

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**Medicare Reimbursement for Parenteral  
Nutrition**



**JUNE GIBBS BROWN  
Inspector General**

**JULY 1997  
OEI-03-96-00230**

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# EXECUTIVE SUMMARY

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## PURPOSE

This report examines Medicare's reimbursement of parenteral nutrition compared to that of State Medicaid agencies, Medicare risk-contract health maintenance organizations (HMOs), and manufacturers' charges to suppliers.

## BACKGROUND

### *Medicare Coverage of Parenteral Nutrition*

For Medicare beneficiaries with severe permanent disease of the gastrointestinal tract, parenteral nutrition may be the only way to receive the nutrients they need.

Parenteral nutrition is a liquid solution provided intravenously through use of an indwelling catheter and a parenteral nutrition infusion pump. Parenteral nutrition is covered under Medicare's prosthetic device provision. According to the Medicare Carriers Manual, section 2130, Medicare covers accessories and/or supplies which are used with a parenteral device to achieve the therapeutic benefit of the device.

Medicare only covers parenteral nutrition for beneficiaries whose gastrointestinal condition (e.g., massive bowel resection) permanently prevents them from absorbing the nutrients needed to maintain weight and strength commensurate with their health status.

According to the Part B Extract and Summary System (BESS), Medicare allowed \$163 million in 1995 for parenteral nutrition solutions, not including pumps or supplies. Eighty-nine percent of this was for just four procedure codes (B4189, B4193, B4197, and B4199) representing pre-mixed parenteral solutions with varying amounts of protein. See Appendix A for a complete description of each code.

We compared Medicare's reimbursement methodology and reimbursement levels for the four parenteral nutrition procedure codes with the highest allowances in 1995 with those of State Medicaid agencies and the 20 Medicare risk-contract HMOs with the highest enrollments. We also compared Medicare's reimbursement levels with manufacturers' contract prices for one low-volume parenteral nutrition supplier.

## FINDINGS

*Medicare reimbursement for the four parenteral nutrition codes is an average of 45 percent higher than lower-paying Medicaid agencies.*

Thirty-two of the 49 Medicaid agencies that responded to our survey were able to provide at least some pricing information on the four selected parenteral nutrition procedure codes. Medicare reimbursement for one or more of the four parenteral nutrition codes is higher than that of the majority of these 32 agencies.

***Medicare reimbursement for the four parenteral nutrition codes is an average of 78 percent higher than lower-paying Medicare risk-contract HMOs.***

Ten of the 17 Medicare risk-contract HMOs that responded to our survey were able to provide pricing information on one or more of the four selected parenteral nutrition codes. Medicare reimburses more than all 10 HMOs for one or more of the four codes examined.

***Medicare reimbursement for the four parenteral nutrition codes is an average of 11 times higher than some manufacturers' contract prices.***

Medicare reimbursement for the four selected codes is between 9 and 12 times percent higher than the contracted price charged by three manufacturers to a low-volume supplier of parenteral nutrition.

## **RECOMMENDATION**

**HCFA should examine other payment methods that could lead to more cost effective reimbursement for parenteral nutrition solutions.**

It is clear that many other payers reimburse less than Medicare for parenteral nutrition. In addition, suppliers may purchase parenteral nutrition solutions at discounted prices which are significantly lower than Medicare's reimbursement rates. We urge HCFA to pursue one or more of the following options to bring Medicare's reimbursement in line with Medicaid and other payers.

### Inherent Reasonableness

The Secretary or the DMERCs can use their "inherent reasonableness" authority to reduce reimbursement to more appropriate levels.

### Acquisition Cost

The HCFA could base its reimbursement on suppliers acquisition costs. There is evidence that acquisition costs for parenteral nutrition are far below Medicare's current reimbursement rate.

### Competitive Bidding

The HCFA could seek legislative authority to use competitive bidding to take advantage of its position as a high-volume purchaser of parenteral nutrition.

## **AGENCY COMMENTS**

The HCFA concurred with our recommendation. The HCFA reported that they have convened a workgroup to focus on ways to reduce and control costs for parenteral nutrition. The HCFA also explained that the President's Fiscal Year 1998 budget includes proposals to give carriers the authority to make inherent reasonableness adjustments for durable medical equipment, to eliminate the mark up for drugs and biologicals and include acquisition cost in the reimbursement calculation, and to authorize the Secretary to set payment rates for Part B services bases on competitive bidding.

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# INTRODUCTION

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## **PURPOSE**

This report examines Medicare's reimbursement of parenteral nutrition compared to that of State Medicaid agencies, Medicare risk-contract health maintenance organizations (HMOs), and manufacturers' charges to suppliers.

## **BACKGROUND**

For Medicare beneficiaries with severe permanent disease of the gastrointestinal tract, parenteral nutrition may be the only way to receive the nutrients they need. Parenteral nutrition is a liquid solution provided intravenously through use of an indwelling catheter and a parenteral nutrition infusion pump. The solution is usually composed of protein, carbohydrates, electrolytes, multivitamins, and trace elements. Beneficiaries using parenteral nutrition may also be administered fat emulsions (lipids) about twice a week.

### *Medicare Program*

Parenteral nutrition is covered under Medicare's prosthetic device provision. According to the Medicare Carriers Manual, section 2130, Medicare covers accessories and/or supplies which are used with a parenteral device to achieve the therapeutic benefit of the device. Medicare only covers parenteral nutrition for beneficiaries whose gastrointestinal condition (e.g., massive bowel resection) permanently prevents them from absorbing the nutrients needed to maintain weight and strength commensurate with their health status. Parenteral nutrition is only covered when administered under a doctor's order.

As of October 1993, the Health Care Financing Administration (HCFA), which administers the Medicare program, began to regionalize the processing of claims for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) into four Durable Medical Equipment Regional Carriers (DMERCs). Prior to this, HCFA contracted with two specialty carriers to process parenteral nutrition claims. Parenteral nutrition, as a supply used with a prosthetic device, is part of the DMERCs' claims processing responsibilities. Establishing the DMERCs was part of an effort by HCFA to prevent fraud and abuse and streamline claims processing. The DMERCs are also responsible for setting the reimbursement amounts based on Medicare guidelines.

### ***Medicare Allowances for Parenteral Nutrition***

According to the Part B Extract and Summary System (BESS), Medicare allowed \$163 million in 1995 for parenteral nutrition solutions, not including pumps or supplies. Eighty-nine percent of this was for just four procedure codes (B4189, B4193, B4197, and B4199) representing pre-mixed parenteral solutions with varying amounts of protein. See Appendix A for a complete description of each code. According to the Medicare Coverage Issues Manual, parenteral nutrition components are normally mixed by the beneficiary or another nonprofessional person. However, Medicare will cover the more expensive pre-mixed solutions if the beneficiary is unable to safely or effectively mix the solution and there is no family member or other person who can do so. In 1993 and 1994, the four pre-mixed solution codes represented, respectively, 89 and 81 percent of all allowances for parenteral nutrition solution.

### ***Medicare Reimbursement Methodology***

Medicare establishes reimbursement for 23 procedure codes related to parenteral nutrition. Medicare uses the reasonable charge methodology to determine the allowances for each parenteral nutrition code. The reasonable charge which is used in determining the allowed amount for a particular procedure code is the lowest of:

1. the actual charge as submitted on the claim;
2. the supplier's customary charge;
3. the prevailing charge;
4. the lowest charge level (LCL); or
5. the inflation index charge (IIC).

According to the Omnibus Budget Reconciliation Act of 1986, reimbursement levels for parenteral nutrition solutions and supplies must include the lowest charge level methodology. The lowest charge level is the 25th percentile of providers' charges.

### ***Other Payers' Reimbursement Methodologies***

According to research conducted by the Office of Inspector General's (OIG) Office of Audit Services (OAS), some other payers pay significantly less for parenteral nutrition than Medicare. Some of these payers' reimbursement formulas include payments based on all-inclusive per diem rates. All-inclusive or global rates include parenteral nutrition solution, supplies, administration kits, infusion pumps, and IV poles.

### ***Related Work by the Office of Inspector General***

In 1993, the OIG's Office of Evaluation and Inspections released a report titled, *Inappropriate Payments for Total Parenteral Nutrition* (OEI-12-92-00460). The inspection found: (1) Medicare overpaid \$69 million for total parenteral nutrition in 1991, 43 percent of the total of \$162 million allowed for this service; (2) 53 percent of the beneficiaries had end-stage renal disease and received parenteral nutrition as a

supplement three times a week, at high cost and with questionable benefits; (3) review of the use of parenteral nutrition among non end-stage renal disease beneficiaries revealed inappropriate patient selection and over- and under-feeding.

## **METHODOLOGY**

We determined Medicare's allowances for each of the 23 procedure codes which cover parenteral nutrition solutions and supplies. We arrayed these codes by allowance for 1993, 1994, and 1995. We determined Medicare's 1996 reimbursement levels based on the Medicare's maximum reimbursement for the four parenteral nutrition solution codes with the highest allowances in 1995.

With the assistance of a pharmacist-consultant, we identified the components which would generally be included in solutions reimbursed under each of the four codes.

We contacted each State Medicaid agency to determine what their reimbursement formulas were and their maximum reimbursement for the solutions representing the four codes. We also determined what items or services, if any, were included in their reimbursement for parenteral nutrition solutions.

We identified the 20 Medicare risk-contract HMOs with the highest enrollments as of July 1996. These HMOs covered 50 percent of all Medicare beneficiaries enrolled in risk-contract HMOs. We contacted each HMO to determine what their reimbursement formulas were and their maximum reimbursement for the solutions representing the four codes. We also determined what other items or services were included in their reimbursement for parenteral nutrition solutions.

### **Supplier**

In order to provide an illustration of provider acquisition costs for parenteral nutrition solution, we obtained one supplier's contracted prices for parenteral nutrition products. We compared the supplier's cost for the nutrition products with Medicare reimbursement rates. These contracted prices are from the three manufacturers that dominate the parenteral nutrition market. Manufacturers provide different contracted prices to suppliers based on the volume purchased. Since we received information from a low-volume supplier, the manufacturers' contracted prices represent the upper threshold of suppliers' contracted acquisition costs. Large volume purchasers would probably receive even further discounts in price from the manufacturers.

While our primary emphasis is on how Medicare's reimbursement compares to that of other payers, we used the supplier's contracted prices with manufacturers to provide a basic comparison of how acquisition costs for parenteral nutrition products compare to Medicare's reimbursement.

## FINDINGS

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### **Medicare Reimbursement for the Four Parenteral Nutrition Codes is an Average of 45 Percent Higher Than Lower-Paying Medicaid Agencies.**

Thirty-two of the 49 Medicaid agencies that responded to our survey provided pricing information on one or more of the four selected parenteral nutrition procedure codes. Medicare reimbursement for one or more of the four parenteral nutrition codes is higher than that of the majority of these 32 agencies (see Chart A on the next page). In 1995, if Medicare reimbursement for each of these four codes were reduced by the average amount Medicare reimburses more than lower-paying Medicaid agencies, total allowances would have been reduced from \$145 million to \$80 million.<sup>1</sup>

#### *Procedure Code B4189*

Medicare reimbursement for B4189 (\$162.39) is higher than more than two-thirds of the State Medicaid agencies that provided prices for this code. Medicare's reimbursement ranges between 3 and 204 percent higher than these Medicaid agencies' reimbursement, averaging 55 percent higher. In 1995, if Medicare reimbursement for this code was reduced by the average amount Medicare reimburses more than lower-paying Medicaid agencies, Medicare allowances would have been reduced from \$24 million to \$10.8 million.

#### *Procedure Code B4193*

Medicare's reimbursement for B4193 (\$209.84) is higher than four-fifths of the State Medicaid agencies that provided prices for this code. Medicare's reimbursement ranges between less than 1 and 215 percent higher than these Medicaid agencies' reimbursement, averaging 39 percent higher. In 1995, if Medicare reimbursement for this code was reduced by the average amount Medicare reimburses more than lower-paying Medicaid agencies, Medicare allowances would have been reduced from \$39 million to \$23.8 million.

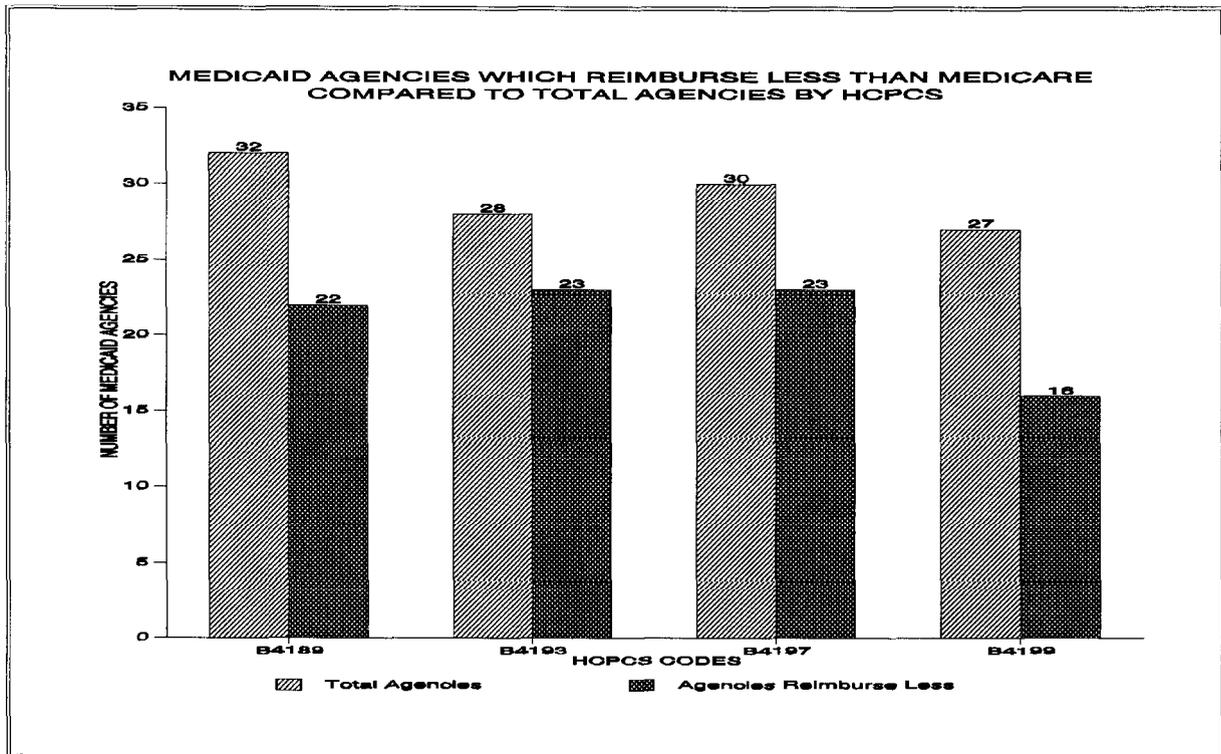
#### *Procedure Code B4197*

Medicare's reimbursement for B4197 (\$248.00) is higher than more than three-quarters of the State Medicaid agencies that provided prices for this code. Medicare's reimbursement ranges between 2 and 217 percent higher than these Medicaid agencies' reimbursement, averaging 46 percent higher. In 1995, if Medicare reimbursement for this code was reduced by the average amount Medicare reimburses more than lower-paying Medicaid agencies, Medicare allowances would have been reduced from \$66 million to \$35.7 million.

*Procedure Code B4199*

Medicare's reimbursement for B4199 (\$276.00) is higher than well over half of the State Medicaid agencies that provided prices for this code. Medicare's reimbursement ranges between less than 1 and 209 percent higher, averaging 39 percent higher. In 1995, if Medicare reimbursement for this code was reduced by the average amount Medicare reimburses more than lower-paying Medicaid agencies, Medicare allowances would have been reduced from \$16 million to \$9.6 million.

**Chart A**



***Other Reimbursement Formulas***

Medicaid agencies which reimburse less than Medicare for parenteral nutrition use a variety of reimbursement formulas. These include, but are not limited to, reimbursement based on: (1) the average wholesale price (AWP), (2) estimated costs, (3) fee schedules, (4) global rates, and (5) previous Medicare rates. Reimbursement may also include dispensing fees, compounding fees, and payments for additives to the parenteral nutrition solution. Many of the Medicaid agencies that reimburse less than Medicare's current reimbursement rate use a global rate or base their reimbursement on Medicare rates from previous years. Many of those agencies which could not give us pricing information reimburse based on average wholesale prices or estimated costs which vary by product. Other agencies apply several formulas to calculate their reimbursement, then reimburse whichever is lowest.

### ***Other Items Included in Parenteral Nutrition Reimbursement***

While Medicare reimburses separately for each parenteral nutrition supply, it does not provide separate reimbursement for services related to parenteral nutrition. In contrast, some Medicaid agencies include both supplies and services in their reimbursement formula. Of the eight agencies that reported including all other items in their reimbursement, six reimburse less than Medicare reimburses for the solution alone for at least one of the four parenteral nutrition codes. Supplies include lipids, administration kits, supply kits, infusion pumps, and IV poles. Some of these agencies also include added medications, education, labor, and lab work in their reimbursement. For example, one agency, which reimburses based on a global rate, reimburses \$76 per liter of parenteral nutrition solution including labor and delivery, the pump, supplies and added ingredients such as lipids. Medicare, on the other hand, reimburses between \$162 and \$276 depending on the grams of protein in the solution and reimburses an additional amount for the pump and other supplies. At least five other Medicaid agencies include some supplies or services in their reimbursement for parenteral nutrition solutions.

### **Medicare Reimbursement for the Four Parenteral Nutrition Codes is an Average of 78 Percent Higher Than Lower-Paying Medicare Risk-Contract HMOs.**

Ten of the 17 Medicare risk-contract HMOs that responded to our survey were able to provide pricing information on one or more of the four selected parenteral nutrition codes. Medicare reimburses more than all 10 HMOs for one or more of the four codes examined (see Chart B on the next page). In 1995, if Medicare reimbursement for each of these four codes were reduced by the average amount Medicare reimburses more than lower-paying Medicare risk-contract HMOs, total allowances would have been reduced from \$145 million to \$31 million.<sup>2</sup>

#### ***Procedure Code B4189***

Medicare reimbursement for B4189 (\$162.39) is higher than two-thirds of the HMOs that provided prices for this code. Medicare's reimbursement ranges between 2 and 195 percent higher than these Medicare HMOs' reimbursement, averaging 74 percent higher. In 1995, if Medicare reimbursement for this code was reduced by the average amount Medicare reimburses more than lower-paying HMOs, Medicare allowances would have been reduced from \$24 million to \$6.3 million.

#### ***Procedure Code B4193***

Medicare reimbursement for B4193 (\$209.84) is higher than nearly three-quarters of the HMOs that provided prices for that code. Medicare's reimbursement ranges between 2 and 282 percent higher than these Medicare HMOs' reimbursement, averaging 87 percent higher. In 1995, if Medicare reimbursement for this code was

reduced by the average amount Medicare reimburses more than lower-paying HMOs, Medicare allowances would have been reduced from \$39 million to \$5.1 million.

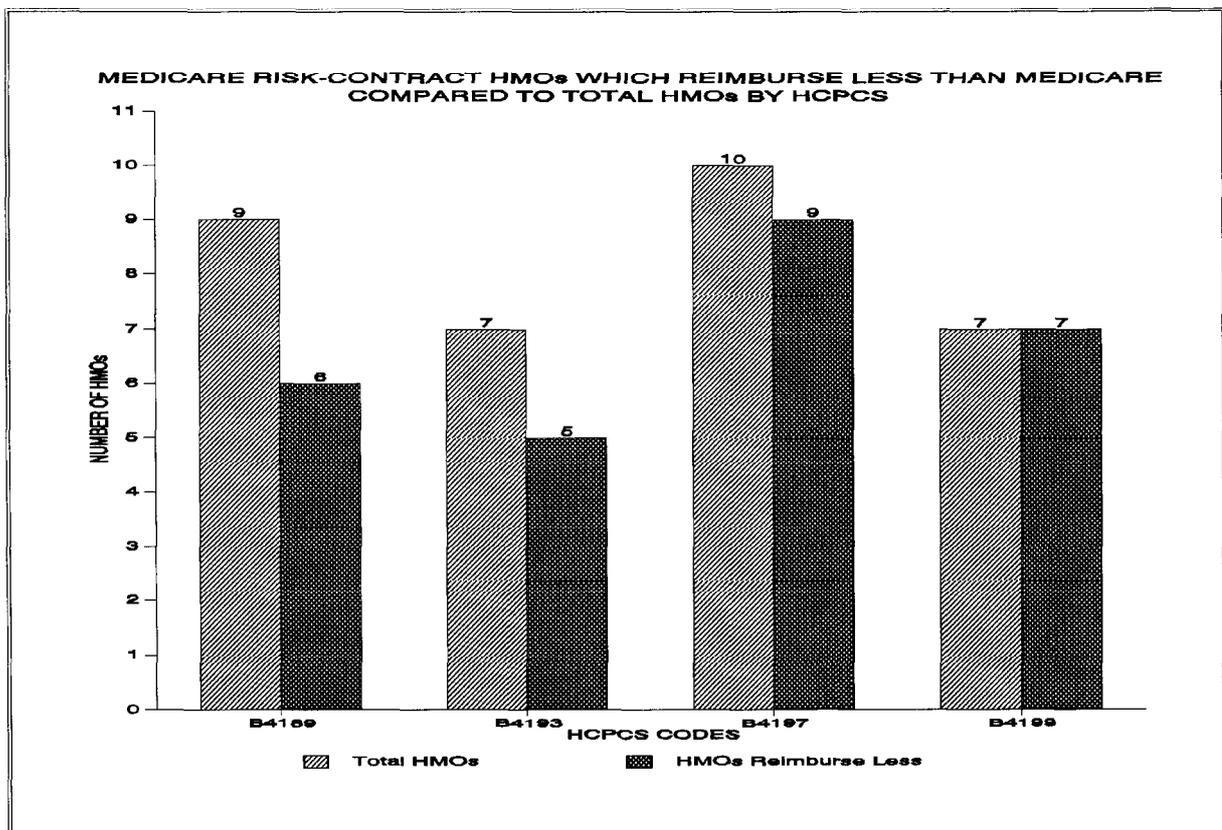
*Procedure Code B4197*

Medicare reimbursement for B4197 (\$248.00) is higher than nearly all of the HMOs that provided prices for that code. Medicare's reimbursement ranges between 1 and 351 percent higher than these Medicare HMOs' reimbursement, averaging 77 percent higher. In 1995, if Medicare reimbursement for this code was reduced by the average amount Medicare reimburses more than lower-paying HMOs, Medicare allowances would have been reduced from \$66 million to \$15.2 million.

*Procedure Code B4199*

Medicare reimbursement for B4199 (\$276.00) is higher than all the HMOs that provided prices for that code. Medicare's reimbursement ranges between 6 and 325 percent higher than these Medicare HMOs' reimbursement, averaging 72 percent higher. In 1995, if Medicare reimbursement for this code was reduced by the average amount Medicare reimburses more than lower-paying HMOs, Medicare allowances would have been reduced from \$16 million to \$4.4 million.

**Chart B**



### *Other Reimbursement Formulas*

Medicare HMOs which reimburse less than Medicare use a variety of reimbursement methods including reimbursement based on AWP, fee schedules, and global rates. However, no particular reimbursement formula used by Medicare HMOs is consistently lower than Medicare's rates.

### *Other Items Included in Parenteral Nutrition Reimbursement*

At least nine Medicare HMOs include items other than the solution in their reimbursement for parenteral nutrition. All nine include administration kits, supply kits, pumps, and IV poles. Six HMOs include lipids and at least five include the services of a health care professional. Seven of the nine HMOs that include some supplies in their reimbursement, reimburse less than Medicare does for the parenteral nutrition solution alone.

Few of the Medicare HMOs that gave us pricing information reimburse more than Medicare for any of the four parenteral nutrition codes. Of those that do, reimbursement is not significantly higher than Medicare's. Four Medicare HMOs reimburse more than Medicare for B4189 by an average of 18 percent. Two Medicare HMOs reimburse more than Medicare for B4193 by an average of 9 percent. One Medicare HMO reimburses 5 percent more than Medicare for B4197. No Medicare HMOs reimburse more than Medicare for B4199.

### **Medicare Reimbursement for the Four Parenteral Nutrition Codes is an Average of 11 Times Higher Than Some Manufacturers' Contract Prices.**

Medicare reimbursement for the four selected codes is between 9 and 12 times higher than the contracted price charged by three manufacturers to a low-volume supplier of parenteral nutrition.<sup>3</sup> It is our assumption that manufacturer charges to higher-volume suppliers would be even lower.

Manufacturers' contract prices for each of the parenteral nutrition solution codes examined ranged between \$13 and \$29 for one supplier. Medicare allows between \$162 and \$276 for each of the four codes. While both the manufacturers' prices and Medicare rates presented here represent only the cost of the parenteral nutrition solution, it is clear that Medicare rates for the solution are significantly higher than the discounted costs of one low-volume supplier.

# RECOMMENDATION

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## **The HCFA Should Examine Other Payment Methods That Could Lead To More Cost Effective Reimbursement For Parenteral Nutrition Solutions.**

It is clear that many other payers reimburse less than Medicare for parenteral nutrition. In addition, suppliers may purchase parenteral nutrition solutions at discounted prices which are significantly lower than Medicare's reimbursement rates. Implementing an alternative reimbursement method could result in significant savings to the Medicare program. We urge HCFA to pursue one or more of the following options to bring Medicare's reimbursement in line with Medicaid and other payers.

### Inherent Reasonableness

The Secretary or the DMERCs could use their "inherent reasonableness" authority to reduce reimbursement to more appropriate levels.

### Acquisition Cost

The HCFA could base its reimbursement on suppliers acquisition costs. There is evidence that acquisition costs for parenteral nutrition are far below Medicare's current reimbursement rate.

### Competitive Bidding

The HCFA could seek legislative authority to use competitive bidding to take advantage of its position as a high-volume purchaser of parenteral nutrition.

## **AGENCY COMMENTS**

The HCFA concurred with our recommendation. The HCFA reported that they have convened a workgroup to focus on ways to reduce and control costs for parenteral nutrition. The HCFA also explained that the President's Fiscal Year 1998 budget includes proposals to give carriers the authority to make inherent reasonableness adjustments for durable medical equipment, to eliminate the mark up for drugs and biologicals and include acquisition cost in the reimbursement calculation, and to authorize the Secretary to set payment rates for Part B services bases on competitive bidding. The full text of HCFA's comments is included in Appendix B.

## ENDNOTES

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1. The average which Medicare reimburses more than Medicaid was calculated in the following manner:

For each code the percentage difference between each lower-paying Medicaid agency's price and Medicare's reimbursement level was calculated. These percentage differences were then averaged for each code. Using the average for each code we calculated the overall percentage difference in prices for parenteral nutrition. Potential Medicare reductions in allowances were calculated by subtracting the overall percentage difference from Medicare's actual 1995 allowances.

The average differences for Medicare risk-contract HMOs and manufacturers' contract prices were calculated in the same manner.

2. See explanation of calculations above.
3. See explanation of calculations above.

## APPENDIX A

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Definition of four parenteral nutrition procedure codes with the highest allowances in 1995.

- B4189 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins including preparation, any strength, 10 to 51 grams of protein - premix.
- B4193 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins including preparation, any strength, 52 to 73 grams of protein - premix.
- B4197 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins including preparation, any strength, 74 to 100 grams of protein - premix.
- B4199 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins including preparation, any strength, over 100 grams of protein - premix.

# **APPENDIX B**

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## **AGENCY COMMENTS**



## Memorandum

DATE JUN 27 1997

TO June Gibbs Brown  
Inspector General

FROM Bruce C. Vladeck *Bruce Vladeck*  
Administrator

SUBJECT Office of Inspector General (OIG) Draft Report: "Medicare Reimbursement for Parenteral Nutrition," (OEI-03-96-00230)

We reviewed the above-referenced report concerning Medicare's reimbursement of parenteral nutrition as compared to other payers.

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

Attachment

Health Care Financing Administration (HCFA) Comments on  
Office of Inspector General (OIG) Draft Report entitled: "Medicare Reimbursement for  
Parenteral Nutrition," (OEI-03-96-00230)

OIG Recommendation

HCFA should examine other payment methods that could lead to more cost-effective reimbursement for parenteral nutrition solutions. We urge HCFA to pursue one or more of the following options to bring Medicare's reimbursement in line with Medicaid and other payers.

Inherent Reasonableness

The Secretary or the durable medical equipment regional carriers (DMERCs) could use their "inherent reasonableness" authority to reduce reimbursement to more appropriate levels.

HCFA Response

We concur. HCFA convened a workgroup to focus on ways to reduce and control costs for parenteral nutrition. In fact, the workgroup is currently considering use of the inherent reasonableness process as one method for reducing cost for the enteral nutrition therapy benefit. The results of our review of this process will enable HCFA to use "lessons learned" to avoid problem experiences with the enteral nutrition inherent reasonableness calculation. In addition, the President's fiscal year (FY) 1998 budget includes a proposal that would restore to Medicare carriers the authority to make inherent reasonableness adjustments for DME, prosthetics (DMEPOS), and surgical dressings. The Secretary's inherent reasonableness authority would apply to all Part B services except physician services.

Acquisition Cost

HCFA could base its reimbursement on suppliers' acquisition costs. There is evidence that acquisition costs for parenteral nutrition is far below Medicare's current reimbursement rate.

HCFA Response

We concur. A proposal that would eliminate the mark-up for drugs and biologicals, such as parenteral nutrition, is included in the President's FY 1998 budget. Under this provision, the Medicare amount payable for the drug or biological would be the lowest of:

- (a) the physician's, supplier's, or other person's actual acquisition cost,
- (b) the average wholesale price, as specified by the Secretary,
- (c) the median actual acquisition cost of all claims for the drug or biological for the 12-month period beginning July 1, 1998, adjusted annually and effective on January 1 of each year, or
- (d) the amount determined otherwise under the Social Security Act.

Competitive Bidding

HCFA could seek legislative authority to use competitive bidding to take advantage of its position as a high volume purchaser of parenteral nutrition.

HCFA Response

We concur. Under a proposal included in the President's FY 1998 budget, the Secretary would be authorized to set payment rates for Part B services (excluding physician services) based on competitive bidding. The items included in a bidding process and the geographic areas selected for bidding would be determined by the Secretary based on availability of entities able to furnish the item or services and the potential for achieving savings. Bids would be accepted from entities only if they met quality standards specified by the Secretary. The Secretary would have the authority to exclude suppliers whose bids are above the cut-off bid determined sufficient to maintain access. Automatic reductions in rates would be triggered for clinical laboratory services and DMEPOS, excluding oxygen services, if by 2001 a 20 percent reduction had not been achieved.