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## **Executive summary**

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As part of its mandate from the Congress, each June the Commission reports on Medicare payment systems and on issues affecting the Medicare program, including changes in health care delivery and the market for health care services. In this report, we consider issues addressing both broad questions confronting the program, such as how to incorporate private plan bidding and fee-for-service in one system, and more sector-specific issues, such as the new hospital readmissions policy. In the first six chapters of this report we consider:

- ***A new payment model we refer to as competitively determined plan contributions (CPC)***—In that model a federal contribution toward the coverage of the Medicare benefit is determined based on the cost of competing options for the coverage, including those offered by private plans and by the traditional Medicare fee-for-service (FFS) program. Specifically, CPC has two defining principles: First, beneficiaries receive a competitively determined federal contribution to buy Medicare coverage; second, beneficiaries' individual premiums vary depending on the coverage option they choose.
- ***Medicare payment differences across ambulatory settings***—Medicare's payment rates often vary for the same (or similar) ambulatory services provided to similar patients in different settings, such as physicians' offices and hospital outpatient departments (OPDs). These variations raise questions about how Medicare should pay for the same service when it is delivered in different settings.
- ***Bundling post-acute care (PAC) services***—Under traditional FFS Medicare, the program pays widely varying rates for the care beneficiaries can receive following a hospital stay among four PAC settings—skilled nursing facilities, home health care, inpatient rehabilitation hospitals, and long-term care hospitals. Nationwide, utilization rates for PAC services vary widely for reasons not explained by differences in beneficiaries' health status. Bundling a range of services together could improve incentives to provide needed care more efficiently.
- ***Refining Medicare's hospital readmissions reduction program***—The Congress enacted a new hospital readmissions reduction program in 2010 that was

implemented by CMS in October 2012. This program is a step forward. However, refinements are needed to improve the program and achieve the aim of reducing readmissions, the penalties assessed on hospitals, and Medicare spending on readmissions.

- ***Hospice payment policy issues***—Issues include implementing payment reforms to better match costs and payments, improving accountability for very long stays, understanding trends in hospice patients who are discharged alive, and revising payment for hospice care in nursing facilities.
- ***The care needs of dual-eligible beneficiaries***—We review the pathways to dual-eligible status, Medicare and Medicaid spending on dual-eligible beneficiaries, and best practices from Medicare–Medicaid coordination programs.

We also include three reports mandated by the Congress in the Middle Class Tax Relief and Job Creation Act of 2012. The Commission voted on the recommendations in these reports in November 2012 to best advise the Congress on provisions that were scheduled to expire at the end of calendar year 2012. The reports concern:

- ***Medicare ambulance add-on payments***—The Commission examined the impacts of certain temporary add-on payments made under the ambulance fee schedule on ambulance providers' Medicare margins and other aspects of the payment system.
- ***Geographic adjustment of payments for the work effort of physicians and other health professionals under the physician fee schedule***—The Commission assessed whether any adjustment is appropriate to distinguish the difference in work effort by geographic area and, if so, what the level of the adjustment should be and where it should be applied.
- ***Medicare payment for outpatient therapy services***—The Commission addressed two specific areas: (1) how to improve the outpatient therapy benefit under Medicare Part B so that the benefit is better designed to reflect patients' functional limitations and severity, as well as the therapy needs of the patient; and (2) private-sector initiatives to manage the outpatient therapy benefit.

In an appendix, as required by law, we review CMS’s preliminary estimate of the update to payments under the physician fee schedule for 2014.

## **Competitively determined plan contributions**

In Chapter 1, we present an overview of a payment model based on government contributions toward purchasing Medicare coverage—an approach we call CPC—and focus on key design elements Medicare would have to consider in adopting such a model. The Commission uses the term CPC to broadly describe a federal contribution toward the coverage of the Medicare benefit, based on the cost of competing options for the coverage, including those offered by private plans and by the traditional Medicare FFS program. Specifically, CPC has two defining principles: First, beneficiaries receive a competitively determined federal contribution to buy Medicare coverage; second, beneficiaries’ individual premiums vary depending on the coverage option they choose. CPC encompasses a set of concepts related to premium support or defined contributions.

An argument for a CPC approach is that a market-based model in which private plans compete with FFS for enrollment might do better at keeping premiums and overall spending down in certain markets than a model based on unrestricted FFS with open-ended provider participation. A successful CPC model would depend on strong competition between FFS and private plans offering lower premiums and more attractive benefits and informed beneficiaries who respond to those offerings. Competing private plans, however, do not necessarily lower cost to the Medicare program if the rules defining how they compete and how they are paid do not encourage them to do so. For example, the current Medicare Advantage (MA) program produces a higher cost to Medicare than the traditional FFS program in many markets. Therefore, whether a CPC approach can lower overall Medicare spending will depend on the characteristics of each market, the specific design of the model, and how different components of the model interact.

In its most basic form, a CPC approach consists of three main actors with different roles. The Medicare program designs the system and makes the rules that result in the CPC contribution amount and payments to plans. (The program also continues to administer the FFS benefit and set FFS payment rates.) Private plans, the second actor, use these rules to guide their business decisions, such as whether to enter or exit a particular market, how much to

bid (which in turn is a factor in determining the level of the government contribution amount), and which benefit designs or products to offer. Beneficiaries, the third actor, then make their purchasing decisions and choose a private plan or Medicare FFS for their Medicare coverage based on the premiums of offered plans (including Medicare FFS) and the contribution from Medicare. Their choice of coverage determines the premiums they pay.

We illustrate implications of certain design elements using an analysis of private plan bids under the current MA program as a proxy. We also discuss key issues specific to low-income beneficiaries under a CPC approach. The purpose of Chapter 1 is to focus on a few first-order questions and issues that must be addressed in designing a CPC model and understand their implications for beneficiaries, private plans, and the Medicare program.

## **Medicare payment differences across ambulatory settings**

Medicare’s payment rates often vary for the same (or similar) ambulatory services provided to similar patients in different settings, such as physicians’ offices and OPDs. As an example of payment differences, in 2013 Medicare pays 141 percent more when a level II echocardiogram is provided in an OPD rather than in a freestanding physician’s office. Such variations raise questions about how Medicare should pay for the same service when it is delivered in different settings, which we address in Chapter 2.

If the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than in another. Payment variations across settings may encourage arrangements among providers that result in care being provided in higher paid settings, thereby increasing total Medicare spending and beneficiary cost sharing. In general, the Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting, adjusting for differences in patient severity, to the extent that severity differences affect costs.

There is increased urgency to address payment variations across settings because many services have been migrating from physicians’ offices to the usually higher paid OPD setting as hospital employment of physicians has grown. This shift toward OPDs has resulted in higher program spending and beneficiary cost sharing without significant changes in patient care. From 2010 to 2011, for example,

the share of evaluation and management (E&M) office visits provided in OPDs increased by 9 percent, the share of echocardiograms provided in OPDs increased by about 15 percent, and the share of nuclear cardiology tests provided in OPDs increased by about 22 percent.

In our March 2012 report, the Commission recommended that Medicare payment rates should be equal whether an E&M office visit is provided in an OPD or in a freestanding office. We focused on nonemergency E&M office visits because they are largely unaffected by differences between OPDs and freestanding offices, such as patient severity and the packaging of services. In Chapter 2, we examine other services that meet the Commission's principles for aligning payment rates across settings.

- We identified 66 groups of services provided in OPDs and offices that are frequently performed in physicians' offices, are infrequently provided with an emergency department (ED) visit when furnished in an OPD, and have average patient severity that is no greater in OPDs than in freestanding offices. Changing OPD payment rates for these services to reduce payment differences between settings would reduce program spending and beneficiary cost sharing by \$900 million in one year.
- Three of these 66 groups of services include cardiac imaging services, which have been migrating rapidly from freestanding offices to OPDs as hospital employment of cardiologists has grown. In addition, payment rates are much higher when these services are provided in OPDs than in offices. Reducing OPD payment rates for these three groups of cardiac imaging services would reduce program spending and beneficiary cost sharing by \$500 million in one year.
- We also identified 12 groups of services that are commonly performed in ambulatory surgical centers (ASCs) for which the OPD payment rates could be reduced to the ASC level. These groups of services are infrequently provided with an ED visit when furnished in an OPD and have average patient severity that is no greater in OPDs than in ASCs. This policy would reduce Medicare program spending and beneficiary cost sharing by about \$600 million per year.

We are concerned about the impact of these policies on hospitals that provide ambulatory services to a disproportionate share of low-income patients, who may

be more likely than other patients to use an OPD as their usual source of care. Because large reductions in Medicare revenue for these hospitals could adversely affect access to physician services for these patients, we consider a stop-loss policy that would limit the loss of Medicare revenue for these hospitals.

### **Bundling post-acute care services**

Under traditional FFS Medicare, the program pays widely varying rates for the care beneficiaries can receive following a hospital stay in the four PAC settings (skilled nursing facilities, home health care, inpatient rehabilitation hospitals, and long-term care hospitals). Nationwide, use rates for PAC services vary widely for reasons not explained by differences in beneficiaries' health status. In 2008, the Commission recommended that the Congress require the Secretary to create a pilot program to test the feasibility of bundled payment around a Medicare hospitalization for selected conditions.

Under a bundled approach, one payment would cover all services furnished across all settings and providers during a defined period of time after a triggering event (e.g., all care provided within 90 days after a hospital discharge). By tying a provider's payment to services furnished beyond "its four walls," bundled payments encourage accountability for cost and quality across a spectrum of care. In contrast to FFS, providers would have an incentive to coordinate care and provide only clinically necessary services rather than furnishing more services to generate revenue. The scope and duration of the bundle and the payment incentives will shape the pressures providers experience to change their current practice patterns.

In Chapter 3, we discuss design aspects of a bundled payment—such as the scope of services covered, the time span, the mechanics of paying multiple providers for a single episode, and ways to ensure quality—and the advantages and disadvantages of possible approaches. Each decision involves trade-offs between increasing the opportunities for care coordination and requiring providers to accept risk for care beyond what they furnish. We illustrate the trade-offs inherent in these design decisions using a design consistent with Commissioners' support for more inclusive bundles that do not require providers to have an infrastructure to make and receive payments for other providers. The illustrative bundle includes the initial hospital stay and any potentially avoidable readmissions, PAC, and physician services furnished during the institutional care that occur within 90 days after

discharge from the hospital. CMS would compare actual average spending for a condition with a benchmark, return some portion of payments if average spending is below the benchmark, and put providers at some risk for spending above the benchmark. We use this illustration to begin a conversation about how best to proceed with this potential payment reform, acknowledging that many other designs are possible, each with different strengths and weaknesses.

Bundled payment is one way to begin to change the delivery system away from the fragmented care inherent in FFS and toward shared accountability that encourages care coordination and cost control during an episode of care. Bundled payments would give providers, especially those not ready to assume the greater risks associated with larger payment reforms (such as accountable care organizations), a way to gain experience in coordinating care that extends across a spectrum of providers and settings. Bundling could help facilitate continued progress toward larger delivery system reforms. The specific design of bundles will shape the risk for providers and the opportunities for care coordination. Over the next year, the Commission plans to continue its conversation about how best to proceed with this potential payment reform.

### **Refining Medicare's hospital readmissions reduction program**

In 2008, the Commission reported on a series of payment reforms to encourage care coordination among physicians, hospital administration, and providers outside the hospital. These initiatives included testing the bundling of payments around an episode, gainsharing between hospitals and physicians, and a direct incentive to reduce hospital readmissions. While not all readmissions can be prevented, there is a concern that Medicare readmission rates have consistently been too high and could be lowered through greater coordination of care.

Following the Commission's report and a series of studies illustrating the problem of readmissions, the Congress enacted a readmissions reduction program in 2010. The program includes a penalty that reduces Medicare payments in 2013 to hospitals that had above-average readmission rates from July 2008 through June 2011. Following enactment in 2010, there was a small decline in risk-adjusted readmission rates. While readmission rates have declined slightly, we find 12.3 percent of all 2011 Medicare admissions were still followed by a potentially preventable readmission. The readmission policy has encouraged hospitals to look beyond their walls and

improve care coordination across providers to reduce readmissions, and the Commission finds that the policy should be refined and continued.

In Chapter 4, we consider four refinements to address issues with the current policy and to continue moving toward improved care coordination and outcomes:

- First, have a fixed target for readmission rates. Penalties would go down when industry performance improves. Under current policy, aggregate penalties remain constant when national readmission rates decline and penalties for individual hospitals vary depending on their performance relative to the new average.
- Second, use an all-condition readmission measure to increase the number of observations and reduce the random variation that single-condition readmission rates face under current policy.
- Third, use an all-condition readmission measure to attenuate the negative correlation between mortality rates and readmission rates that exist for some conditions. For some conditions (e.g., heart failure) there is a negative correlation between mortality rates and readmission rates; for other conditions there is no significant relationship. Using an all-condition readmission measure would remove the problem of systematically having higher readmission penalties for hospitals with low mortality rates for conditions such as heart failure. Over the longer term, we could also pursue a joint readmission/mortality measure.
- Fourth, evaluate a hospital's readmission rate against rates for a group of peer hospitals with a similar share of poor Medicare beneficiaries as a way to adjust readmission penalties for socioeconomic status. Under current policy, hospitals' readmission penalties are positively correlated with their share of low-income patients.

These refinements would help overcome issues with current policy, maintain or increase the average hospital's incentive to reduce readmissions, increase the share of hospitals that have an incentive to reduce readmissions, and not increase Medicare spending relative to current law. They would require legislative changes, because the current formula to compute the readmission penalty is set in law. The end goal is to see a decline in readmissions, a decline in penalties paid by hospitals, and a decline in Medicare spending on readmissions.

## Medicare hospice policy issues

The Commission made recommendations in March 2009 to improve the hospice payment system, increase accountability in the benefit, and improve data collection. Since then, several steps have been taken to increase accountability and data collection via the Patient Protection and Affordable Care Act of 2010 (PPACA) and CMS administrative actions. In addition, the Congress gave CMS the authority to revise the hospice payment system as the Secretary determines appropriate as soon as fiscal year 2014.

In Chapter 5, we report on additional analyses we conducted to support hospice payment reform, enhanced accountability, and other areas of concern, including the policy implications of patients discharged alive from hospice and considering whether a different payment rate is warranted for hospice provided to patients living in nursing facilities.

- **Payment reform**—Using currently available data, the Commission estimated how the labor cost of hospice visits changes over the course of a hospice episode. These data demonstrate a U-shaped pattern of labor costs throughout hospice episodes and offer policymakers the evidence needed to begin reforming the payment system away from the current flat per diem payment. We present an illustrative example of a revised payment system that could be implemented now using existing data. Given the magnitude of hospice spending on long-stay patients, who are more profitable under the current payment system than other patients, it is important that an initial step toward payment reform be taken as soon as possible.
- **Accountability**—There are two steps needed to improve accountability for hospice payments. First, consistent with a Commission recommendation, PPACA required medical review of hospice stays exceeding 180 days for hospices with an unusually large share of long-stay patients. To date, CMS has not implemented that provision. Our recent analysis of Medicare spending data for hospice stays exceeding 180 days shows that these expenditures are sizable—underscoring the need for medical review of very long stays. Second, 18 percent of hospice patients in 2010 were discharged alive from hospices. Among some hospices the rates were much higher. Little is known about what happens to those hospice patients after they are discharged. The Commission’s new analysis of rates of live discharges and outcomes by beneficiary

and provider characteristics supports the need to ensure that beneficiaries are appropriate candidates for hospice at initial admission and throughout long episodes.

- **Payment for hospice care in nursing facilities**—The Commission has previously raised the issue of whether a different payment structure is needed for hospice care in nursing facilities. Our prior work has shown that hospices with more patients in nursing homes compared with other hospices have higher-than-average Medicare margins. In Chapter 5, we explore the potential for a reduction to the hospice payment rate for patients residing in nursing facilities in light of the overlap in responsibility between hospices and nursing facilities for those patients.

## Care needs for dual-eligible beneficiaries

In Chapter 6, we discuss Medicare and Medicaid spending and the care needs of dual-eligible beneficiaries. Dual-eligible beneficiaries are eligible for both Medicare and Medicaid benefits. In 2011, about 19 percent (10 million) of Medicare beneficiaries were dual eligible. The dual-eligible population is diverse and includes individuals with multiple chronic conditions, difficulties with activities of daily living, and cognitive impairments such as dementia; individuals with physical disabilities, developmental disabilities, and severe mental illness; and some individuals who are relatively healthy. Because of their diverse needs, dual-eligible beneficiaries require a mix of medical care, long-term care, behavioral health services, and social services. Given the challenges this population faces in accessing services through two separate payer and delivery systems, programs that coordinate dual-eligible beneficiaries’ Medicare and Medicaid benefits (which we refer to as Medicare–Medicaid coordination programs) have the potential to improve dual-eligible beneficiaries’ access to services and quality of care.

We conducted structured interviews with stakeholders (federally qualified health centers (FQHCs), community health centers (CHCs), primary care physicians, health systems, behavioral health providers, aging services organizations, community-based care managers, beneficiary advocates, and health plans) in five states with Medicare–Medicaid coordination programs. In general, the interviewees reported that dual-eligible beneficiaries (both those enrolled in Medicare–Medicaid coordination programs and those not enrolled in those programs) tend to have more complex medical and nonmedical needs than non-dual-eligible Medicare beneficiaries. Dual-eligible beneficiaries were consistently reported to need

high-contact, on-the-ground, intensive care management given that their issues are not likely to be resolved in a few physician visits. Dual-eligible beneficiaries' providers tend to operate only in their respective settings and communication with one another across settings regarding a patient's care is not common. Medicare–Medicaid coordination programs focus on getting providers in various settings—for example, hospitals, physicians' offices, and social service agencies, among others—to communicate with one another regarding a beneficiary's care. These programs also seek to leverage community-based resources, including care coordination activities at FQHCs and CHCs. Many FQHCs and CHCs are uniquely positioned to coordinate care for dual-eligible beneficiaries because they provide primary care, behavioral health services, and care management services, often at the same clinic site.

### **Mandated report: Medicare payment for ambulance services**

Section 3007(e) of the Middle Class Tax Relief and Job Creation Act of 2012 directed the Commission to report to the Congress by June 15, 2013, on the Medicare ambulance fee schedule. Specifically, the Commission was directed to examine the impact of certain temporary add-on payments made under the ambulance fee schedule on ambulance providers' Medicare margins. In addition to the three temporary add-ons, two permanent add-on payment policies apply if the ZIP code from which a patient is transported is rural.

In Chapter 7, we find:

- Of the approximately \$5.3 billion in Medicare payments for ambulance services 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 services. We observed consistent growth in ambulance service use per beneficiary and spending for these services. 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 services grew more rapidly than more complex types of services. Much of the growth in BLS nonemergency transports was concentrated among a small share of ambulance suppliers and

providers. Many of the newest suppliers entering the marketplace focus on providing BLS nonemergency services. Further, even more pronounced growth has occurred in nonemergency ambulance transports to and from dialysis facilities, and there is tremendous variation across states and territories 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 Government Accountability Office (GAO) surveyed a sample of ambulance suppliers in 2012 and found that the 2010 median Medicare margin for the survey sample was 2 percent with the temporary add-ons and estimated that the margin would be –1 percent without the add-ons. GAO found that higher costs were associated with lower volume, more emergency versus nonemergency transports, and higher levels of government subsidies. The recent entry of for-profit suppliers and private equity firms into the ambulance industry indicates that profit opportunities in the industry were available.
- The current ground ambulance add-ons are not well targeted.

On the basis of these findings, the Commission made two recommendations to the Congress. The first recommendation would allow the temporary add-ons to expire. Because their expiration might raise concerns about access, the recommendation includes two steps to maintain access: One step is to direct the Secretary to rebalance the relative values for ambulance services by lowering the relative value of BLS nonemergency services and increasing the relative values of other ground transports. Rebalancing should be budget neutral relative to current law and maintain payments (and thus access) for other ground transports at their level before expiration of the temporary ground ambulance add-on. The second step directs 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.

Because of evidence of clinically inappropriate use of certain BLS nonemergency transports, we made a second recommendation that the Congress direct the Secretary 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; identify geographic areas and ambulance suppliers and providers that display aberrant patterns of use; and use statutory authority to address clinically inappropriate use of BLS nonemergency ground ambulance transports. Reducing clinically inappropriate use of BLS nonemergency services should result in program savings.

### **Mandated report: Geographic adjustment of payments for the work of physicians and other health professionals**

The Middle Class Tax Relief and Job Creation Act of 2012 also mandated that the Commission consider whether Medicare’s fee schedule for physicians and other health professionals should include an adjustment to reflect geographic variation in the cost of these professionals’ labor. The fee schedule includes geographic practice cost indexes (GPCIs) that adjust payment rates for costs such as rent and office staff wages that vary depending on the geographic area where a service is furnished. However, arguments for and against one of the GPCIs—the GPCI for the work effort of the physician or other health professional—have persisted since the development of the fee schedule in the 1980s. The chief argument made in favor of a work GPCI is that the cost of living varies across areas. If payment rates for fee schedule services are not adjusted with a work GPCI, the supply of physicians and other health professionals might not be sufficient in high-cost areas and beneficiary access to care in those areas could suffer. The basic argument against a work GPCI is one of equity; work should be rewarded equally regardless of the location where a service is furnished. The Congress directed the Commission: (1) to consider whether there should be a work GPCI and, if so, what the level of the GPCI should be and where it should be applied, and (2) to assess the impact of the current work GPCI, including its impact on access to care.

In Chapter 8, we find that there is evidence of a need for some level of geographic adjustment of fee schedule payments for professional work. Cost of living varies geographically. Earnings vary geographically for the professionals in the work GPCI’s reference occupations. To the extent we can measure geographic variation in physicians’ earnings, those earnings vary.

However, the current GPCI is flawed. Conceptually, it is based on the earnings of professionals in certain reference occupations, but the labor market for those professionals may not resemble the labor market for physicians and

other health professionals. Implementation of the work GPCI is flawed because there appear to be 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 the quality of care, but there is no evidence that the GPCI affects access. Moreover, any access concerns may be better addressed through other targeted policies, such as the health professional shortage area bonus and the primary care bonus.

In light of the need for some geographic adjustment, but recognizing that there are insufficient data in the short run to revise the work GPCI, the Commission recommends that Medicare payments for the work effort of physicians and other health professionals be geographically adjusted. The adjustment should reflect geographic differences in labor costs per unit of output across markets for physicians and other health professionals. Further, the Congress should allow the GPCI floor to expire (the GPCI floor defines the work GPCI in certain states to be no less than the national average), adjust payments for the work of physicians and other health professionals only by the current one-fourth GPCI (because of uncertainty in the data), and direct the Secretary to develop an adjuster to replace it.

### **Mandated report: Improving Medicare’s payment system for outpatient therapy services**

Medicare’s outpatient therapy benefit covers services for physical therapy, occupational therapy, and speech–language pathology. Outpatient therapy services are designed to restore function patients have lost due to illness or injury and to maintain improved function. These services can be beneficial when necessary but may be subject to inappropriate use. The Middle Class Tax Relief and Job Creation Act of 2012 required the Commission to study therapy services provided under Medicare Part B and make recommendations for reforming Medicare’s payment system for outpatient therapy. The legislation also directed the Commission to examine: (1) how to better document patients’ functional limitations and severity of condition and thus better assess patients’ therapy needs and (2) private sector initiatives to manage outpatient therapy.

In 2011, Medicare spending on outpatient therapy totaled \$5.7 billion for 4.9 million beneficiaries. There are two annual spending limits (caps) on outpatient therapy services per beneficiary to restrain excessive spending and utilization. There is one cap for physical therapy and speech–language pathology services combined and

another cap for occupational therapy services. Each cap equals \$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. A manual review process was implemented in October 2012 for beneficiaries whose annual spending on physical therapy and speech–language pathology services combined or on occupational therapy exceeds \$3,700. However, the manual review process does not apply to the majority of beneficiaries who exceed the caps. While the caps are permanent by statute, the exceptions process expires periodically under current law unless explicitly reauthorized by the Congress.

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. Due to the lack of comprehensive coverage guidelines and effective mechanisms to control volume, 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.

In Chapter 9, the Commission makes three recommendations that are intended to decrease inappropriate use of outpatient therapy services and to provide the program with essential data on patients’ conditions, services they received, and outcomes. The recommendations would improve payment accuracy by fully accounting for the efficiencies of a single provider delivering multiple therapy services to a patient on the same day, increase physician oversight of outpatient therapy regimens, and provide physicians and therapy practitioners with clear guidance regarding when such services are medically indicated and the outcomes that should be expected. The recommendations also lay out a rigorous review process designed to minimize the potential for abuse of the outpatient therapy benefit while giving beneficiaries who need higher levels of outpatient therapy the means to obtain it. The Commission’s recommendations would increase Medicare spending for outpatient therapy services relative to a policy of hard therapy caps (i.e., caps with no exceptions). However, hard therapy caps would decrease access to therapy services not only for those who might otherwise receive questionable levels of therapy but also for those whose medical conditions appropriately warrant high levels of therapy services.

## **Review of CMS’s preliminary estimate of the 2014 update for physician and other professional services**

CMS’s preliminary estimate of the 2014 update for physician and other professional services is –24.4 percent. The prescribed reduction is due to a series of temporary increases enacted over several years that—under current law—expire at the end of 2013. Those increases have prevented a series of negative updates under the sustainable growth rate (SGR) formula—the statutory formula for annually updating Medicare’s payment rates for physician and other health professional services. If the temporary increases expire, the physician fee schedule’s conversion factor must decrease by 26.5 percent. The difference between this reduction and the 2013 update would be the SGR formula’s update—specific to 2013—of 2.8 percent. This increase would be applied to the conversion factor after it had been reduced by 26.5 percent.

In the appendix, we provide the Commission’s mandated review of CMS’s estimate. Absent a change in law, the expiration of the temporary increases and the formula’s update for 2013 are very unlikely to produce an update that differs substantially from –24.4 percent. The temporary increases—by far, the largest factor influencing the payment reduction—were specified by law. The 2.8 percent estimate of the SGR update for 2014 could change between now and when CMS would implement the update in January, but any such changes are likely to be small compared with the total reduction prescribed by law.

While the appendix is limited to a review of the preliminary update estimate, the Commission has concerns about the SGR formula as a payment policy. The SGR formula may have resulted in lower updates, but it has failed to restrain volume growth; in fact, for some specialties the formula may have exacerbated growth. In addition, the temporary increases, or “fixes,” to override the SGR formula are undermining the credibility of Medicare by engendering uncertainty and frustration among providers, which may be causing anxiety among beneficiaries. In an October 2011 letter to the Congress, the Commission recommended repealing the SGR formula and replacing it with legislatively specified updates that would no longer be based on an expenditure-control formula. We reaffirmed our position in a letter sent to the Congress on April 10, 2013, emphasizing that the time to repeal the SGR is now. ■