

A P P E N D I X

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**Commissioners' voting
on recommendations**

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In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to call for individual Commissioner votes on each recommendation and to document the voting record in its report. The information below satisfies that mandate.

Chapter 1: Competitively determined plan contributions

No recommendations

Chapter 2: Medicare payment differences across ambulatory settings

No recommendations

Chapter 3: Approaches to bundling payment for post-acute care

No recommendations

Chapter 4: Refining the hospital readmissions reduction program

No recommendations

Chapter 5: Medicare hospice policy issues

No recommendations

Chapter 6: Care needs for dual-eligible beneficiaries

No recommendations

Chapter 7: Mandated report: Medicare payment for ambulance services

7-1 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.

Yes: Armstrong, Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

7-2 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.

Yes: Armstrong, Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

Chapter 8: Mandated report: Geographic adjustment of payments for the work of physicians and other health professionals

8 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 geographic practice cost index (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.

Yes: Armstrong, Baicker, Butler, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Naylor, Nerenz, Redberg, Samitt, Uccello

No: Coombs, Miller

Chapter 9: Mandated report: Improving Medicare’s payment system for outpatient therapy services

9-1 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.

Yes: Armstrong, Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

9-2 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.

Yes: Armstrong, Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

9-3 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.

Yes: Armstrong, Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

Appendix A: Review of CMS’s preliminary estimate of the 2014 update for physician and other professional services

No recommendations