1.

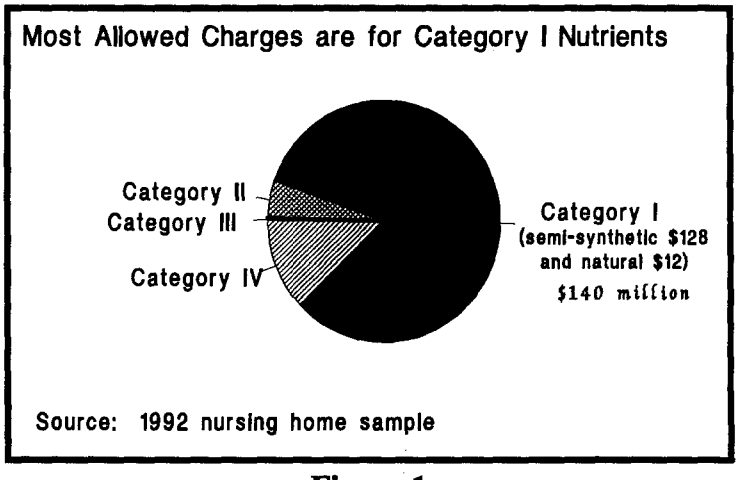

Figure 1

Surveyed nursing homes and hospitals most often purchase one of three products for enteral nutrition therapy. These products are Ensure, Jevity, and Osmolite. Each is manufactured by ROSS labs. Other products used for enteral nutrition therapy are manufactured by SANDOZ, MEAD JOHNSON, and CLINTEC.

SANDOZ markets Fibersource, Isosource, Meritene, and Resource. MEAD markets Isocal, Sustacal, and Ultracal. Finally, CLINTEC markets Nutren and Replete.

According to IMS data (see methodology), most purchases through pharmacies for enteral nutrients are about equally divided between Ensure, Fibersource, Isosource, and Ultracal. The difference between what nursing homes and hospitals reported and the IMS data may be explained by the likelihood that most common (off-the-shelf) enteral products (Ensure, Jevity, and Osmolite) are purchased through the nursing home's dietary center (often directly from ROSS Labs or a supplier) rather than through the nursing home's pharmacy or other pharmaceutical supplier. The IMS data focused on food supplements purchased through pharmacies.

Medicare payments for enteral nutrients for nursing home residents are excessive because reimbursement rates are set too high.

Data from several sources confirm that nursing homes can purchase enteral nutrients at significantly lower prices than current Medicare reimbursement levels. To illustrate, Medicare reimbursement for Category I semi-synthetic enteral nutrients (B4150) is $0.61 per 100 calorie unit. The average cost at which nursing homes can buy this category of nutrient product (according to nursing homes in our sample) was estimated to be $0.43 per unit for their most frequently used product *(thus Medicare is paying on average 42 percent more).* Proprietary data gathered by IMS validates this finding, showing an identical average estimated purchase cost of $0.43 for Category I nutrients.

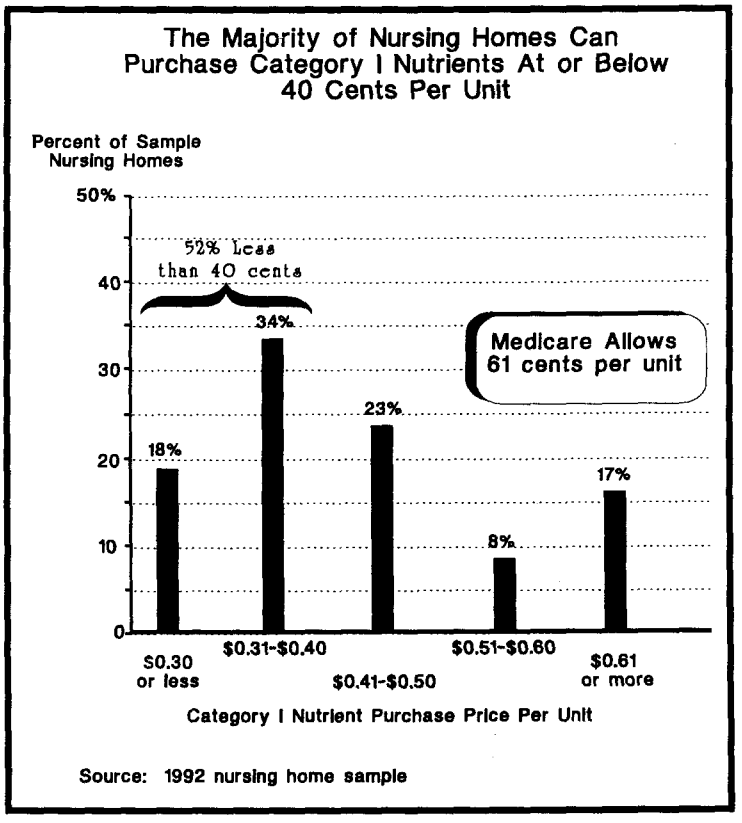

Figure 2

While the average cost is $0.43 per 100 calories, the majority of nursing homes pay less than the average and 83 percent pay less than the Medicare allowable amount. (See Figure 2.)

Of the 17 percent of nursing homes reporting enteral costs in excess of Medicare reimbursement, it is not clear whether the nursing home actually loses or would lose money if nutrients were purchased by the nursing home.

In the sample nursing homes reporting purchase costs above $0.61, contact with the nursing home revealed that outside suppliers were billing Medicare, or that a contractual relationship exists with the supplier causing the nursing home to pay more. Thus, the nursing facility incurred no losses directly related to Medicare reimbursement. In only one case did the supplier ask the nursing home to pay additional costs beyond the Medicare allowed amount. This nursing home experienced high enteral nutrient costs because the nursing home had entered into a contractual relationship with a supplier to exclusively purchase supplies. The pricing was artificially high because of the contractual terms whereby the supplier was able to demand high payments from the nursing home in order to repay loans made by the supplier when the nursing home was constructed.

Medicare costs are also higher because most nursing homes (75 percent) do not directly purchase enteral nutrients for residents, but instead, allow outside suppliers to provide them and bill Medicare.

Although a majority of nursing homes report being able to purchase nutrients below Medicare reimbursement levels, most nursing homes (an estimated 75 percent) prefer having an outside supplier provide, and bill Medicare for, the nutrients used by Medicare residents. These suppliers, in turn, bill Medicare at or above the established maximum reimbursement levels. Even when a nursing home provides the nutrients (25 percent), it typically acts as a supplier, billing Medicare Part B at current reimbursement levels rather than at or slightly above its actual procurement costs.

Survey results indicate many suppliers (30 percent) are directly affiliated with the nursing home. This affiliation could be contractual (29 percent) or through common ownership (49 percent). The remaining 22 percent were unspecified by the nursing home respondents.

Additionally, many suppliers (at least one-third) provide supplies to the nursing home on a consignment basis, with billing supposedly done after items are used. This practice exemplifies the lucrative nature of the nursing home supply business. In few other businesses are products provided first and billed for later. Nor is it common for businesses to store merchandise at the nursing home until used. Medical products are more commonly bought in advance for a specific resident.

With no incentive to purchase nutrients below Medicare reimbursement levels, it is not surprising that some nursing homes report purchase prices at or above Medicare reimbursement levels.

While the average cost for enteral products in each reimbursement category is far below what Medicare allows, the range within categories is more extreme. Some nursing homes pay far more than the Medicare rate for nutrients, while others pay substantially less than the average prices reported above. In category B4150, for example, prices ranged from $0.11 to $0.88. Interestingly, in two reimbursement categories (B4151 and B4154), no nursing home reported

paying more than Medicare reimbursement. (See Table 2.) Additionally, no significant cost differences were identified between States.

Table 2

Nutrient Category	Category I Semi-synthetic B4150	Category I Natural B4151	Category II Intact Protein B4152	Category III Hydrolized Protein B4153	Category IV Defined Formula B4154
Medicare Pays	$0.61	$1.43	$0.51	$1.74	$1.14
Most Paid by a Nursing Home	$0.88	$1.15	$0.88	$2.08	$0.95
Least Paid	$0.11	$0.47	$0.13	$1.05	$0.40

Hospitals, on the other hand, and many nursing homes obtain preferred pricing on enteral nutrients through buying groups or by arranging other contractual relationships with vendors.

Based on a random survey of 200 hospitals, Category I semi-synthetic nutrients are purchased at an average of only $0.35 per 100 calorie unit. Unlike nursing homes, hospitals do have an incentive to keep their costs down. This is because Medicare pays a fixed amount for each type of hospital admission no matter what costs that hospital incurs. This average represents a good proxy for the best overall average price available in the community. Hospitals report negotiated pricing or membership in buying groups as their primary methods for securing low costs for products such as enteral nutrients.

Exhibiting a similar ability to negotiate preferred pricing, sampled Veterans Administration hospitals reported routinely purchasing Category I nutrients at a comparably low rate. Some Veterans Administration hospitals reported costs as low as $0.12 per 100 calories.

Although most buying groups representing hospitals and nursing homes were reluctant to provide contract pricing to us, a few did provide such information. One of these buying groups offered Category I semi-synthetic nutrients to member hospitals and affiliated nursing homes for as little as $0.16 per unit (100 calories). Another buying group offered a slightly higher price of only $0.25 per unit.

Use of enteral nutrition varies between States and, especially, between nursing homes.

In our ten-State nursing home sample, estimated use of enteral nutrition therapy ranged from a high of eight percent of resident stays in Louisiana to a low of one percent in Maine and Wyoming. (See Figure 3.)

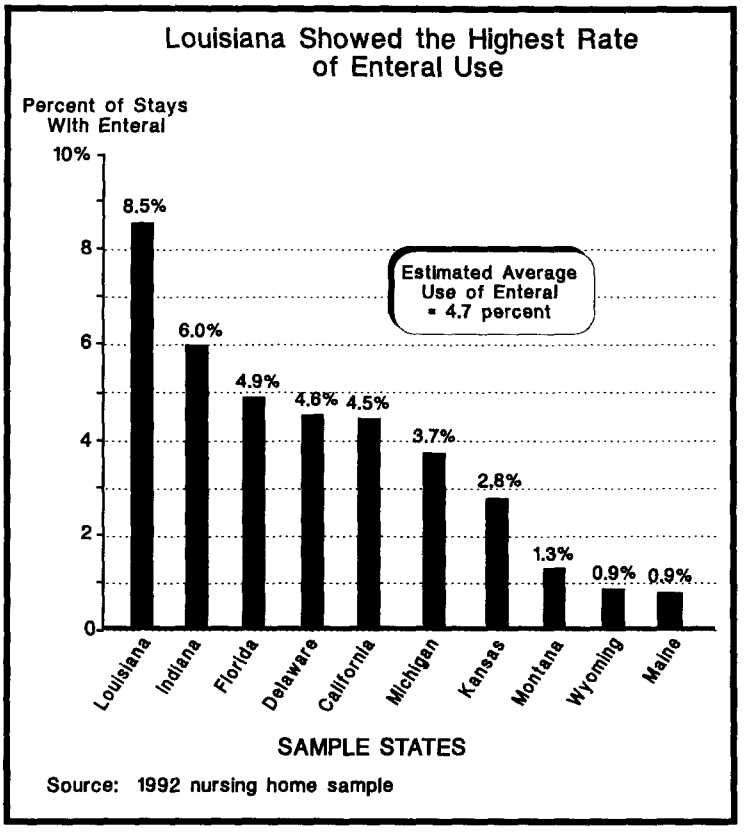

Figure 3

We cannot explain Louisiana's higher overall Medicare covered enteral nutrition use without further work. However, we can speculate that either a higher percentage of nursing home residents in Louisiana need tube feedings or Louisiana's uncommon Medicaid policy of not including enteral nutrients under its nursing home daily rate increases billing to Medicare Part B.

Some nursing homes showed heavy use of enteral nutrients relative to the majority of nursing homes. In many cases, this heavy use was not explained by the certification status of the facility or the level of SNF residents in the facility. For example, 20 percent of facilities certified as Medicaid-only provided enteral nutrients to more than 10 percent of their resident populations. In contrast, none of the Medicare-only SNF facilities exceeded five percent and only 10 percent of the dually-certified facilities exceeded this amount. Such high levels of

enteral nutrient use raise quality of care, as well as excessive cost, concerns. If residents are being tube fed as a convenience to the facility, rather than as a necessity to the well being of the resident, abuse is occurring. Further study is needed to validate the prevalence of inappropriate enteral tube feedings.

RECOMMENDATIONS

Medicare reimbursement policies fail to recognize the ability of a nursing home to purchase nutrients and supplies at costs less than those incurred by the average beneficiary through bulk purchasing and institutional buying power. Nor do these policies provide incentives for the nursing home to exert its buying power to save the taxpayer money.

Further, and possibly more critical, current coverage of enteral nutrients does not recognize enteral nutrients as "food." If recognized as food, payment for enteral nutrients would be made as a part of the facility payment, rather than separately billed to Medicare Part B. Thus, the current excessive Part B payments would be eliminated, along with Medicare's exposure to fraud involving enteral nutrients when they are used as a food supplement (not covered by Medicare) rather than as the primary source of nutrition (covered by Medicare). Additionally, Medicare's exposure to duplicate payments would be eliminated.

To address excessive payments for enteral nutrients, we offer the following options ***(each requiring legislation to implement)*** and our recommendation for consideration:

PAYMENT OPTIONS

OPTION 1 ***Exclude enteral nutrients from Part B reimbursement when the patient resides in a nursing home.***

Option 1A: Exclude enteral nutrient payments for anyone in a nursing home, regardless of payment status (Part A Medicare extended care benefit, Medicaid covered stay, or private pay resident).

Option 1B: Exclude enteral nutrient payments for anyone in a nursing home whose stay is paid by Medicare or Medicaid. Thus, Medicare Part B would continue to pay part B for private pay residents only.

OPTION 2 ***Continue Part B reimbursement, but lower enteral nutrient reimbursement levels when provided to residents of nursing homes.***

Option 2A: Move enteral nutrient reimbursement to a fee schedule, with a reduction to the fee schedule, if a nursing home is involved. Base fee schedules on average retail pricing. Implement a modifier which causes a reduction to the fee schedule if a nursing home resident is involved.

Option 2B: Continue the current reimbursement system and apply inherent reasonableness to the charges for nursing home residents.

Cost Savings: The exact amount of savings that could be obtained by the Federal government, in implementing this recommendation, depends on a number of factors, including the specific option selected, and programmatic controls implemented to expressly allow or expressly prevent cost shifting to other parts of the program, the Medicaid program, or beneficiaries.

For example, by simply not paying for enteral nutrition products under Medicare Part B, the Medicare program could save $136 million per year. However, if some of these costs were shifted to other sources, including Medicare Part A, savings could be reduced or even eliminated. If Medicare Part B continued to pay for enteral products, but reimbursed nursing homes at a lower fee schedule amount, reflecting the reduced prices they could obtain for these products, savings of $41 million to the Medicare program would result, as well as $10 million to beneficiaries or their representatives in reduced coinsurance.

RECOMMENDATION

We support either option. However, we believe Option 1 (either A or B) is preferable for the following reasons:

- ***It is Food*** - the Food and Drug Administration categorizes enteral nutrient products as food. Medicare does not typically reimburse for dietary expenses unless provided in an institutional setting and then only to the institution.

- ***Incentives to nursing homes*** - this option provides an incentive to a nursing home to exert its buying power to get preferred pricing on nutrients, given Medicare's expectation and enforcement of prudent buying practices. Also, since nursing homes would make little or no profit from nutrients, no incentives would exist to over-utilize enteral feeding.

- ***Consistent with Rebundling*** - it is consistent with HCFA's effort to consolidate billing for services provided in skilled nursing facilities.

- ***Covered in the Medicaid Daily Rate*** - virtually all Medicaid agencies consider enteral nutrients a supply covered under the daily rate.

- ***Part B Payment Policy is Inconsistent*** - Medicare will not pay for a wheelchair in a nursing home (DME is noncovered unless provided in the beneficiary's "home"); however, Part B pays for enteral nutrients. If a nursing home is expected to provide a wheelchair at no additional cost to the beneficiary, why is a beneficiary's meal (enteral) an additional cost to Part B and the beneficiary?

- ***Enteral Costs and Typical Meal Costs are Roughly Comparable*** - it can be argued that, at a minimum, Category I and II nutrient costs ($6-$8 per day), are about equivalent to the daily cost of meals provided in a nursing home (cost of food plus preparation - $7).[1] Consequently, beneficiaries should receive enteral feeding nutrients as a facility reimbursed cost, just as a meal would be.

These conclusions and recommendations will be shared with appropriate Federal and State entities involved in Operation Restore Trust.

COMMENTS

Both the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE) provided comments on this report. Both concur that Medicare is paying too much for enteral nutrients and support the recommendation's first option on the grounds that enteral nutrients are "food" and, thus, should not be billed separately to Medicare Part B. Rather, the cost of enteral nutrients should be included in a facility's costs and covered as a part of payment to the facility for the nursing home stay. The HCFA emphasizes legislation would be required to change current payment rules for enteral nutrients to implement this payment option.

The ASPE does express reservations about the impact of this recommendation on the general nursing home population whose nursing home stay is paid by other payers (e.g., Medicaid). We appreciate ASPE's concerns and wish to emphasize that the cost of enteral nutrients is comparable to that of a meal. Since meals are provided by the nursing home and paid by whomever is paying for the nursing home stay, we do not believe a change in reimbursement policy for enteral nutrients would pose a financial hardship on the beneficiary. However, to ensure this, exceptions might be made for some categories of enteral nutrients where it can be shown that costs substantially exceed general food costs.

ENDNOTES

1. The following are dietary costs provided from Texas nursing homes in the 1993 Medicaid cost report. Expressed as average per diem expenses, they represent a good approximation of the cost of food for nursing home residents.

Food (fresh, frozen, canned, etc.)	$3.30
Food staff	$2.88
Supplies (dishes, utensils, etc.)	$0.32
Miscellaneous	$0.42
Total Average Daily Cost	$6.92

APPENDIX A

CATEGORIZATION OF PRODUCTS INTO PROCEDURE CODES

CATEGORY 1 - B4150

Attain
Attain LS
Attain KDS
Ensure
Ensure HN
Ensure Powder
Ensure with Fiber (Enrich)
Entera
Entera Isotonic
Entera Isotonic Fiber
Entralife HN
Entralife HN Fiber
Entralife HN-2
Entrition HN
Fiberlan
Fibersource
Fibersource HN
Fortison
Hearty Balance
Introlite
Isocal
Isocal HN
Isocal II
Isofiber
Isolan
Isomil
Isosource
Isosource HN
Jevity
Lonalac
Meritene
Newtrition (Flavors)
Newtrition HN
Newtrition Isofiber
Newtrition Isotonic
Nitrolan
Nutrapak
Nutren 1.0
Nutren 1.0 with Fiber
Nutrilan
Osmolite
Osmolite HN
Pediasure
Pediasure with Fiber
Portagen
Pre-Attain
Profiber
Replete
Resource
Susta II
Sustacal
Sustacal Fiber
Ultracal

CATEGORY 1 - B4151

Compleat-B
Compleat-B Modified
Vitaneed

CATEGORY II - B4152

- Comply
- Ensure Plus
- Ensure Plus HN
- Entrition 1 ½
- Isocal HCN (Deliver 2.0)
- Isotera Isotonic
- Lipisorb
- Maganacal
- Newtrition 1 ½
- Nutren 1.5
- Nutren 2.0
- Nutrivent before 5/93
- Resource Plus
- Respalor
- Sustacal HC
- Sustacal Plus
- Twocal HN
- Ultralan

CATEGORY III - B4153

- Accupepha
- Criticare HN
- Isotein
- Precision HN
- Precision Isotera
- Reabilan
- Travasorb HN
- Vital HN
- Vivonex HN

CATEGORY IV - B4154

- Alitraq
- Citrotein
- Fulfil SLD
- Peptomin VHP
- Promote
- Promote with Fiber
- Vivonex Plus

CATEGORY IV LOCAL CODES ***(XX - temporary Codes developed by DMERCs)***

- Accupep HPF (XX030)
- AmidAid (XX031)
- Entera OPD (XX032)
- Glucerna (XX033)
- Hepatic Aid (XX034)
- Impact (XX035)
- Impact with Fiber (XX036)
- ImunAid (XX037)
- Lipisorb (XX038)
- Nepro (XX039)
- New Replete (XX040)
- New Replete with Fiber(XX041)
- NutriHep (XX042)
- Nutrivent after 5/93 (XX043)
- Peptamen (XX044)
- Peprative (XX045)
- Pregestimil (XX046)
- Protain XL (XX047)
- Provide (XX048)
- Pulmocare (XX049)
- Reabilan HN (XX050)
- Suplena (Replena) (XX051)
- Stresstein (XX052)
- Traumacal (XX053)
- TraumAid HBC (XX054)
- Travasorb Hepatic (XX055)
- Travasorb Renal (XX057)
- Vivonex TEN (XX058)

CATEGORY V LOCAL CODES

- Casec (XX059)
- Conrtolyte (XX060)
- Polycose (XX068)
- Promod (XX069)

Elementra (XX061)
Fibrad (XX062)
Lipomul (XX063)
MCT Oil (XX064)
Microlipid (XX065)
Moducal (XX066)
Nutrisource (XX067)
Promix (XX070)
Propac (XX071)
Sumacal (XX072)
Advera (XX073)
Crucial (XX074)
Diabetasource (XX075)
Isosource VHN (XX076)

CATEGORY VI - 84156

Prevision LR Powder
Tolerex
Travasorb STD Powder
Vivonex STD Powder

APPENDIX B

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of the Secretary

Washington, D.C. 20201

JAN 16 1996

TO: Claudia Cooley
Executive Secretary

FROM: Acting Assistant Secretary for
Planning and Evaluation

SUBJECT: Formal Comments Regarding OIG Draft Reports On Medicare Payments for Services Provided to Nursing Home Residents

In our earlier response to the three OIG reports on Medicare payments for nursing home residents, we expressed concern that the reports could inadvertently lead to the conclusion that Medicare Part B payments should not be made on behalf of nursing home residents and that we would discuss this concern and other issues during a meeting with OIG staff on December 12, 1995. As a result of this discussion between ASPE and OIG staff the following formal ASPE comments are offered regarding the three OIG reports entitled "Part B Services in Nursing Homes - An Overview," "Durable Medical Equipment Payments in Nursing Homes," and "Enteral Nutrients Payments in Nursing Homes".

Enteral Nutrients Payments in Nursing Homes

We agree with the OIG conclusion that food should be considered a basic nursing home service that is included in a nursing home payment rate. In addition, we agree that enteral nutrition is a way for certain persons to meet daily nutritional requirements. Further, we agree, to the extent that the costs of enteral nutrition are comparable to the costs of meals for the general nursing home population, that the costs of enteral nutrition should be included in the basic nursing home payment rate. Based on the preceding, we agree that Medicare Part B payments for enteral nutrition should not be made on behalf of persons residing in nursing homes.

However, we recommend the report note that the extent to which other payers (e.g., Medicaid) take into account the costs of enteral nutrition or meals for the general nursing home population is unknown, and, as a result, the impact on nursing home residents of a policy prohibiting Medicare Part B payments for enteral nutrition is unknown.

Durable Medical Equipment (DME) Payment in Nursing Homes

We are opposed to the OIG recommendation to expand the current prohibition on Part B DME payments on behalf of persons in a Part A covered SNF stay to also include persons in non-Part A covered stays. At this time, there is no agreement on the core services that should be included

in a nursing home payment rate. As a result, we are unable to identify which Medicare Part B DME payments are made for routine nursing home services (i.e., services that should be included in a nursing home payment rate) and which are not. Further, while we understand current law limits Part B DME to persons who are residing in their "home," it is not clear when a nursing home resident (i.e., in non-Part A covered stay) is permanently residing in such a facility, and, thus, is at home in the facility, versus a resident that is receiving short-term care and intends to return home. To ensure that beneficiaries are not inappropriately denied needed coverage, a policy prohibiting Part B DME payments to all nursing home residents would have to assume that Part B DME payments are for routine or core nursing home services and that there are no long-term, permanent nursing home residents for whom the nursing home has, in fact, become their home. We do not believe that these are accurate assumptions. Further, we are concerned that denying Medicare Part B DME payments to nursing home residents could have a negative effect on their quality of care. Therefore, we believe, at least in the interim, the Department should presume that nursing home residents in a non-Part A covered SNF stay are residing in their "home" and permit Part B DME payments on behalf of such residents in need of these supplies. We recommend the OIG study this issue and recommend a categorization of equipment routinely covered in nursing home payment rates and DME not routinely included in such rates. A review of State Medicaid nursing facility payment methods may provide some insight into this issue.

Finally, we recommend that the conclusion of this report clearly indicate that Part B DME payments made within a week of discharge for any nursing home resident (regardless of payer) who is eligible for Part B are appropriate to facilitate discharge planning.

Part B Services in Nursing Homes

We recommend including in the Background section a discussion of the circumstances under which Medicare Part B payments on behalf of nursing home residents are appropriate, the difficulties in identifying when such payments are inappropriate, and the variable impact that proposals to limit Medicare Part B payments will have on different nursing home residents (i.e., those in a Part A covered SNF stay, those who are not, and those who are also eligible for Medicaid) and on State and Federal governments.

We understand that the OIG intends to undertake a study of State Medicaid nursing facility payment rates and methods. We agree that such a study is needed in order to understand when duplicate payments have been made (i.e, Medicare and Medicaid both have paid) and when Medicaid cost sharing is inappropriate.

Peter Edelman

Peter Edelman

HEALTH CARE FINANCING ADMINISTRATION
COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE DEC 15 1995

TO June Gibbs Brown
Inspector General

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General Draft Report: "Enteral Payments in Nursing Homes," (OEI-06-92-00861)

We reviewed the subject draft report which discusses whether Medicare Part B is paying too much for enteral nutrition therapy for nursing home residents.

Our detailed comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments further.

Attachment

Health Care Financing Administration (HCFA) Comments
on Office of Inspector General (OIG) Draft Report:
"Enteral Nutrient Payments in Nursing Homes."
OEI-06-92-00861

OIG Recommendation

HCFA should consider ways to address excessive payments for enteral nutrients. Two options are offered.

OPTION 1

The HCFA should exclude enteral nutrients from Part B reimbursement when the patient resides in a nursing home.

OPTION 2

The HCFA should continue Part B reimbursement, but lower enteral nutrient reimbursement levels when provided to residents of nursing homes.

HCFA Response

We concur with Option 1. We believe this option is consistent with HCFA's efforts to control overutilization by encouraging nursing homes to exert buying power to get preferred pricing on nutrients and by removing the incentive to overutilize enteral feeding. As defined by the Food and Drug Administration, most, if not all, enteral nutrient products are considered food. Thus, with changes in the statute that currently defines enteral nutrients as a prosthetic device, these products could be included in Medicare Part A payments. This option is also consistent with HCFA's current attempt to consolidate billing for services provided in skilled nursing facilities.

Technical/General Comments

1. Include in the Executive Summary a condensed version of the methodology found in the body of the report.

2. State more clearly that all figures are estimates or projections. (The report was based on 5-percent sample data).

3. Include data on the cost of a "meal" versus the cost of "enteral feedings."

4. State in the Executive Summary (and more forcefully in the body of the report) that both options would require legislation.

OPERATION RESTORE TRUST AND NURSING HOMES

On May 3, 1995, President Clinton announced a new anti-fraud initiative undertaken by the Department of Health and Human Services. Led by the Office of Inspector General in partnership with the Health Care Financing Administration and the Administration on Aging, this project utilizes the expertise of many Federal, State, and private sector personnel. They will direct their combined energies to crack down on Medicare and Medicaid fraud, waste, and abuse initially associated with home health agencies, nursing homes, hospices, and durable medical equipment suppliers. They will work closely with the Department of Justice and an intergovernmental team comprised of other Federal and State personnel.

In addition to identifying and penalizing those who defraud the government, the project is designed to alert the public and industry to the fraud schemes or vulnerable areas in policy. To aid in this endeavor, the Office of Evaluation and Inspections will work within the Office of the Inspector General to perform its primary mission of conducting evaluations that provide timely, useful, and reliable information and advice to the pertinent decision makers involved in the demonstration. To this end, the following reports on nursing homes have been completed:

Medicare Services Provided to Residents of Skilled Nursing Facilities (OEI-06-02-00863)

Medicare Payments for Nonprofessional Services in Skilled Nursing Facilities (OEI-06-92-00864)

Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays (OEI-06-92-00860)

Part B Services in Nursing Homes - An Overview (OEI-06-92-00865)

Enteral Nutrient Payments in Nursing Homes (OEI-06-92-00861)

Durable Medical Equipment Payments in Nursing Homes (OEI-06-92-00862)

Ongoing evaluations are being conducted related to Medicare payments for residents of nursing homes for such services as mental health therapy, wound care, imaging, hospice, ambulance transportation, and nail debridement. Also under review are duplicate payments between Medicare and Medicaid for nursing home services.