

MedPAC June 2013 Report to the Congress - Mandated Reports

The Middle Class Tax Relief and Job Creation Act of 2012 directed the Commission to study three issues: Medicare's add-on payments to ambulance providers, geographic adjustment of payments for work under the physician fee schedule, and Medicare payments for outpatient therapy services. Each of the studies was intended to inform policy debate about provisions that were set to expire by January 1, 2013. At the request of the committees of jurisdiction for timely assistance, the Commission provided extensive information regarding its completed analyses and transmitted its final recommendations to the Congress in November 2012. The Commission's analyses, findings, and recommendations are printed in the June 2013 report.

The Commission's recommendations in these reports reflect the following considerations:

- What effect would a potential action have on program spending relative to current law?
- Would a potential action improve beneficiaries' access to care?
- What effect would a potential action have on the quality of care?
- Does a potential action advance payment reform? Does it move Medicare payment policy away from fee-for-service payment and encourage a more integrated delivery system?

Below we present the findings and recommendations for each report.

MEDICARE AMBULANCE ADD-ON PAYMENTS

- Under the Medicare program, there are three temporary add-on payments to: (1) increase payments for ground ambulance transports provided to beneficiaries in urban areas by 2 percent and in rural areas by 3 percent, (2) increase payments for ground ambulance transports in "super-rural" areas by 22.6 percent, and (3) designate certain counties as rural for purposes of applying a 50 percent increase in payments for air ambulance transports provided in rural areas.
- In addition to the temporary add-on payments, two permanent add-on payment policies apply if the ZIP code from which a patient is transported is rural. One increases the standard mileage rate by 50 percent for the first 17 miles for ground ambulance transports, and the other pays 50 percent more for air ambulance transports.
- Of the approximately \$5.3 billion in Medicare payments for ambulance transports in 2011, the three temporary add-on payment policies accounted for about \$192 million and the two permanent add-on payment policies accounted for approximately \$220 million more.
- There was no evidence of Medicare beneficiaries having difficulty accessing ambulance transports. We observed consistent growth in ambulance transport use per beneficiary and spending for these transports. The number of ambulance suppliers participating in Medicare grew steadily from 2007 to 2011.
- Medicare ambulance volume grew by roughly 10 percent from 2007 to 2011, and basic life support (BLS) nonemergency transports grew more rapidly than more complex types of transports. There was higher growth of BLS transports in urban areas than in rural.

- Pronounced growth has occurred in nonemergency ambulance transports to and from dialysis facilities, and there is tremendous variation across states in per capita spending for those types of transports.
- Medicare currently does not collect supplier cost data to set or update ambulance payment rates. The recent entry of for-profit suppliers and private equity firms into the ambulance industry indicates that payment rates are attractive.
- The current ground ambulance add-ons are not well targeted. The criteria of transports being rural, short mileage, or in “super-rural areas” are not good indicators of high cost related to low volume or isolation.

Recommendations

Recommendation 1: The Congress should:

- allow the three temporary ambulance add-on policies to expire;
- direct the Secretary to rebalance the relative values for ambulance services by lowering the relative value of basic life support nonemergency services and increasing the relative values of other ground transports. Rebalancing should be budget neutral relative to current law and maintain payments for other ground transports at their level prior to expiration of the temporary ground ambulance add-on; and
- direct the Secretary to replace the permanent rural short-mileage add-on for ground ambulance transports with a new budget neutral adjustment directing increased payments to ground transports originating in geographically isolated, low-volume areas to protect access in those areas.

Recommendation 2: The Congress should direct the Secretary to:

- promulgate national guidelines to more precisely define medical necessity requirements for both emergency and nonemergency (recurring and nonrecurring) ground ambulance transport services;
- develop a set of national edits based on those guidelines to be used by all claims processors; and
- identify geographic areas and/or ambulance suppliers and providers that display aberrant patterns of use, and use statutory authority to address clinically inappropriate use of basic life support nonemergency ground ambulance transports.

GEOGRAPHIC WORK ADJUSTMENT UNDER THE PHYSICIAN FEE SCHEDULE

- Geographic practice cost indexes (GPCIs) adjust payments under the physician fee schedule to account for resource costs as they vary in different parts of the country. By law, one of GPCIs—the GPCI applied to the work of physicians and other health professionals, based on the earnings of professionals in certain reference occupations—is limited to one-quarter of its full impact. The resulting impact of the work GPCI generally ranges from reducing physician fees by 2.9 percent in places well below the national average cost index to increasing them by 3.8 percent in places well above the national average.
- Since 2003, the Congress has set a temporary floor suspending the work GPCI in localities with costs below the national average. As a result, geographic localities below the national average that would have received a negative GPCI adjustment are instead set to the national average.
- The report finds there is evidence of the need for some level of geographic adjustment of fee schedule payments for professional work because there is geographic variation in the cost of living and the earnings of professionals in the reference occupations.
- However, the current index is flawed both conceptually and in implementation.

- Conceptually, the labor market for professionals in the reference occupations (lawyers, architects, etc.) may not resemble the labor market for physicians and other health professionals.
- Implementation of the work GPCI is flawed because there are no sources of data on the earnings of physicians and other professionals of sufficient quality to validate the GPCI.
- We are unable to determine whether the work GPCI has an effect on quality of care, but there is no evidence that the GPCI or the GPCI floor affect access. Moreover, any access concerns may be better addressed through other targeted policies.

Recommendation

Medicare payments for work under the fee schedule for physicians and other health professionals should be geographically adjusted. The adjustment should reflect geographic differences across labor markets for physicians and other health professionals. The Congress should allow the GPCI floor to expire per current law and, because of uncertainty in the data, should adjust payments for the work of physicians and other health professionals only by the current one-quarter GPCI, and direct the Secretary to develop an adjuster to replace it.

MEDICARE PAYMENT FOR OUTPATIENT THERAPY SERVICES

- In 2011, Medicare spending on outpatient therapy totaled \$5.7 billion for 4.9 million beneficiaries.
- There are two per beneficiary annual spending limits (caps) on outpatient therapy services to restrain spending and excessive utilization. There is one cap for physical therapy and speech–language pathology services combined, and another cap for occupational therapy services. Each cap is set at \$1,900 in 2013.
- A broad exceptions process allows providers to deliver services above either spending cap relatively easily, limiting the effectiveness of the caps. Since 2007, clinicians may certify the medical necessity of therapy services in excess of the cap by adding a modifier to the therapy procedure code on a claim. These claims are subject to manual review for medical necessity, but in practice the frequency of the reviews and subsequent denials is relatively low. While the caps are permanent by statute, the broad exceptions process expires periodically unless explicitly reauthorized by the Congress.
- Because the clinical evidence is limited, Medicare lacks clear guidelines to determine the appropriate frequency, type, and duration of services for patients needing outpatient therapy. Further, Medicare’s physician oversight requirements for outpatient therapy are relatively weak.
- The use of outpatient therapy varies widely across the country. Medicare spending on outpatient therapy users in the highest spending areas of the country is five times more than that in the lowest spending areas of the country, even after controlling for differences in patients’ health status.
- The Commission believes that outpatient therapy can be valuable for a given patient, but some level of management more rigorous than the current exceptions process is needed. The Commission is also concerned that therapy caps with no exceptions (hard caps) could impede access for those whose medical conditions genuinely warrant high therapy levels.

Recommendations

Recommendation 1: The Congress should direct the Secretary to:

- reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days, and
- develop national guidelines for therapy services, implement payment edits at the national level based on these guidelines that target implausible amounts of therapy, and use authorities granted by

the Patient Protection and Affordable Care Act of 2010 to target high-use geographic areas and aberrant providers.

Recommendation 2: To avoid caps without exceptions, the Congress should:

- reduce the therapy cap for physical therapy and speech–language pathology services combined and the separate cap for occupational therapy to \$1,270 in 2013. These caps should be updated each year by the Medicare Economic Index.
- direct the Secretary to implement a manual review process for requests to exceed cap amounts, and provide the resources to CMS for this purpose.
- permanently include services delivered in hospital outpatient departments under therapy caps.
- apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day.

Recommendation 3: The Congress should direct the Secretary to:

- prohibit the use of V codes as the principal diagnosis on outpatient therapy claims, and
- collect functional status information on therapy users using a streamlined, standardized, assessment tool that reflects factors such as patients’ demographic information, diagnoses, medications, surgery, and functional limitations to classify patients across all therapy types. The Secretary should use the information collected using this tool to measure the impact of therapy services on functional status, and provide the basis for development of an episode-based or global payment system.