Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Payments For Enteral Nutrition Therapy Equipment and Supplies in Nursing Homes

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To describe the extent of Medicare Part B payments and potential vulnerabilities related to enteral nutrition therapy equipment and supplies for nursing facility patients and to discuss possible alternative Medicare payment policies.

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. Medicare covers enteral nutrition therapy under the prosthetic device benefit, because the therapy is required due to an absent or malfunctioning body part (which would normally permit food to reach the digestive tract). Enteral nutrition therapy supplies typically include tubing, bags to hold nutrient formulas, and syringes. Equipment involves infusion pumps and intravenous (I-V) poles. Enteral nutrient formulas (e.g., ENSURE, JEVITY) were separately covered in our report, "Enteral Nutrient Payments in Nursing Homes" (OEI-06-92-00861).

For this inspection, we reviewed Medicare payment policy and gathered data on the utilization of enteral nutrition therapy equipment and supplies in Medicare- or Medicaid-certified nursing facilities from a 1 percent sample taken from the Medicare National Claims history file for calendar years 1992-95.

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 facilities and home health agencies, as well as by durable medical equipment (DME) suppliers.

FINDINGS

The costs for equipment and supplies associated with enteral nutrition therapy are substantial, totaling approximately $260 million in 1995. This includes such items as intravenous (I-V) poles, infusion pumps, feeding kits, and tubing.

Equipment used for enteral nutrition therapy meets the definition of durable medical equipment (DME), which is not covered during a typical nursing facility stay. Although Medicare pays for durable medical equipment like beds, wheelchairs, canes, crutches, oxygen concentrators, and intravenous I-V poles when used in patients' homes, it does not make separate payments for them in nursing facilties. These items are considered standard equipment for nursing facility operations and are covered as part of the daily rate that Medicare or Medicaid pay for the stay. However, Medicare does pay for equipment used in connection with enteral feeding in nursing facilities, even if the same equipment would not otherwise be covered. An example is the simple I-V pole. Recently (1994), Medicare began paying for such poles when used for enteral feeding, but not for other

purposes. As a result, Medicare paid $3.4 million that year, and $3.5 million in 1995, for I-V poles used in nursing facilities.

Equipment used for enteral nutrition therapy costs more than identical equipment billed under the DME fee schedule. Not only does Medicare pay for enteral feeding equipment in nursing homes, but it pays more than if payment was based on the DME fee schedule. Again, the I-V pole is a good example. If it is used for enteral nutrition, it is reimbursed at the monthly rental rate of approximately $24. In contrast, the same I-V pole used to hang cancer fighting intravenous solutions in a resident's home is reimbursed using the DME fee schedule at a monthly rental rate of approximately $17. This represents a 29 percent reimbursement difference.

Current Medicare payment policy for enteral nutrition therapy equipment and supplies fails to capitalize on market forces and efficiencies available to nursing facilities, which could substantially reduce costs. Payment rates for feeding supply kits and equipment exceed market costs. As an example, we estimate that Medicare could be paying nearly three times the cost of the necessary components billed as a supply kit. In 1995, the excessive payments could have exceeded $140 million (65 percent of $216 million). Additionally, the potential exists for overutilization of expensive delivery systems utilizing infusion pumps. In 1995, most patients (85 percent) utilized the more costly pump delivery method. Discussion with program integrity staff at the DMERCs confirms that cases of medically unnecessary billing for pumps has occurred. In some of these cases, it is suspected that the pump, rather than gravity feeding, is used more for the convenience of the nursing facility staff than based on a patient's need for the more costly controlled delivery system.

RECOMMENDATIONS

This report is not intended to suggest that suppliers or nursing facilities are submitting false claims for equipment and supplies associated with nutrition therapy. Rather, the purpose is to illustrate an area of Medicare payment which is vulnerable to excess and conflicts with other related payment policies. Approaches to solve vulnerabilities and wasteful spending associated with enteral nutrition therapy payment policy range from resolving specific areas of identified excess to restructuring the global payment mechanism for Medicare services provided to nursing facility patients. The following discussion describes these two approaches.

APPROACH I: Addressing Specific Payment Areas

I-V Poles

The Health Care Financing Administration (HCFA) should take appropriate action to prevent excessive payments for the rental and purchase of I-V poles used in nursing facilities. We recommend that total rental payments be limited to the purchase cost of the pole and that the following two options be considered:

Option 1: Utilize the lower of the enteral nutrition payment and the DME fee schedule payment. Annual savings could be $1.3 million ($0.4 million due to limitations on total rental payments and $0.9 million (29 percent of the remaining $3.1 million) based on limiting payment to the lower of the fee schedule or the reasonable and customary charge).

Option 2: Evaluate the inherent reasonableness of payment rates under reasonable charge.[1] Payment levels for residents of nursing facilities should be based on a typical facility's ability to purchase I-V poles economically. Annual savings could exceed $0.9 million assuming HCFA's inherent reasonableness study finds the typical monthly rental rates are $17 or less, instead of the current $24.

Feeding Supply Kits

The HCFA should take appropriate action to prevent excessive payments for supplies related to enteral nutrition therapy. We recommend three options be considered:

Option 1: Review the inherent reasonableness of payment rates. Annual savings could be as much as $140 million (assuming the payment rate is set at a price 65 percent below 1995 allowed charges of $216 million).

Option 2: Place these supplies on a fee schedule (seek legislation if necessary). If fee schedule rates are set conservatively at 75 percent of current rates, annual savings could exceed $54 million.

Option 3: Discontinue payment for the "kit" and establish codes specific to each necessary component of the kit. One code might be established for the bag (with tubing) and the other code would be for the syringe. Assuming the payment rate for each new code is set at the lowest price we identified (see body of report) and assuming no other items are deemed to be necessary, annual savings could be as much as $140 million.

Enteral Infusion Pumps

We did not separately examine the reasonableness of Medicare payments for pumps; however, based on our finding that Medicare Part B payments for I-V poles, supply kits, and nutrient formulas (discussed in a prior report) appear to be excessive, HCFA should consider beginning a review of the appropriateness of payment rates for pumps. Assuming HCFA's review yields a disparity between nursing facility costs and Medicare payment rates similar to those found for I-V poles (29 percent difference), the annual savings could exceed $10.3 million.

APPROACH II: Global Payment Restructuring

Structural changes in the way Medicare pays for services provided to nursing facility patients may address some or all of our concerns with enteral nutrition therapy payments.

Structural changes include 1) folding payment into the nursing facility per diem (daily rate), 2) consolidated billing, 3) competitive bidding strategies, and 4) capitation payments. Each of these strategies attempts to take advantage of the ability of nursing facilities to more economically provide services and supplies to their patients with the cost savings passed on to Medicare. Additionally, these payment mechanisms recognize the importance of the nursing facility in achieving a more cost effective program. Since nursing facilities are significantly involved in the planning and provision of patient care, they, arguably, are the most appropriate entity to scrutinize providers and determine the most cost effective methods of obtaining and utilizing the services and supplies needed to meet the medical needs of their patients.

The following summarizes some of the options HCFA is or should be considering.

A. Folding Payment into the Per Diem

Institutions are expected to provide certain routine equipment and supplies in addition to the cost of room and board. Generally, nursing facilities are reimbursed for these services based on a daily per diem payment. By including enteral nutrition therapy as a part of the per diem payment, Medicare could reduce the overall cost of providing care. Savings to Medicare Part B would total approximately $260 million based on 1995 data. However, some or all of the savings could be passed on as costs to States (for dually eligible patients), Part A (for Medicare skilled nursing facility (SNF) patients), and to beneficiaries (in the case of private pay patients). The extent of savings depends on the routine charge limits Medicare and Medicaid impose, exceptions to these limits, and the extent to which nursing homes act as prudent purchasers.

B. Consolidated Billing

Consolidated billing involves a policy that restricts anyone but the nursing facility from billing for Part B services the nursing facility is authorized to furnish. Currently, HCFA is considering a consolidated billing proposal for routine nursing facility services provided to Medicare SNF patients. We support HCFA's efforts in this area. By making the nursing facility the focal point of services to its patients, the nursing facility is far more accountable for patient care. Further, such an approach lessens opportunities for fraud and abuse by outside suppliers and makes Government monitoring efforts less complicated. While we are unable to determine the savings that could result from such a policy change, if payment rates are modified to reflect the impact of a nursing facility's buying power, substantial savings could be realized. Assuming enteral nutrition therapy payment rates are reduced by 25 percent (a conservative estimate given estimates of excessive payment levels noted in the report), savings of $65 million could be realized based on 1995 data.

C. Competitive Bidding

As another cost saving option, the Government could establish competitive bidding contracts to provide nursing facilities with access to services and supplies at lower costs than currently available. Additionally, such contracts could provide enhanced access to patient care services and supplies. We support HCFA's efforts in this area. Currently, HCFA is evaluating the potential for competitive bidding. Any competitive bidding strategy should include enteral equipment and supplies. Assuming competitive bidding results in pricing at or below the costs noted in this report, savings could total $152 million ($140 million for supply kits, $1.3 million for I-V poles, and $10.3 million for pumps).[2]

D. Capitation

Another option would be to switch payment for Part B services in nursing facilities from a fee-for-service mode to a flat rate per beneficiary. Capitation would provide incentives to the nursing facility to provide services in the most economical fashion. This is because Medicare will not pay more if the nursing facility utilizes a more costly approach (e.g., provides a more costly service although less expensive equally effective alternatives exist or the nursing facility is not purchasing services and supplies as a prudent purchaser). By setting the capitation payment at 75 percent of the 1995 average allowed charge for equipment and supplies, the savings would be $65 million.

Although we support all of the options raised in this report, we believe restructuring Medicare's payment mechanism for Part B services to patients of nursing facilities (Approach II) is most responsive to our overall concerns. Enteral nutrition therapy is but one example of the possible benefits from changes to current policy which will ensure Medicare is paying the most reasonable cost. Payment mechanisms that utilize a nursing facility's capability to purchase medical supplies more cost effectively than the average beneficiary offer the greatest potential. We recognize that further study would be needed to assess the relative costs and benefits of the global options and the extent of cost shifting to other programs, States, and beneficiaries. Finally, we recognize that any efforts to modify the enteral nutrition therapy benefit and global restructuring strategies will require legislation and must be accompanied by adequate protections for nursing facility patients.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration (HCFA). (See Appendix B for the full text.) The HCFA concurred with the recommendations made in this report. To resolve identified problems noted in this report, HCFA is pursuing a number of actions such as evaluating the reasonableness of payment for pumps and I-V poles, applying DME reimbursement criteria to I-V pole coverage, and pursuing research of broader payment restructuring through capitation, competitive bidding, and bundling of enteral nutrition services.

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INTRODUCTION

PURPOSE

To describe the extent of Medicare Part B payments and potential vulnerabilities related to enteral nutrition therapy equipment and supplies for nursing facility patients and to discuss possible alternative Medicare payment policies.

BACKGROUND

Enteral Nutrition Therapy

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 nutrition may be administered by syringe, gravity, or pump. Some enteral patients may experience complications associated with the syringe or gravity method of administration. In such cases, an enteral infusion pump can be used. The pump allows controlled delivery of the nutrients to the digestive tract. If a pump is ordered, there must be documentation accompanying the certificate of medical necessity (CMN) to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload).

Medicare Coverage Guidelines

Although Medicare pays for durable medical equipment like beds, wheelchairs, canes, crutches, oxygen concentrators, and intravenous (I-V) poles when used in patients' homes, it does not make separate payments for them in nursing homes. These items are considered standard equipment for nursing home operations and are covered as part of the daily rate that Medicare or Medicaid pay for a nursing home stay. However, Medicare does pay for equipment used in connection with enteral feeding in nursing homes, even if the same equipment would not otherwise be covered.

Medicare guidelines classify enteral nutrition therapy under the prosthetic device benefit, because the therapy is required due to an absent or malfunctioning body part which would normally permit food to reach the digestive tract. The Health Care Financing Administration's (HCFA) decision to consider enteral nutrition equipment and supplies as a prosthetic benefit was a direct response to 1980 Congressional deliberations during 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 (i.e., outside suppliers).

Issued in 1981, HCFA instructions for the Part B prosthetic device benefit state that if coverage requirements are met, medically necessary nutrients, administration supplies, and equipment are covered. Covered items are to be billed to the Durable Medical Equipment Regional Carrier (DMERC) unless provided by the nursing facility during a Part A covered stay. If provided by the nursing facility during a Part A covered stay, costs are covered as ancillary costs rather than included in the routine per diem payment. Additionally, dually entitled patients, in a nursing facility stay not paid for by Part A, will qualify for Part B coverage even though States routinely cover enteral nutrition therapy in their daily payment rate to nursing facilities.

Enteral nutrition therapy supplies typically include tubing, bags to hold the nutrients, and syringes. Equipment involves enteral infusion pumps and intravenous (I-V) poles. Nutrient formulas refer to products such as Ensure, Jevity, and Osmolite.

Previous Work in this Area

This report is an extension of work previously discussed in our reports, "Enteral Nutrient Payments in Nursing Homes" (OEI-06-92-00861), "Durable Medical Payments in Nursing Homes" (OEI-06-92-00862), and "Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays" (OEI-06-92-00860). In the report on enteral nutrients, we described how only about five percent of nursing facility patients receive enteral nutrition therapy; however, the costs of enteral nutrient formulas alone exceeded $170 million in 1992 (the period of review). We also discussed how Medicare payments for nutrients are considerably higher (often by over 40 percent) than the cost to nursing facilities which buy nutrients through volume (bulk) purchasing or other contractual relationships. Further, and possibly more critical, current payment of enteral nutrients does not recognize enteral nutrients as "food." If recognized as food, payment for enteral nutrients would be made as part of the facility payment, rather than paid by Medicare Part B under the prosthetic benefit.

In the other reports, we discuss the extent of billing during 1992 for DME such as wheelchairs, oxygen concentrators, nebulizers, hospital beds, I-V poles, and crutches. Since DME is not covered unless provided for use in a beneficiary's home, most of the money allowed by Medicare ($35 million) was inappropriate. This conclusion is based on a recognition that most nursing facilities are not considered a beneficiary's home. When a facility is determined to be primarily engaged in providing "skilled" care, Medicare law specifically precludes the facility from being considered a beneficiary's home. Thus, patients in such facilities are denied Part B DME payment, as it is expected that the facility (not outside suppliers) will provide DME when needed by any patient.

METHODOLOGY

For this inspection, we reviewed Medicare payment policy and gathered data on the utilization of enteral nutrition therapy equipment and supplies in nursing facilities from a 1 percent sample taken from the Medicare National Claims history file for calendar years 1992-95. Payments for enteral nutrition therapy were extracted whenever the place of service was coded as a nursing facility (place of service "31" or "32"), which we determined was an accurate indicator of nursing facility services based on our review of a 1992 nationally projectable two-stage random sample of 150 nursing facilities.[3] (This review showed that 98 percent of the enteral nutrition therapy services provided to nursing facility patients were accurately coded as provided in a nursing facility.)

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 facilities and home health agencies, as well as by DME suppliers.

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

The Costs for Equipment and Supplies Associated With Enteral Nutrition Therapy are Substantial, Totaling Approximately $260 Million in 1995.

During 1995, we project (at the 95 percent confidence level) that Medicare allowed between $257 and $264 million for the equipment, supply kits, and tubing used for enteral nutrition therapy.[4] (See Figure 1.) When added to the cost of the nutrient formula ($221 to $228 million), these costs bring the total Part B cost of enteral nutrition therapy in nursing facilities to nearly one-half billion dollars ($480 to $490 million). This represents one of the most expensive components that Medicare Part B paid for nursing facility patient supplies. This is especially striking when one considers that only a small percentage (five percent) of nursing facility patients receive enteral nutrition therapy services.

Part B Allowed Charges for Enteral Infusion Therapy Equipment and Supplies
(in millions)

	1992	1993	1994	1995
EQUIPMENT				
Infusion Pumps	$46.2	$38.6	$34.2	$35.2
I-V Poles	<$0.01	<$0.01	$3.4	$3.5
SUPPLIES				
Supply Kits	$200.7	$193.7	$202.5	$216.2
Tubing	$6.3	$4.7	$5.3	$5.3
TOTAL	$253.2	$237.0	$245.4	$260.2

Source: Projections from an Office of Inspector General (OIG) 1 Percent Sample
See Appendix A for Confidence Intervals

FIGURE 1

One contributing factor to the high cost of enteral nutrition therapy is that most enteral nutrients are delivered by infusion pumps, the most costly method available. For those patients receiving enteral nutrition therapy during 1995, approximately 85 percent (83 to 87 percent at the 95 percent confidence level) utilized pumps to deliver the nutrient formulas; the remaining 15 percent used gravity or syringe delivery. The percentage of patients utilizing pumps has remained relatively constant over the four year period of this review, marked only by a slight decrease in 1995 from the 88 percent level of prior years.

While the percentage of pump use has remained relatively constant, the overall cost dropped noticeably between 1992 and 1993 and has remained somewhat constant in subsequent years. We were unable to determine the factors contributing to the 1993 decline.

Equipment used for enteral nutrition therapy meets the definition of durable medical equipment (DME), which is not covered during a typical nursing facility stay.

DME is equipment which can withstand repeated use, is primarily used to serve a medical purpose, and is generally not useful to a person in the absence of illness or injury. Typical DME includes such items as wheelchairs, hospital beds, canes, crutches, oxygen concentrators, and nebulizers.

This definition clearly includes enteral infusion pumps and I-V poles. In fact, I-V poles and infusion pumps are considered DME when used for purposes other than nutrition therapy (e.g., I-V pole used to hang intravenous solutions, infusion pump used for pain management or chemotherapy). If used for these other purposes, the equipment would not be payable in a "skilled" nursing facility.[5]

Such a policy of providing payment for equipment in some cases (under the prosthetic device benefit) and not others (under the DME benefit) appears inconsistent. If both services are medically necessary, the payment policies in the nursing facility setting, arguably, should be the same.

- **Payment policies have fluctuated over the years with regard to I-V poles. Between 1987 and 1994, I-V poles were considered DME and not covered in nursing homes. In 1994, this policy was reversed (I-V poles were covered under the prosthetic device benefit), resulting in an escalation of I-V pole payments.**

Over the years, payment policy for I-V poles has fluctuated. Prior to 1987, an I-V pole was covered in a "skilled" nursing facility under the prosthetic device benefit. In 1987, carriers responsible for processing enteral and parenteral nutrition therapy claims reversed this policy, declaring I-V poles were no longer covered in a nursing facility; payment was limited to a patient's home. An I-V pole was considered DME and limited to DME payment policies.

This policy remained in effect until 1994 when the DMERCs began processing enteral claims and reversed the long-standing policy of not paying for I-V poles in a nursing facility. We were unable to determine the reasons for this policy change or whether HCFA requested the change.

The 1994 change in policy, providing for the payment of I-V poles in nursing facilities, resulted in a sharp rise in payments. With I-V poles not payable except in a beneficiary's home, virtually no payments were allowed between 1987 and 1994. However, the payment policy change in 1994 resulted in an immediate escalation of payments for I-V poles to over $3.4 million in 1994 and $3.5 million in 1995. (See Figure 1.)

More recent data from the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) suggests that I-V pole costs are escalating at an ever higher rate. From the last quarter of 1995 to the first quarter of 1996, payments for I-V poles in the home and nursing facility increased by over 285 percent. It may be that only recently have some nursing facilities and suppliers recognized the "new" policy covering I-V poles.

Equipment Used for Enteral Nutrition Therapy Costs More Than Identical Equipment Billed Under the DME Fee Schedule.

- **Enteral nutrition therapy reimbursement policies result in higher costs than if payments were based on the DME fee schedule.**

Although the SNF Coverage Manual (260.4) states "reimbursement rules relating to DME will continue to apply" to equipment used for enteral nutrition therapy, the reimbursement methodologies continue to remain different (DME is paid based on a fee schedule, while enteral nutrition therapy equipment is paid based on reasonable charge). ***This results in a different payment amount for the same piece of equipment.*** To illustrate, an I-V pole used for enteral nutrition is reimbursed at the monthly rental rate of $24. In contrast, the same I-V pole used to hang cancer fighting intravenous solutions in a resident's home is reimbursed using the DME fee schedule at a monthly rental rate of approximately $17. This represents a 29 percent reimbursement difference.

- **By allowing unlimited rental, Medicare pays considerably more than the purchase cost for I-V poles.**

Review of payment claims shows that current payment policy allows unlimited rental payments for I-V poles used for enteral nutrition therapy. We noted cases where rental payments for a single I-V pole exceeded the purchase cost. At the 95 percent confidence level, we project this occurred for 26 to 34 percent of the cases. Five percent of such payments exceeded $400 which is <u>four times</u> the current Medicare reimbursement amount for the purchase of a pole on the DME fee schedule ($80-94 depending on the State).

An unlimited rental payment policy conflicts sharply with current DME reimbursement rules which do not allow rental payments to exceed the purchase cost.[6] This is especially troubling given that enteral infusion pumps are subject to the rules for DME capped rental (i.e., 15 month rental); however, I-V poles are not subject to the payment rules for inexpensive, frequently purchased DME. If payments were subject to these limitations, rental payments for I-V poles would not exceed purchase costs.

Current Medicare Payment Policy for Enteral Nutrition Therapy Equipment and Supplies Fails to Capitalize on Market Forces and Efficiencies Available to Nursing Facilities, Which Could Substantially Reduce Costs.

- **Payment rates for feeding supply kits exceed market costs for kit components.**

The components of a feeding supply kit are not well defined. According to a discussion with one DMERC medical director, the "components of a kit are anything the nursing facility needs to facilitate use of the pump." In our review, we found only two items are usually needed in association with pump or gravity administration.[7] These items are a bag (typically comes with tubing) to hold the nutrient formula and a syringe to irrigate and deliver fluids to the patient. These items, when purchased in bulk by nursing facilities, can cost nursing facilities considerably less than current reimbursement rates. As an example, it is possible for a nursing facility to purchase nutrient bags for as little as $2.88 from a national supplier and syringes for as little as $0.81. At a total cost of $3.69, this is considerably less (by 65 percent) than Medicare's average allowed payment of $10.46 (based on 1995 data). Thus, Medicare could be paying nearly three times the cost of the components for a supply kit. Were Medicare to have paid this lower cost, savings of $140 million could have been realized (65 percent of $216 million).

This finding is consistent with prior inspection results showing that Medicare is paying too much for enteral nutrient formulas. Our prior inspection report, "Enteral Payments in Nursing Facilities," showed that Medicare reimbursement rates for enteral nutrients averaged 42 percent higher than costs for the typical nursing facility. Assuming similar price differences between the cost of feeding supply kits and nursing facility prices, the excessive cost to the taxpayer was nearly $91 million in 1995 (42 percent of $216 million).

- **Also, payment rates for enteral equipment appear excessive.**

The I-V pole represents an example of an item of equipment whose reimbursement rate may be excessive. If purchased in bulk rather than individually, I-V poles can cost as little as $33 (4 wheel, 2 hook model). This estimate is based on contact with several local equipment suppliers in the Dallas area. While the pricing varied considerably and could differ in other parts of the country, it is clear that I-V poles can be purchased at prices considerably lower than Medicare's current reimbursement amount of between $110 and $130. Thus, prudent purchasing by nursing facilities and competitive bidding strategies could yield Medicare savings by reducing the purchase cost of a new I-V pole to only 27 percent of the current reimbursement. This finding reaffirms that nursing facilities can obtain medical equipment and supplies at considerably lower prices when purchased in bulk, through competitive bidding strategies, or from suppliers offering such prices to attract the nursing facility's overall business.

In addition to the purchase cost difference, rental rates are excessive. As discussed earlier, reimbursement is considerably higher than the reimbursement rate on the DME fee schedule ($17 versus $24 per month). With prudent purchasing utilizing cost saving strategies, nursing facilities might achieve even lower rental rates. We found a local supplier whose rental rate was only $15.

- **In addition to the excessive cost of equipment and supplies, the potential exists for overutilization of expensive delivery systems.**

Currently, nursing facilities have little incentive to limit excessive use of infusion pumps to deliver the nutrient formula to the patient. This is due to current payment mechanisms which do not encourage nursing facilities and physicians to use less costly enteral nutrition delivery systems when medically appropriate. One incentive for the nursing facility is to utilize delivery systems requiring less nursing facility staff involvement with the patient. Infusion pump delivery is often less labor intensive and can result in less nursing staff involvement than is needed to administer and monitor non-pump delivery systems. Discussion with program integrity staff at the DMERCs confirms that cases of medically unnecessary billing for pumps has occurred. In some of these cases, it is suspected that a pump rather than gravity feeding is used more for the convenience of the nursing facility staff than based on a patient's need for the more costly controlled delivery system.

RECOMMENDATIONS

This report is not intended to suggest that suppliers or nursing facilities are submitting false claims for equipment and supplies associated with nutrition therapy. Rather, the purpose is to illustrate an area of Medicare payment which is subject to excess and conflicts with other related payment policies.

Approaches to solve vulnerabilities and wasteful spending associated with enteral nutrition payment policy range from resolving specific areas of identified excess to restructuring the global payment mechanism for Medicare services provided to nursing facility patients. The following discussion describes these two approaches in detail.

APPROACH I: ADDRESSING SPECIFIC PAYMENT AREAS

I-V Poles

The Health Care Financing Administration (HCFA) should take appropriate action to prevent excessive payments for the rental and purchase of I-V poles used in nursing facilities. We recommend that total rental payments be limited to the purchase cost of the pole and that the following two options be considered:

Option 1: Utilize the lower of the enteral nutrition payment and the DME fee schedule payment. Annual savings could be $1.3 million ($0.4 million due to limitations on total rental payments and $0.9 million (29 percent of the remaining $3.1 million) based on limiting payment to the lower of the fee schedule or the reasonable and customary charge).

Option 2: Evaluate the inherent reasonableness of payment rates under reasonable charge. Payment levels for residents of nursing facilities should be based on a typical facility's ability to purchase I-V poles economically. Annual savings could exceed $0.9 million assuming HCFA's inherent reasonableness study finds the typical monthly rental rates are $17 or less, instead of the current $24.

We support either of these options. However, we believe **Option #1 is preferable** for the following reasons:

- **Payments should be the same for the same item.** Whether an I-V pole is covered as DME (covered under the DME benefit) or used in conjunction with enteral nutrition therapy (covered under the prosthetic benefit), it seems inconsistent to pay different amounts.

- **Recognizes HCFA's efforts to evaluate the appropriate costs for DME.** HCFA is currently conducting studies to determine the appropriate reimbursement for

several items of DME (including I-V poles). If DME rates are adjusted accordingly, the payments will reflect the most reasonable amounts, thereby obviating the need to conduct an inherent reasonableness study.[8]

- **Recognizes and encourages economies available to nursing facilities when purchasing supplies.** Nursing facilities present a unique environment. Options such as bulk purchasing and competitive bidding can yield significant price reductions to the nursing facility. The proposed reduction in payment levels for nursing facility patients recognizes this fact. Without a reduction, Medicare will not realize the potential savings, since payment rates currently reflect the cost to the average beneficiary and not a nursing facility.

One practical method of implementing either option is to use an adjustment (reduction) in the normal beneficiary payment rate when the service or supply is provided to a beneficiary residing in a "skilled" nursing facility.

Feeding Supply Kits

The HCFA should take appropriate action to prevent excessive payments for supplies related to enteral nutrition therapy. We recommend that three options be considered:

Option 1: Review the inherent reasonableness of payment rates. Annual savings could be as much as $140 million (65 percent of $216 million).

Option 2: Place (seek legislation if necessary) these supplies on a fee schedule. If fee schedule rates are set conservatively at 75 percent of current rates, annual savings could exceed $54 million.

Option 3: Discontinue payment for the "kit" and establish codes specific to each necessary component of the kit. One code might be established for the bag (with tubing) and the other code would be for the syringe. Assuming the payment rate for each new code is set at the lowest price we identified (see body of report) and assuming no other items are deemed to be necessary, annual savings could be as much as $140 million.

We support all of these options. However, we believe **Option 1 is preferable** for the following reasons:

- **Payment levels appear to substantially exceed costs**. To ensure equity, payment levels should be set after a thorough review of what components are necessary and routinely used and what is a fair price, given that nursing facilities can obtain these products at rates typically lower than the average beneficiary.

- **Recognizes and encourages economies available to nursing facilities when purchasing supplies.** Nursing facilities present a unique environment. Utilization of such opportunities as bulk purchasing and competitive bidding can provide

significant price reductions to the nursing facility. The proposed reduction in payment levels for nursing facility patients recognizes this fact. Without a reduction, Medicare will not realize the potential savings, since payment rates should reflect the cost to the average beneficiary and not a nursing facility.

Enteral Infusion Pumps

We did not separately examine the reasonableness of Medicare payments for pumps; however, based on our finding that Medicare Part B payments for I-V poles, supply kits, and nutrient formulas (discussed in a prior report) appear to be excessive, HCFA should consider beginning a review of the appropriateness of payment rates for pumps. Assuming HCFA's review yields a disparity between nursing facility costs and Medicare payment rates similar to those found for I-V poles (29 percent difference), the annual savings could exceed $10.3 million.

APPROACH II. GLOBAL PAYMENT RESTRUCTURING

Structural changes in the way Medicare pays for services provided to nursing facility patients may address some or all of our concerns with enteral nutrition therapy payments. Structural changes attempt to take advantage of the ability of nursing facilities to more economically provide services and supplies to their patients with the cost savings passed on to Medicare. Each of these payment mechanisms recognizes the importance of the nursing facility in achieving a more cost effective program. Since nursing facilities are significantly involved in the planning and provision of patient care, they arguably are the most appropriate entity to scrutinize providers and determine the most cost effective methods of obtaining and utilizing the medical services and supplies needed by their patients.

The following summarizes some of the options HCFA is or should be considering.

A. Folding Payment into the Per Diem

Institutions are expected to provide certain routine equipment and supplies in addition to the cost of room and board. Generally, nursing facilities are reimbursed for these services based on a daily per diem payment. By including enteral nutrition therapy as a part of the per diem payment, Medicare could reduce the overall cost to the taxpayer of providing care. Savings to Medicare Part B would total $260 million based on 1995 data. However, some of the savings could be passed on as costs to States (for dually eligible patients), Part A (for Medicare SNF patients), and to beneficiaries (in the case of private pay patients). The extent of savings depends on the routine charge limits Medicare and Medicaid impose, exceptions to these limits, and the extent to which nursing homes act as prudent purchasers.

Under current Medicare Part B reimbursement policy, nursing facilities have little or no incentive to employ money saving techniques (e.g., bulk purchasing). In fact, most enteral nutrition equipment and supplies are provided by suppliers rather than the nursing facility.

Not only does the nursing facility exert little influence on the cost paid for enteral nutrition therapy, but the nursing facility provides little oversight to ensure the least expensive, medically appropriate alternative is utilized.

In addition to the argument that savings can be achieved through folding enteral nutrition therapy into the per diem, the following factors support such a policy decision:

> **Enteral nutrients are just "food."** Because enteral nutrition is clearly "food," an argument can be made that nursing facilities should pay for enteral nutrients in the same manner as traditional food consumed by the average facility patient.
>
> **Enteral delivery systems are DME.** Delivery systems (i.e., equipment and supplies) are arguably just DME which is not separately reimbursable, except as a part of the per diem. The same argument for not covering DME in a "skilled" nursing facility setting could be applied to enteral nutrition therapy.
>
> **States include enteral nutrition therapy in their per diem.** Including enteral nutrition therapy as a part of the per diem payment is consistent with the Medicaid policies of most states. Only a few states allow additional billing beyond the per diem rate. States with case-mix systems provide for a daily rate which could be higher if the patient requires infusion pump or gravity feeding.

B. Consolidated Billing

Consolidated billing would restrict anyone but the nursing facility from billing for Part B services the nursing facility is authorized to furnish. We support HCFA's efforts in this area. Currently, HCFA is considering a consolidated billing proposal for routine nursing facility services provided to Medicare SNF patients. By making the nursing facility the focal point of services to its patients, the nursing facility is far more accountable for patient care. Further, such an approach lessens opportunities for fraud and abuse by outside suppliers and makes Government monitoring efforts less complicated.

While we are unable to determine the savings that could result from such a policy change, if payment rates are modified to reflect the impact of a nursing facility's buying power, savings could be realized. Assuming enteral nutrition therapy payment rates are reduced by 25 percent (a conservative estimate), savings of $65 million could be realized based on 1995 data.

C. Competitive Bidding

As another cost saving option, the Government could establish competitive bidding contracts to provide nursing facilities with access to services and supplies at lower costs than currently available. Such contracts could provide enhanced access to some services and supplies. We support HCFA's efforts in this area. Currently, HCFA is evaluating the potential for competitive bidding. Any competitive bidding strategy should include enteral equipment and supplies. Assuming competitive bidding results in pricing at or below the

costs noted in this report, savings could total $152 million ($140 million for supply kits, $1.3 million for I-V poles, and $10.3 million for pumps).

D. Capitation

Another option would be to switch payment for Part B services in nursing facilities from a fee-for-service mode to a flat rate per beneficiary. Such a system could base the fixed payment on some type of case-mix payment scheme where payments are based on the level of illness and resource needs of the patient (e.g., a prospective payment system for Medicare SNFs is currently being developed[9]). Additionally, payment could be based on a daily rate similar to those found in Medicaid programs (per diem rate) or a monthly rate similar to managed care programs such as Health Maintenance Organizations (HMOs).

The payment rate could also be a function of the type of service or supply. For example, a daily rate of $10 might be determined to be an equitable payment for patients needing enteral nutrition therapy. Capitation would incentivize the nursing facility to provide services in the most economical fashion, since Medicare will not pay more if the nursing facility utilizes a more costly approach (e.g., provides a more costly service although less expensive equally effective alternatives exist or the nursing facility is not purchasing services and supplies as a prudent purchaser).

By setting the capitation payment conservatively at 75 percent of the 1995 average allowed charge (a 25 percent reduction) for equipment and supplies, the savings could be $65 million.

Capitation for Nursing Facility Dual Eligibles

Dual eligibles are patients of nursing facilities for whom Medicaid is paying for the nursing facility stay and Medicare is paying for an assortment of services and supplies (e.g., physician care, physical therapy, lab testing, and supplies). The shared responsibility for payment exists because Medicaid is considered the payor of last resort. Since dual eligibles are entitled to Medicare, Medicaid pays for only those services and supplies not covered by Medicare (i.e., coinsurance and deductible). This overlap in coverage creates a complicated system of payment which is very difficult to audit and assess whether services provided under Medicare overlap payments made by Medicaid (i.e., the Medicaid daily rate paid the nursing facility).

In addition to the complexity of monitoring "who pays for what," such a system of multiple payers and providers able to bill for services creates an attractive environment for fraudulent and abusive practices. Currently, providers can submit claims for services directly to Medicare without the nursing facility or attending facility affirming whether the services were necessary and provided as claimed. Further, Medicare payment systems cannot determine whether a dual eligible is in a Medicaid covered stay in a nursing facility (i.e., States are not required to provide stay information to Medicare). This makes it impossible to determine whether some types of services are covered (e.g., DME is not covered in a nursing facility).

One solution to this dilemma is to limit Part B payments for dual eligibles. Rather than Medicare paying for the services, Medicaid would be responsible for payment. To compensate States, Medicare could develop a capitation payment provided directly to the State. Such a payment scheme could significantly reduce Medicare costs. Since nursing facilities are paid a per diem, nursing facilities would have an incentive to utilize cost constraining methods (bulk purchasing, competitive bidding, limiting overutilization, selection of the least expensive medically appropriate treatment, etc.).

Although we support all of the options raised in this report, we believe restructuring Medicare's payment mechanism for Part B services to patients of skilled nursing facilities (Approach II) is most responsive to our overall concerns. Enteral nutrition therapy is but one example of the possible benefits from changes to current policy which will ensure Medicare is paying the most reasonable cost. Payment mechanisms that utilize a nursing facility's capability to purchase medical equipment and supplies more cost effectively than the average beneficiary offer the greatest potential.

We recognize that further study would be needed to assess the relative costs and benefits of the global options and the extent of cost shifting to other programs, States, and beneficiaries. The projections of cost savings in this report are used as illustrations and are based on various stated assumptions. The savings refer to the Medicare Part B program and include savings to both the Part B program and the beneficiary.

Any efforts to modify the enteral nutrition therapy benefit and global restructuring strategies will require legislation and must be accompanied by adequate consideration and protections (liability, access and quality of care, etc.) for nursing facility patients, nursing homes, and States.[10]

AGENCY COMMENTS

We received comments from the Health Care Financing Administration (HCFA). (See Appendix B for the full text.) The HCFA concurred with the recommendations made in this report. To resolve identified problems noted in this report, HCFA is pursuing a number of actions such as evaluating the reasonableness of payment for pumps and I-V poles, applying DME reimbursement criteria to I-V pole coverage, and pursuing research of broader payment restructuring through capitation, competitive bidding, and bundling of enteral nutrition services.

ENDNOTES

1. In some instances, the use of customary and prevailing charge data alone may lead to a result that is not inherently reasonable for the purpose of reimbursing items and services furnished by suppliers of services. If standard rules for calculating reasonable charges result in grossly deficient or grossly excessive charges, HCFA and contractors can apply other factors to set reasonable charge limits. Examples of circumstances which may result in excessive charges include: the marketplace is not competitive, Medicare is the primary source for payment, charges are grossly in excess of acquisition costs, etc. When inherent reasonableness criteria have been applied, the contractor must solicit comments from the affected group on the proposed limitation and the methodology and documentation used. A minimum of a 30-day comment period is provided.

2. $140 million for supply kits (assuming the payment rate is set at a price 65 percent below 1995 allowed charges of $216 million)

   $1.3 million for IV poles (Annual savings could be $1.3 million ($0.4 million due to limitations on total rental payments and $0.9 million (29 percent of the remaining $3.1 million) based on limiting payment to the lower of the fee schedule or the reasonable and customary charge)

   $10.3 million for pumps (29 percent of $35 million).

3. Data was obtained from a nationally projectable two-stage random sample of 150 Medicare or Medicaid nursing homes from California, Delaware, Florida, Indiana, Kansas, Louisiana, Maine, Michigan, Montana, and Wyoming (15 per State). 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 the nursing home during 1992, along with each resident's corresponding date(s) of stay. After verification of the beneficiaries' health insurance claim numbers (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 Supplementary Medical Insurance (SMI) for the Aged and Disabled services (Part B Medicare), processed by both the carrier and the intermediary, were identified. Data from the sample were projected to the total nursing home population (patients in Medicare or Medicaid-certified nursing homes).

4. During 1995, Medicare allowed $260 million (+/- $3.6 million at the 95 percent confidence level) for the equipment, supply kits, and tubing used for enteral nutrition therapy. When added to the cost of the nutrient formula ($225 +/- $3.7 million at the 95 percent confidence level), these costs bring the total Part B cost of enteral nutrition therapy in nursing homes to nearly one-half billion dollars ($485 million +/- $5.3 million at the 95 percent confidence level).

5. Durable medical equipment may be covered under Medicare's Supplemental Insurance Program (Part B), if it is furnished for use in the beneficiary's home. Medicare defines a beneficiary's home as his or her dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, a nursing facility primarily engaged in providing to inpatients skilled nursing care or rehabilitation may not be considered a beneficiary's home for purposes of DME coverage.

6. An IV pole billed as DME is considered to be paid under the category of inexpensive or other routinely purchased DME. Such DME is defined as equipment costing less than $150 or which is purchased at least 75 percent of the time.

7. While these two items (bag and syringe) are the main components of kits. Contact with some suppliers yielded the following list of items that might be included under the broad category of a kit:

   Tubing (4 - 5 feet)
   Flow clamp control regulator
   Interlocking feeding set connector
   Additional connectors (Y port) as needed
   Gauze pads for gastrostomy site wound care
   Alcohol swabs, antibiotics as necessary
   Tape
   Gloves
   In some cases, a secondary bag and tubing combination
   to permit automatic hydration

8. HCFA is currently conducting several projects related to DME to establish more reasonable reimbursement rates and take advantage of competitive bidding strategies. These studies are:

   Study 1 — A study of variations in DME supplier costs. This study will collect data on supplier costs of DME and will determine the proportions of such costs attributable to the services and the proportion attributable to the product components. The review will analyze this by type of equipment and geographic area.

   Study 2 — An evaluation of the inherent reasonableness of payment levels for decubitus care equipment, TENS, and any other items considered appropriate by the Secretary (IV poles are considered appropriate). The contractor will obtain cost data from private payers, Medicaid, and other Federal health programs. A cost-benefit and actuarial analysis will also be undertaken.

   Study 3 — HCFA is using its current authority to undertake a project on competitive bidding. HCFA has contracted with Palmetto

Government Benefit Administrators test whether competitively bid prices can be used to purchase some types of DME.

9. HCFA is currently administering a six-State Medicare skilled nursing facility (SNF) prospective payment system (PPS) demonstration to: 1) develop a patient classification system, 2) develop a payment rate based on the patient classification, and 3) evaluate the adequacy of facility payments under the demonstration. Many of the basic elements of the demonstration will be incorporated into the structure of a national SNF PPS. HCFA believes that the quality of care rendered to Medicare beneficiaries is not hindered. HCFA is committed to implementing a SNF PPS as soon as it is technically possible and the Administration has offered a legislative proposal to Congress.

10. Most beneficiaries (75 percent) are covered under a Part A SNF stay or a Medicaid stay. The remaining beneficiaries (25 percent) pay for nursing home stays themselves or with the aid of alternate insurance programs.

APPENDIX A

MEDICARE PART B PAYMENTS FOR ENTERAL EQUIPMENT AND SUPPLIES

	Point Estimate	95 Percent Confidence Interval
Enteral Equipment and Supplies - Total		
1992	$253,240,044	+/- $3,211,207
1993	$237,035,251	+/- $3,156,623
1994	$245,704,806	+/- $3,624,939
1995	$260,156,084	+/- $3,640,331
Enteral Infusion Pumps		
1992	$46,191,376	+/- $713,576
1993	$38,651,228	+/- $791,357
1994	$34,249,692	+/- $898,646
1995	$35,244,409	+/- $802,948
Enteral Feeding Supply Kits		
1992	$200,709,626	+/- $2,197,334
1993	$193,718,048	+/- $2,170,587
1994	$202,655,147	+/- $2,685,116
1995	$216,137,807	+/- $2,772,656
Intravenous (I-V) Poles		
1992	$6,791	+/- $7,728 *
1993	$7,054	+/- $7,739 *
1994	$3,391,134	+/- $99,702
1995	$3,502,864	+/- $106,377
Tubing		
1992	$6,332,251	+/- $155,784
1993	$4,658,921	+/- $133,517
1994	$5,408,833	+/- $210,376
1995	$5,271,004	+/- $178,606

** This calculation resulted because of an extremely low precision caused by so few claims.*

Source: Based on Analysis of an OIG 1 Percent File extracted from the National Claims History file.

APPENDIX B

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: MAR 17 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Payments for Enteral Nutrition Therapy Equipment and Supplies in Nursing Homes," (OEI-06-92-00866)

We reviewed the above-referenced report that describes the extent of Medicare Part B payments and potential vulnerabilities related to enteral nutrition therapy equipment and supplies provided to residents of nursing homes.

Our detailed comments on the report recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Comments of the Health Care Financing Administration (HCFA) on Office of Inspector General (OIG) Draft Report: "Medicare Payments for Enteral Nutrition Therapy Equipment and Supplies in Nursing Homes," (OEI-06-92-00866)

OIG Recommendation - Equipment Payment Policy

HCFA should take appropriate action to prevent excessive payments for the rental and purchase of intravenous (I-V) poles used in nursing facilities.

HCFA Response

We concur with the report finding that payments for poles used in nursing facilities are excessive. HCFA created a parenteral and enteral nutrition (PEN) workgroup that will concentrate on current PEN issues impacting on program costs and abuses. The workgroup includes staff from central office and the regional offices.

The workgroup is reviewing the appropriate skilled nursing facility manual section and plans to issue a clarification or revision, as necessary, that would support a carrier policy to pay for PEN poles as inexpensive/routinely purchased durable medical equipment (DME). The workgroup will also review the reimbursement rules that apply to DME used in the nursing facility when the stay is covered under Part A, and will evaluate the inherent reasonableness of payment rates under the reasonable charge system. The projected completion date for this activity is March 31.

OIG Recommendation - Enteral Infusion Pumps

HCFA should consider beginning a review of the appropriateness of payment rates for pumps.

HCFA Response

We concur. The PEN workgroup is applying the same review to enteral infusion pumps as it is to its review if I-V poles as discussed in response to the first recommendation.

OIG Recommendation - Global Payment Restructuring

HCFA should consider structural changes in the way Medicare pays for services provided to nursing facility patients.

HCFA Response

We concur and are currently developing a competitive bidding demonstration. The use of the competitive market mechanism would establish Medicare's payment for enteral nutrition.

The workgroup will consider other payment mechanisms that include inherent reasonableness, bundling of enteral nutrition services, and capitation. Staff from our Dallas Regional Office are working closely with DME regional carriers to develop a pricing scheme to collapse enteral nutrient codes for categories IV and V by weighting the 1995 Medicare allowances for each enteral code in these categories and using the average of product specific allowances paid under codes from within the respective categories. The workgroup will design a model to work with the statistical analysis DME regional carrier to study the use of inherent reasonableness and bundling as approaches to price PEN. We expect to complete this project and propose a new mechanism for these categories by April.