

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PART B SERVICES
DURING NON-PART A NURSING
HOME STAYS: ENTERAL
NUTRIENT PRICING**



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OBJECTIVE

To compare Medicare's Part B fee schedule for enteral nutrients provided during non-Part A stays to prices available to nursing home suppliers and other purchasers.

BACKGROUND

Medicare Part A covers nursing home care for up to 100 days in a skilled nursing facility during which Part A will pay for enteral nutrition therapy (ENT) as part of the nursing home's daily rate. After the 100 days or in cases when beneficiaries do not qualify for Part A stays, Medicare Part B may provide coverage for enteral nutrients, supplies, and equipment during these non-Part A stays. Enteral nutrients are delivered directly to an individual's digestive tract through a feeding tube inserted through the nose or placed in the small intestine or stomach. Nutrients are delivered through the tube using a syringe, gravity, or a pump. Medicare contractors use a fee schedule to reimburse for enteral nutrient claims. During 2006, Medicare Part B allowed \$284 million for ENT provided to nursing home residents during non-Part A stays (\$142 million for enteral nutrients and \$142 million for enteral supplies and equipment).

Two codes of the Healthcare Common Procedure Coding System, B4150 and B4154, accounted for nearly all (\$117.8 million) of the \$142 million allowed for enteral nutrients provided during non-Part A stays in 2006. As such, we focused our evaluation on these two codes. We used resident assessment data from the Centers for Medicare & Medicaid Services (CMS) to identify all nursing home stays nationwide during 2006. We then analyzed related Medicare claims data for any allowed ENT payments during these stays as well as information provided by a sample of nursing homes and suppliers relating to their costs. Additionally, we supplemented these results with industry pricing data gathered and maintained by a marketing research firm that reports capturing 84 percent of national market activity for enteral nutrients, including 94 percent of the volume sold to nursing homes in 2006.

FINDING

Medicare's fee schedule for enteral nutrients provided under Part B during non-Part A stays was more than double the prices available to suppliers of nursing homes and other purchasers in 2006. We

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estimate that the Medicare fee schedule amount of \$0.67 exceeded the average unit price available to suppliers responding to our survey by \$0.35 for B4150 nutrients. The Medicare fee schedule amount of \$1.22 exceeded the average unit price by \$0.66 for B4154 nutrients. Using the calculated average unit prices available to the suppliers, we estimate that Medicare's allowance for these two most frequently billed enteral nutrient codes exceeded supplier prices by approximately \$61 million for non-Part A nursing home stays in 2006. Specifically, fee schedule amounts exceeded the median unit prices available to long term care entities by 52 percent for B4150 nutrients and 54 percent for B4154 nutrients. In addition to obtaining pricing data directly from nursing homes and suppliers, the Office of Inspector General (OIG) purchased industry pricing data. These data confirmed that Medicare's fee schedule amounts exceeded unit prices available to nursing homes and other purchasers.

RECOMMENDATION

This evaluation is consistent with prior OIG reports that have found that Medicare's fee schedule amounts exceed available market prices for ENT. To ensure appropriate reimbursement for ENT, CMS should:

Adjust the Medicare fee schedule amounts for enteral nutrients to more accurately reflect supplier prices for nutrients provided to nursing home residents. CMS can use inherent reasonableness reviews or may be able to act on available pricing information from other sources.

Payments for ENT could be further impacted if Congress changed the prosthetic device benefit to restrict Part B coverage to a beneficiary's home and thereby recognized enteral nutrients as food covered under nursing home room and board payment. Such a policy change would end Part B payments for ENT costs in nursing homes and would affect nearly half of all current Part B ENT payments annually. The rationale behind a change to the benefit is that enteral nutrient feeding costs may be comparable to conventional meal costs incurred for other nursing home residents. These conventional meal costs are reimbursed under the nursing home's room and board payment. Further, a change to the prosthetic device benefit is consistent with a nursing home's responsibility to feed its residents and DME payment policy that places the responsibility on nursing homes, as institutions, to provide for the basic equipment needs of residents. Such a payment policy change would encourage nursing homes to act as prudent purchasers and to exert their

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institutional buying power in obtaining nutrients, supplies, and equipment for ENT. Limiting the prosthetic device benefit to the home setting would require legislative action and could result in as much as \$284 million in program savings. However, additional assessment is needed to establish the comparability of conventional meal costs to ENT and the impact of such a policy change on nursing homes.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS agreed with our recommendation and described specific actions it is taking to more accurately reflect supplier prices for nutrients provided to nursing home residents. We did not make any changes to the report based on CMS comments.

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OBJECTIVE

To compare Medicare’s Part B fee schedule for enteral nutrients provided during non-Part A stays to prices available to nursing home suppliers and other purchasers.

BACKGROUND

Enteral Nutrition Therapy

In 2006, Medicare Part B allowed \$284 million for enteral nutrition therapy (ENT) services, including enteral nutrients, supplies, and equipment, during non-Part A nursing home stays. This represents nearly 47 percent of the \$608 million Part B paid for ENT used in any environment (e.g., nursing homes, beneficiaries’ homes).

The ENT services involve the delivery of liquid nutrients directly to an individual’s digestive tract through a feeding tube inserted through the nose or placed in the small intestine or stomach. Nutrients are delivered through the tube using a syringe, gravity, or a pump. Enteral nutrients, supplies, and equipment are assigned procedure codes from the Healthcare Common Procedure Coding System (HCPCS).

Enteral nutrients. A wide range of enteral nutrients exists to meet health care needs, including special formulas for patients with pulmonary or metabolic diseases. In 2006, Medicare Part B allowed \$142 million for enteral nutrients provided during non-Part A nursing home stays.¹ Two HCPCS codes, B4150 and B4154, accounted for nearly all of these allowed charges (\$117.8 million). HCPCS code B4150 represents the most frequently used nutrient; HCPCS code B4154 covers a more expensive class of nutrients for patients with special metabolic needs (e.g., diabetes).

Enteral nutrients are billed and reimbursed by “units,” defined by Medicare as 100 calories.² For example, if a patient is prescribed 2,000 calories of enteral nutrients per day, Medicare reimbursement is based on 20 units of nutrients per day (2,000 ÷ 100). (See Appendix A

¹ For purposes of this evaluation, the term “nursing homes” is generic for any nursing home regardless of primary payer (e.g., Medicare, Medicaid, or private resources).

² Centers for Medicare & Medicaid Services (CMS), *Medicare Claims Processing Manual*, ch. 20, § 100.2.2.2. Available online at <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf>. Accessed in January 2009.

for a list of the HCPCS enteral nutrient codes and their related Medicare reimbursement rates in 2006 per unit.) Nutrient packaging generally ranges from closed system containers (i.e., bags or bottles), ready to hang from an intravenous pole for immediate administration, to containers (usually cans) that require the nutrient to be transferred into containers that are ready for administration.

Enteral supplies and equipment. Enteral supplies and equipment are used to administer the required nutrients. Patients can receive enteral nutrients through three delivery methods: a syringe (the least expensive method), a feeding bag that uses gravity to deliver the formula, or a pump (the most expensive method). (See Appendix B for a list of HCPCS codes covering enteral supplies and equipment and their related Medicare fee schedule amounts.) In 2006, Medicare Part B allowed \$142 million for enteral supplies and equipment during nursing home stays not paid for by Part A.

Medicare and Medicaid Programs

Nursing homes offer daily living assistance to elderly and disabled individuals who are either physically or mentally unable to live independently. Nursing home patients receive a wide array of services ranging from medical treatment to meals and from skilled to custodial care. Of the available public programs that pay for nursing home care, Medicare and Medicaid represent the largest.

Medicare. Medicare covers most people 65 years or older, people under age 65 with certain disabilities, and people of any age diagnosed with end stage renal disease. It provides a wide range of benefits for eligible beneficiaries from institutional care (e.g., nursing home stays) to medical products and supplies (e.g., wheelchairs).

Medicare is administered by CMS, which contracts with entities called Medicare Administrative Contractors (MAC) to process and pay claims for covered services. Medicare-covered services most frequently fall under Parts A and B, constituting 46 percent and 41 percent, respectively, of Medicare's 2006 expenditures.³ Medicare paid \$408.3 billion in 2006, of which nursing home services accounted for \$20.5 billion (5 percent).⁴

³ CMS, *op.cit.*

⁴ CMS, *Health Care Financing Review*, 2007 Statistical Supplement.

The ENT provided to nursing home residents in a skilled nursing facility (SNF) may or may not be paid by Medicare Part A depending on how long the beneficiary remains in the facility and whether the beneficiary meets other medical qualifications.

- **Part A (hospital insurance)** helps cover skilled or rehabilitative care during beneficiary stays in SNFs; these stays are called Part A stays. Medicare Part A was the primary payer for 13 percent of the nursing home residents in 2006.^{5, 6} Medicare Part A pays for the beneficiary's services in a SNF during the first 100 days of a Part A stay. During a Part A stay in a SNF, Medicare Part A pays for the beneficiary's services in the facility using a consolidated daily rate. This daily rate covers many routine services provided by SNFs, including room and board, skilled care, and rehabilitative care.

When a beneficiary exhausts the 100 days of care allowed under the Part A benefit (or did not otherwise qualify for a SNF stay) and continues to reside in the SNF, the subsequent days then constitute a non-Part A stay. During a non-Part A stay, Medicare no longer pays for the stay; however, Part B may pay for therapy and supplies previously included in the daily rate paid to the SNF.

- **Part B (medical insurance)** helps cover a wide range of medical services and supplies. All individuals eligible for Part A may enroll voluntarily in Part B by payment of a monthly premium. In 2006, 93 percent of all individuals with Part A elected to also enroll in Part B.

Although Medicare Part A does not pay for non-Part A nursing home stays, Medicare Part B covers enteral nutrients, as well as the equipment and supplies necessary for administration, under Medicare's prosthetic device benefit.⁷ Non-Part A stays can occur in Medicare-certified SNFs, Medicaid-certified nursing facilities (NF),

⁵ Medicare Part A pays for up to 100 days in a SNF benefit period, also known as spell of illness, if a beneficiary meets certain conditions, such as a prior hospitalization. The SNF benefit period begins the day a beneficiary enters the SNF and ends when the beneficiary has not received any subsequent hospital or SNF care for 60 consecutive days.

⁶ C. Harrington, H. Carrillo, and B. W. Blank, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2000 Through 2006*, p. 18, Department of Social and Behavioral Sciences, University of California, San Francisco. Available online at <http://www.nccnhr.org/uploads/PartI-PagesfromHarringtonOSCARcomplete2006.pdf>. Accessed in March 2008.

⁷ Social Security Act (the Act), § 1861(s)(8).

and dually certified SNF/NFs. In 2006, Medicare allowed nearly \$284 million for more than 1.2 million claims for ENT during non-Part A nursing home stays.

The Medicare-allowed ENT claims were associated with 19 HCPCS codes that were spread across 61,876 beneficiaries, 11,097 nursing homes, and 4,323 suppliers. Three of the nineteen allowed HCPCS codes (B4035, B4154, and B4150) accounted for 78 percent (\$222 million) of the allowed payments, and 10 codes each accounted for less than 1 percent of the allowed payments. The HCPCS code with the highest allowed payments, the pump supply kit (B4035), represented nearly 37 percent (\$105 million) of the total amount. The two most frequently billed enteral nutrient codes (B4150 and B4154) accounted for 41.5 percent (\$118 million) of the \$284 million allowed by Medicare Part B.

The average allowed amount for ENT nutrients, supplies, and equipment during non-Part A nursing home stays in 2006 was \$4,597 per beneficiary, \$25,634 per nursing home, and \$65,802 per supplier. The average daily ENT allowance per nursing home resident in a non-Part A stay in 2006 was \$19.81.

Medicare Part B fee schedule for enteral nutrition therapy. Section 1842(s) of the Act authorized a fee schedule for enteral nutrients, equipment, and supplies associated with ENT. Medicare-enrolled suppliers provide ENT services to Medicare beneficiaries and then submit claims to one of CMS's four regional payment contractors, called Durable Medical Equipment (DME) MACs. Each DME MAC is also associated with a program safeguard contractor that conducts benefit integrity activities, including medical reviews. Medicare contractors use the fee schedule to reimburse claims for ENT products. CMS does not take nutrient packaging into account when setting fee schedule amounts. The fee schedule is updated annually and percentage increases in the urban Consumer Price Index determine changes in the reimbursement amounts.

Fee schedules can also change as a result of CMS revisions and/or through application of inherent reasonableness. CMS has authority to establish a realistic and equitable (inherently reasonable) payment amount for most Medicare Part B services, other than physicians' services, when the existing payment amounts are inherently unreasonable. This may result when the payment amounts are either grossly excessive or deficient. Generally, these amounts are defined as

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requiring an adjustment of over 15 percent to produce an equitable and realistic payment amount. Factors that CMS may consider in its determination include price markup, charge differences, the noncompetitiveness of the market place, payments in particular localities that grossly exceed those of other localities for the same services, payments that grossly exceed acquisition or production costs, payment increases that cannot be explained by inflation or technology, and payments for which Medicare and Medicaid are the sole or primary payment sources.⁸

Medicaid. Medicaid was the primary payer for 65 percent of nursing home stays during 2006.⁹ All of these stays were non-Part A stays, because Medicare did not pay for them. Unlike Medicare, Medicaid is a joint State-Federal program administered by the States. Within broad Federal guidelines, States establish their own eligibility standards encompassing Federal requirements and available options; thus, every State Medicaid program is different. All other available third party resources, including Medicare, must meet their legal obligation to pay for covered health care services before Medicaid makes any payments.¹⁰ To ensure that Medicaid recipients with Medicare eligibility receive Part B benefits during their NF stays and to facilitate payment by Part B, State Medicaid programs routinely pay Part B premiums for eligible beneficiaries.

Stays in a NF are always considered non-Part A stays because a NF is not certified for Medicare Part A services. NF residents who are eligible only for Medicaid and require enteral nutrients may have them paid as part of Medicaid's daily payment rate to the nursing homes. For those NF residents who are eligible for both Medicaid and Medicare Part B, Part B will pay for their enteral nutrients.

All State Medicaid programs provide payment for ENT.¹¹ State Medicaid programs' coverage and subsequent payment for ENT generally occurs under one of three reimbursement methods:

⁸ 42 CFR § 405.502.

⁹ C. Harrington, et al., loc. cit.

¹⁰ The Act, § 1902(a)(25).

¹¹ The Henry J. Kaiser Family Foundation, *Medicaid Benefits: Online Database*. Available online at <http://www.kff.org/medicaid/benefits/index.jsp?CFID=32790568&CFTOKEN=15412220>. Accessed in June 2008.

- (1) the DME benefit as a prosthetic device, under which the State uses the Medicare fee schedule and HCPCS codes;
- (2) the pharmacy benefit, under which the State uses National Drug Codes (NDC); or
- (3) a combination of (1) and (2) above using both HCPCS and NDC codes.

Related Payment Legislation

Congress enacted legislation, such as the Balanced Budget Act of 1997 (BBA)¹² and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA),¹³ to further define Medicare payment criteria for nursing homes. The BBA established a prospective payment system for Part A stays and required nursing homes to arrange for and consolidate into a single Medicare bill the Part B services that are needed by a resident during his or her nursing home stay.¹⁴ Prior to the BBA, suppliers and providers of Part B services for nursing home residents (e.g., physical therapists) billed Medicare directly for their services. Implementation of consolidated billing first occurred only for Part A stays. In 2000, before the BBA was implemented for non-Part A stays, the BIPA was enacted. It maintained consolidated billing for Part A stays and therapy services but repealed consolidated billing requirements for non-Part A stays. Therefore, claims for beneficiaries during non-Part A stays continue to be individually submitted by suppliers and providers.

Mandate for Office of Inspector General To Monitor Part B Payments

In repealing the BBA's consolidated billing provisions for non-Part A nursing home stays, section 313 of the BIPA directed the Office of Inspector General (OIG) to perform monitoring of Medicare Part B payments during non-Part A stays. This ENT evaluation revisits prior OIG reports. Several additional studies will address other, previously identified, vulnerable Part B payment areas (e.g., DME and psychotherapy). The prior OIG reports regarding ENT include:

¹² P.L. No. 105-33.

¹³ P.L. No. 106-554.

¹⁴ BBA, § 4432.

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- *Coverage of Enteral Nutritional Therapy: Medicare and Other Payers*¹⁵ and *Medicare Payments for Enteral Nutrition Therapy Equipment and Supplies in Nursing Homes*¹⁶ both reported Medicare's vulnerability to excessive payments and the need for payment restructuring, particularly as related to ENT supplies and equipment.
- *Medicare Payments for Enteral Nutrition*,¹⁷ *Payments for Enteral Nutrition: Medicare and Other Payers*,¹⁸ and *Enteral Nutrient Payments in Nursing Homes*¹⁹ each reported excessive Medicare payment for enteral nutrients when compared to the actual cost of their purchase. These reports also recommended payment restructuring. Additionally, one of these reports argued that enteral nutrients should be redefined as "food" for Medicare payment purposes and thus should not be billed to Part B but included in a nursing home's daily rate.

In response to OIG's recommendations in the reports referenced above, CMS agreed that Medicare reimbursement for ENT was excessive and that there was a need for payment restructuring. However, CMS noted that any payment restructuring and related definitional changes would require legislation.

CMS also agreed with prior recommendations relating to consolidated billing. Past OIG evaluations supported CMS's seeking legislation to exclude enteral nutrients, supplies, and equipment from Part B reimbursement for residents in nursing homes engaged primarily in providing skilled care or rehabilitation. Such legislation would seek to treat the provision of ENT as room and board costs and thereby include them in the facility's daily room rate. CMS further agreed with the

¹⁵ OIG, *Coverage of Enteral Nutritional Therapy: Medicare and Other Payers* (OEI-03-94-00020), May 1995. Available online at http://oig.hhs.gov/oei/subject_index.asp. Accessed in June 2008.

¹⁶ OIG, *Medicare Payments for Enteral Nutrition Therapy Equipment and Supplies in Nursing Homes* (OEI-06-92-00866), May 1997. Available online at http://oig.hhs.gov/oei/subject_index.asp. Accessed in June 2008.

¹⁷ OIG, *Medicare Payments for Enteral Nutrition* (OEI-03-02-00700), March 2004. Available online at http://oig.hhs.gov/oei/subject_index.asp. Accessed in June 2008.

¹⁸ OIG, *Payments for Enteral Nutrition: Medicare and Other Payers* (OEI-03-94-00021), May 1996. Available online at http://oig.hhs.gov/oei/subject_index.asp. Accessed in June 2008.

¹⁹ OIG, *Enteral Nutrient Payments in Nursing Homes* (OEI-06-92-00861), March 1996. Available online at http://oig.hhs.gov/oei/subject_index.asp. Accessed in June 2008.

need for CMS to apply its authority to require competitive bidding for enteral nutrition products and inherent reasonableness. CMS noted that for application of inherent reasonableness, its payment contractors would have to develop written procedures for conducting reviews according to statute and regulation.

Efforts To Reduce Medicare Payments

As authorized by the BBA, CMS conducted a competitive bidding demonstration for enteral nutrients and associated supplies and equipment in Polk County, Florida, from October 1999 to September 2001. The project revealed that demonstration allowances were lower than the existing fee schedule for 22 of the 24 enteral items.²⁰ Project reviewers estimated that 2001 Medicare fee schedule reimbursement rates for the ENT would have decreased by 15.8 percent using demonstration prices.²¹

Subsequently, section 302 of the Prescription Drug, Improvement, and Medicare Modernization Act of 2003 (MMA) authorized use of the competitive acquisition authority outlined in section 1847(a) of the Act.²² Section 302(b)(1) of the MMA requires CMS to replace the current Medicare payment methodology for certain items (including ENT) with a competitive acquisition process that, according to CMS, “provides a way to harness marketplace dynamics to create incentives for suppliers to provide quality items in an efficient manner, at a reasonable cost to the Medicare beneficiaries with expected savings for Medicare.”²³ Although the competitive process is not yet implemented nationally, CMS is introducing it in nine markets for suppliers of

²⁰ Demonstration allowances, or the “fee schedule” for the bidding demonstration, were determined from demonstration suppliers’ bid submissions. Demonstration suppliers were selected using a four-stage bid evaluation process that included determining a composite bid and a cutoff bid based on supplier bid submissions. Suppliers that bid at or below the cutoff bid were eligible to participate in the demonstration if they met quality standards.

²¹ CMS, *Evaluation of Medicare’s Competitive Bidding Demonstration for DMEPOS* (durable medical equipment, prosthetics, orthotics, and supplies), September 2000 (revised January 2001). RTI Project Number 7346-002-008. Available online at http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/karon_2001_1.pdf. Accessed in January 2009.

²² P.L. No. 108-173.

²³ CMS, *Competitive Acquisition for DMEPOS*. Available online at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2812&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=false&choOrder=date>. Accessed in March 2009.

selected DMEPOS. Medicare suppliers of DMEPOS, unless exempt, were required to be accredited and obtain surety bonds by October 1, 2009, and October 2, 2009, respectively. CMS expected to begin the 60-day bid window for Round 1 Rebid by October 21, 2009, and to implement the program by January 1, 2011.²⁴

METHODOLOGY

Scope

This evaluation identifies pricing for the most frequently billed enteral nutrient HCPCS codes, B4150 and B4154, during non-Part A stays in 2006. These codes represent \$117.8 million (83 percent) of Medicare Part B-allowed charges for enteral nutrients during these stays.

Identification of Enteral Nutrients, Supplies, and Equipment During a Nursing Home Stay

We used several databases obtained from CMS to identify Part B payments allowed for ENT during nursing home stays. These databases included the: Minimum Data Set (MDS), Online Survey Certification and Reporting system (OSCAR), Enrollment Database (EDB), and National Claims History (NCH).

Minimum Data Set. We used the MDS to identify all 2006 nursing home residents, related nursing homes, and nursing home stay dates. The MDS, a component of the resident assessment instrument, includes information about each resident's health, physical functioning, mental status, and general well-being.²⁵ Each nursing home reports these individual assessments electronically upon admission and updates them at least quarterly.²⁶ The MDS includes nursing home admission and discharge dates. States receive assessments from nursing homes and transmit the data to CMS. Using the MDS data, we identified all assessed residents and their Social Security numbers (SSN). To determine stay dates, we extracted all nursing home admission and discharge dates for each resident.

²⁴ CMS, *DMEPOS Competitive Bidding, Latest News and Announcements*. Available online at <http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/DocsCat/Home> (CMS's Competitive Bidding Implementation Contractor is Palmetto). Accessed on August 25, 2009.

²⁵ OBRA.

²⁶ More frequent assessments are required for stays paid under the Part A SNF benefit.

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We used assessment dates as proxies for missing admission or discharge dates according to the following assumptions:

- *Missing Admission Date.* If the resident was in the nursing home on January 1, 2006 (determined from subsequent assessments that the nursing homes conducted), we used the date of the first assessment conducted in 2005 as the admission date.
- *Missing Discharge Date.* In this instance, we defined the date of the last assessment (received through March 2007) as the discharge date.

Online Survey Certification and Reporting. To obtain information about the nursing home (e.g., facility name, address, number of beds, and SNF or NF certification), we linked the MDS facility identification number with the facility numbers maintained in OSCAR. OSCAR contains survey results from certification and complaint surveys.

Enrollment Database. We used the EDB to identify Medicare beneficiaries. This database includes beneficiary-level data (i.e., name, SSN, and Medicare Health Insurance Claim Number (HICN)). Using this database, we matched SSNs in the MDS file to SSNs in the EDB to identify Medicare beneficiaries and their associated HICNs. We excluded beneficiaries having no matching SSN from further analysis.

National Claims History. We used the NCH to identify Part B ENT payments made during non-Part A stays. We matched the HICNs in the EDB to those in the NCH to identify all ENT claims allowed for Medicare beneficiaries during any nursing home stay. We then removed all ENT claims billed for beneficiaries during Part A paid nursing home or inpatient hospital stays.²⁷ The resulting dataset comprised all ENT nutrient HCPCS codes (see Appendix A) and all ENT supplies and equipment HCPCS codes (see Appendix B) for which billing was allowed under Part B during non-Part A stays in 2006.

Identification of Enteral Nutrient Prices

To obtain prices and packaging information for enteral nutrients covered under HCPCS codes B4150 and B4154, the most frequently billed enteral nutrient HCPCS codes, we surveyed nursing homes and suppliers represented in a random sample of claims. We also purchased

²⁷ OIG's Office of Audit Services routinely conducts audits related to inappropriate Part B payments occurring during Part A stays. Consequently, we excluded all Part A stays from our review.

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industry pricing data from a market research firm. We then compared Medicare-allowed payments and fee schedule amounts to data from these two sources.

Survey of nursing homes and suppliers. We identified nursing homes associated with at least one claim for either HCPCS codes B4150 or B4154 in 2006 and divided the population into two strata based on ENT volume. The first stratum contained 8,018 nursing homes associated with allowed ENT payments of \$17,000 or less, and the second stratum contained 2,692 nursing homes associated with allowed ENT payments of more than \$17,000. We randomly selected 160 nursing homes from each stratum, for a total of 320 nursing homes. We then randomly selected three enteral nutrient claims having service dates in 2006 associated with each of the 320 nursing homes (or all claims if there were fewer than three). This resulted in a sample of 938 claims submitted by 216 suppliers for 712 beneficiaries. For these 938 claims, Medicare allowed nearly \$280,000 and reimbursed nearly \$223,000. For the sampled claims, the 216 suppliers billed as little as \$15 and as much as \$13,394, with an average of \$1,295 per supplier.

We mailed surveys to the 320 nursing homes and the 216 associated suppliers. We removed 10 suppliers from the sample because of incorrect addresses on file; we removed an additional 7 suppliers because of company dissolution or ongoing investigations by other governmental departments. Of the remaining 199 suppliers, 190 responded to the surveys (88 percent); of the 320 nursing homes, 304 responded (95 percent). Responding suppliers represent about 80 percent of claims associated with HCPCS code B4150 (366 claims) in the sample and about 75 percent of the claims associated with HCPCS code B4154 (230 claims) in the sample.²⁸

Using survey results, we organized enteral nutrient packaging into two categories: ready-to-hang (RTH) and ready-to-use (RTU). We calculated unit prices for RTH and RTU packaging categories for HCPCS codes B4150 and B4154. Using these data, we calculated an average unit price for B4150 and B4154 and identified the higher of the two packaging prices for each supplier. For each claim in the sample, we used this higher identified price to calculate an average unit price, which provided a

²⁸ Of the 320 nursing homes represented in the sampled claims, 12 percent (39) reported that they served as their own suppliers for purchasing enteral nutrients, supplies, and equipment.

conservative estimate of prices available to nursing home suppliers. We then calculated the difference between the actual Medicare-allowed amount and the estimated prices available to suppliers. We performed this calculation using the population of 2006 claims for HCPCS codes B4150 and B4154 and their respective estimated average unit prices from our sample. We weighted the sample statistics according to the sampling design.

Industry pricing data. To buttress results from our sample and to identify pricing for other purchasers, we obtained pricing data for 2006 from a market research firm that routinely surveys different sectors of the business community (i.e., hospitals, nursing homes, and retail outlets).²⁹ The purchased dataset contained sales information for specific enteral nutrients, defined as complete food supplements. It contains the dollar amounts from the actual invoice prices, meaning that the provided amounts were exactly what the outlets paid wholesalers to acquire these products. The market research firm estimates that it captures 84 percent of the total U.S. market, including 94 percent of the volume sold to nursing homes for their residents in 2006. We calculated unit prices for nutrients identified as either HCPCS code B4150 or code B4154 and compared the medians of these prices with Medicare's fee schedule amounts. We used median prices because outliers skewed the average. We also used the data to identify enteral nutrition prices available to hospitals, home health agencies, and the public through retail outlets.

Limitations

We did not validate the supplier-reported prices or the market research firm's pricing data. Nor did we identify the specific brands of enteral nutrients associated with the sampled claims. Although we did obtain some supply contracts, rebate information, and purchase agreements from nursing homes and suppliers, very little of this information provided specific cost information. Such information could have lowered the average unit prices for the enteral nutrients.

²⁹ The company performs surveys of different sectors of the business community to identify purchase patterns of various products. It markets these data to the provider community. One of the products tracked is complete food supplements (enteral nutrients) purchased by hospitals, long term care facilities (including nursing homes), and other entities. A sample of sales information is obtained and then projected to the Nation. Specifically, this database contains direct sales from manufacturers to retail and nonretail outlets as well as indirect sales from wholesalers to retail and nonretail outlets.

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Prices obtained from surveys of nursing homes and suppliers also did not include shipping and delivery costs. Further, we did not include administrative costs or staffing costs associated with administering the enteral nutrients. Using these costs could have raised the average unit prices for the enteral nutrients.

Finally, we were unable to reliably determine the actual cost of conventional food per patient per day among typical nursing homes for comparison to enteral nutrient product costs. Two avenues attempted were an assessment of SNF cost reports and a request for cost information from large nursing home chains.

First, SNFs' annual cost reports submitted to CMS are not reliable for determining an accurate measure of food costs. We reviewed the 2006 annual cost summary report and found that reported dietary expenses varied widely because the dietary cost center may include not only the actual cost of food products but other expenses. These other expenses might include costs associated with food preparation or procurement, salaries of feeding assistants (typically a nursing service), and utensils.

Second, we contacted the 10 largest nursing home chains to request the average cost range (from low to high) of conventional food per patient per day in their nursing homes. However, we received data from only four and are not able to project the results. Among these four, representing approximately 5 percent of all nursing homes, the reported current average daily patient food costs ranged from a low of \$4.75 to a high of \$7.27 in 2009. This compares to \$6.40 for enteral nutrients (B4150) calculated using the average supplier cost determined in this evaluation and assuming a typical resident's dietary needs. We did not verify the costs reported by these chains or obtain more current supplier cost data. However, one of these chains reported that while the cost of conventional food has steadily increased since 2006, its cost for enteral nutrition therapy products has remained relatively flat.

Standards

This study was conducted in accordance with the *Quality Standards for Inspections* approved by the Council of the Inspectors General on Integrity and Efficiency.

► F I N D I N G

Medicare’s fee schedule for enteral nutrients provided under Part B during non-Part A stays was more than double the prices available to suppliers of nursing homes and other purchasers in 2006

We estimated that the average unit price available to suppliers responding to our survey was \$0.32 for HCPCS nutrient code B4150 and \$0.56 for nutrient code

B4154.³⁰ (See Appendix C for confidence intervals.) Medicare’s fee schedule amount for HCPCS code B4150 in 2006 (\$0.67) exceeded the estimated price by \$0.35, which is 52 percent of the fee schedule amount for code B4150. Further, Medicare’s fee schedule amount for HCPCS code B4154 in 2006 (\$1.22) exceeded the estimated price by \$0.66, which is 54 percent of the fee schedule amount. Using average unit prices estimated from our surveys, we determined that Medicare’s allowance for these two most frequently billed enteral nutrient codes exceeded prices available to suppliers by approximately \$61 million for non-Part A nursing home stays in 2006. (See Table 1.)

Table 1: Actual Medicare Allowances and Estimated Supplier Prices Available for Selected Enteral Nutrient HCPCS Codes During Non-Part A Nursing Home Stays in 2006

HCPCS	Actual Medicare Allowance*	Estimated Supplier Prices**	Difference***
B4150	\$52.8 million	\$26.0 million	\$26.8 million
B4154	\$65.0 million	\$30.6 million	\$34.4 million
TOTAL	\$117.8 million	\$56.6 million	\$61.2 million

*Actual Medicare allowance for HCPCS codes B4150 and B4154 during non-Part A nursing home stays in 2006.

**Using survey prices, the estimated supplier prices for HCPCS codes B4150 and B4154 during non-Part A nursing home stays in 2006.

***Difference between actual Medicare allowance and estimated supplier prices for HCPCS codes B4150 and B4154 during non-Part A nursing home stays in 2006.

Source: OIG’s analysis of supplier surveys and ENT claims made for residents during non-Part A stays in 2006.

Industry pricing data confirmed that Medicare’s fee schedule amounts exceeded unit prices available to other purchasers, including nursing homes

No purchaser type in the industry data paid at or above Medicare’s fee schedule amounts for claims with HCPCS codes B4150 or B4154. The fee schedule amount for HCPCS code B4150 exceeded the median unit price available to long term care entities, including nursing homes, by

³⁰ We estimate that the median unit price was \$0.32 and \$0.54 for HCPCS codes B4150 and B4154, respectively.

F I N D I N G

52 percent; the fee schedule amount for HCPCS code B4154 exceeded the median unit price available to long term care entities by 100 percent. (See Table 2.) The unit price closest to the fee schedule was for HCPCS code B4150 in Federal facilities at 79 percent of the fee schedule amount. The largest unit price difference was for HCPCS code B4154 purchased by non-Federal hospitals at 34 percent of the fee schedule amount.

Table 2: Comparison of Medicare’s Fee Schedule Amounts to Prices Available to Other Purchasers of Enteral Nutrients in 2006

Type of Purchaser in Industry Report	B4150		B4154	
	Median Unit Price (N)	Fee Schedule Exceeds Price By:	Median Unit Price (N)	Fee Schedule Exceeds Price By:
Chain Stores	\$0.48 (269)	\$0.19 (40%)	\$0.61 (133)	\$0.61 (100%)
Clinics	\$0.46 (239)	\$0.21 (46%)	\$0.59 (106)	\$0.63 (107%)
Federal Facilities	\$0.53 (98)	\$0.14 (26%)	\$0.61 (58)	\$0.61 (100%)
Food Stores	\$0.50 (219)	\$0.17 (34%)	\$0.62 (101)	\$0.60 (97%)
Health Maintenance Organizations	\$0.52 (55)	\$0.15 (29%)	\$0.59 (30)	\$0.63 (107%)
Home Health	\$0.41 (263)	\$0.26 (63%)	\$0.60 (125)	\$0.62 (103%)
Independent	\$0.48 (247)	\$0.19 (40%)	\$0.62 (120)	\$0.60 (97%)
Long Term Care	\$0.44 (285)	\$0.23 (52%)	\$0.61 (135)	\$0.61 (100%)
Mail Service	\$0.42 (192)	\$0.25 (59%)	\$0.49 (86)	\$0.73 (149%)
Non-Federal Hospitals	\$0.31 (278)	\$0.36 (116%)	\$0.41 (153)	\$0.81 (198%)
Prisons	\$0.43 (85)	\$0.24 (56%)	\$0.59 (44)	\$0.63 (107%)
Selected Markets	\$0.43 (384)	\$0.24 (56%)	\$0.56 (196)	\$0.66 (118%)
Universities	\$0.52 (35)	\$0.15 (29%)	\$0.57 (8)	\$0.65 (114%)
Other	\$0.49 (143)	\$0.18 (37%)	\$0.58 (49)	\$0.64 (110%)
Medicare Fee Schedule	\$0.67 NA	NA NA	\$1.22 NA	NA NA

Median unit prices are shown because outliers skewed the average unit prices.

“N” represents the number of entities included in industry dataset.

The “long term care” type of provider includes nursing homes and is bolded for easy comparison to the Medicare Fee Schedule.

Source: OIG’s analysis of 2006 industry pricing data.

Nutrient packaging had little effect on pricing

Although we used the highest packaging price to compare the Medicare fee schedule amounts to supplier prices, average unit prices for RTU and RTH products were similar.³¹ For HCPCS code B4150, 81 percent of the suppliers associated with the sampled claims purchased RTU and

³¹ These averages are unweighted average unit prices among the suppliers in our sample.

F I N D I N G

91 percent purchased RTH. The average supplier unit price for RTH was \$0.01 higher than the average supplier unit price for RTU (\$0.32 and \$0.31, respectively). For HCPCS code B4154, 79 percent of suppliers purchased RTU and 84 percent purchased RTH. The average supplier unit price for RTH was \$0.07 higher than the average supplier unit price for RTU (\$0.58 and \$0.51, respectively).

► R E C O M M E N D A T I O N

This evaluation is consistent with prior OIG reports that have found that Medicare's fee schedule amounts exceed available market prices for ENT. Current Medicare payments do not reflect the buying power of nursing home suppliers to obtain nutrients at lower prices than reflected in the Medicare fee schedule. To more appropriately reimburse ENT, CMS should:

Adjust the Medicare fee schedule amounts for enteral nutrients to more accurately reflect supplier prices for nutrients provided to nursing home residents

CMS can use inherent reasonableness reviews or may be able to act on pricing information from the competitive bidding program for DMEPOS. In response to prior OIG reports, CMS has indicated its willingness to pursue inherent reasonableness reviews; however, no such reviews have been reported.

Payments for ENT could be further impacted if Congress changed the prosthetic device benefit to restrict Part B coverage to a beneficiary's home and thereby recognized enteral nutrients as food covered under nursing home room and board payment. Such a policy change would end Part B payments for ENT costs in nursing homes and would affect nearly half of all current Part B ENT payments annually. The rationale behind a change to the benefit is that enteral nutrient feeding costs may be comparable to conventional meal costs incurred for other nursing home residents. These conventional meal costs are reimbursed under the nursing home's room and board payment. Further, a change to the prosthetic device benefit is consistent with a nursing home's responsibility to feed its residents and DME payment policy that places the responsibility on nursing homes, as institutions, to provide for the basic equipment needs of residents. Such a payment policy change would encourage nursing homes to act as prudent purchasers and to exert their institutional buying power in obtaining nutrients, supplies, and equipment for ENT. Limiting the prosthetic device benefit to the home setting would require legislative action and could result in as much as \$284 million in program savings. However, additional assessment is needed to establish the comparability of conventional meal costs to ENT and the impact of such a policy change on nursing homes.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS agreed with our recommendation that Medicare payments for enteral nutrients be adjusted to more accurately reflect supplier prices for nutrients provided to nursing home residents. CMS cited two actions it is taking to accomplish this. First, the rebid of the DMEPOS competitive bidding program is scheduled to take effect on January 1, 2011, and includes enteral nutrients, supplies, and equipment. Second, CMS will consider adjusting the Medicare fee schedule for enteral nutrients once sufficient data are available from the bidding process. For the full text of CMS's comments, see Appendix D.

We did not make any changes to the report based on CMS's comments.

▶ A P P E N D I X A

Table A-1: Healthcare Common Procedure Coding System Enteral Nutrient Codes and Related Fee Schedule Amounts During Non-Part A Nursing Home Stays in 2006

Code	Description	Fee Schedule Amount*
B4149	Manufactured, blenderized natural foods with intact nutrients	\$1.57
B4150	Nutritionally complete with intact nutrients	\$0.67
B4152	Nutritionally complete, calorically dense, with intact nutrients	\$0.56
B4153	Nutritionally complete, hydrolyzed proteins (amino acids and peptide chain)	\$1.91
B4154	Nutritionally complete, for special metabolic needs	\$1.22
B4155	Nutritionally incomplete/modular nutrients, includes specific nutrients	\$0.95
B4157	Nutritionally complete, for special metabolic needs for inherited disease of metabolism	**
B4159	Nutritionally complete, soy based with intact nutrients, for pediatrics	**

Bolded codes are those that represent the majority of enteral nutrient claims and for which we determined pricing.

*Per unit (100 calories).

**No national fee schedule amount available from the Centers for Medicare & Medicaid Services (CMS) in the Durable Medical Equipment Coding System; Durable Medical Equipment Medicare Administrative Contractors must be contacted for pricing information.

Source: CMS national fee schedule available from the Statistical Analysis Durable Medical Equipment Regional Carrier, the national entity contracted by CMS.



A P P E N D I X B

Table B-1: Healthcare Common Procedure Coding System Enteral Supply and Equipment Codes and Related Fee Schedule Amounts During Non-Part A Nursing Home Stays in 2006

Code	Description	Fee Schedule Amount
B4034	Syringe feeding supply kit, per day	\$6.12
B4035	Infusion pump feeding supply kit, per day	\$11.66
B4036	Gravity feeding supply kit, per day	\$8.00
B4081	Nasogastric tubing with stylet	\$21.62
B4082	Nasogastric tubing without stylet	\$16.09
B4083	Stomach tube – Levine type	\$2.46
B4086	Gastrostomy/jejunostomy tube	\$25.69
B9000	Infusion pump without alarm	\$1,226.26 ¹ \$919.69 ² \$112.68 ³
B9002	Infusion pump with alarm	\$1,126.26 ¹ \$919.69 ² \$118.77 ³
B9998	Enteral supply not otherwise classified	*
E0776	Intravenous pole (must have a BA modifier)	\$101.98 ¹ \$76.49 ² \$25.81 ³

¹ New equipment.

² Used equipment.

³ Rented equipment.

*No national fee schedule amount available from the Centers for Medicare & Medicaid Services (CMS) in the Durable Medical Equipment Coding System; Durable Medical Equipment Medicare Administrative Contractors must be contacted for pricing information.

Source: CMS's national fee schedule obtained from the Statistical Analysis Durable Medical Equipment Regional Carrier.

▶ A P P E N D I X C

Table C-1: Confidence Intervals for Selected Statistics*

Statistic	N	Estimate	95-Percent Confidence Interval
Estimated average unit price for Healthcare Common Procedure Coding System (HCPCS) code B4150, using highest packaging price	366 claims	\$0.32	\$0.31–0.34
Estimated prices available to suppliers for HCPCS code B4150, using unit prices obtained from supplier surveys	366 claims	\$26.0 million	\$24.9–27.1 million
Difference between actual Medicare allowance and estimated supplier prices for HCPCS code B4150	366 claims	\$26.9 million	\$25.8–28.0 million
Estimated average unit price for HCPCS code B4154, using highest packaging price	230 claims	\$0.56	\$0.54–0.59
Estimated prices available to suppliers for HCPCS code B4154, using unit prices obtained from supplier surveys	230 claims	\$30.6 million	\$29.1–32.1 million
Difference between actual Medicare allowance and estimated supplier prices for HCPCS code B4154	230 claims	\$34.3 million	\$32.8–35.9 million

*The estimates and 95-percent confidence intervals are based on the population of HCPCS codes B4150 or B4154 claims, using the weighted average unit prices estimated from our sample.

Source: Office of Inspector General's sample analysis and projections of enteral nutrient claims for non-Part A nursing home stays during 2006.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 12 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera */S/*
Acting Administrator

SUBJECT: Office of Inspector General Draft Report: "Medicare Part B Services During Non-Part A Nursing Home Stays: Enteral Nutrient Pricing" (OEI-06-07-00590)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report entitled "Medicare Part B Services During Non-Part A Nursing Home Stays: Enteral Nutrient Pricing." The report compares the Medicare fee schedule amounts for these items to prices available to suppliers of nursing homes and other purchasers in 2006.

The Centers for Medicare & Medicaid Services (CMS) included enteral nutrients, supplies, and equipment as a product category in Round 1 of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. Under the competitive bidding program, payment in competitive bidding areas is limited to suppliers who have submitted and been awarded contracts with Medicare. Payment is set at the "single payment amount," which is determined using bid amounts and is lower than the fee schedule payment amount. The competitive bidding program went into effect in 10 competitive bidding areas on July 1, 2008.

The single payment amounts for enteral nutrients, supplies, and other covered equipment resulting from this competition were 26 percent lower, on average, than the corresponding Medicare fee schedule amounts at that time. However, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) delayed Round 1 of the DMEPOS competitive bidding program and required that re-bidding occur in 2009. The MIPPA mandated that the Round 1 re-bid program include the same items that were bid in Round 1, which includes enteral nutrients, supplies, and equipment. The bidding for the Round 1 re-bid of the program began on October 21, 2009, and the program is scheduled to take effect on January 1, 2011.

The OIG draft report provides valuable insight for CMS on suppliers' costs for enteral nutrients.

OIG Recommendation:

Adjust the Medicare fee schedule amounts for enteral nutrients to more accurately reflect supplier prices for nutrients provided to nursing home residents.

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CMS Response:

We agree that Medicare payments for enteral nutrients should be adjusted to more accurately reflect supplier prices for nutrients provided to nursing home residents. CMS is taking several actions to accomplish this. First, the Round 1 re-bid of the DMEPOS competitive bidding program includes the product category for enteral nutrients, supplies, and equipment. The program is scheduled to take effect on January 1, 2011. As of the effective date of the program, payment for enteral nutrients, supplies, and equipment in the competitive bidding areas will be at the single payment amounts. Second, in accordance with section 1842(s)(3) of the Social Security Act, information from the DMEPOS competitive bidding program can be used to adjust payment amounts in other (non-competitive bidding) areas. CMS will carefully consider applying that authority and adjust the Medicare fee schedule for enteral nutrients once sufficient data is available from the bidding process.

The CMS would like to thank the OIG for their efforts and insight on this important Medicare issue. The report provides valuable information that will assist the Agency in its efforts to ensure appropriate Medicare coverage and payment for enteral nutrients. We look forward to working with the OIG further on this and other critical issues.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Kevin K. Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and A. Blaine Collins, Deputy Regional Inspector General.

Leah K. Bostick served as the team leader for this evaluation, and Dana McClellan served as lead analyst. Other principal Office of Evaluation and Inspections staff from the Dallas regional office who contributed to this study include Petra Johansson, Sai Loganathan, and Jeremy Moore; central office staff who contributed include Robert L. Gibbons, Scott Horning, Jennifer Jones, and Sandy Khoury.

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