

Temporary Payment Policies in Medicare

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Statement of

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Chairman Pitts, Ranking Member Pallone, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's recommendations as they concern temporary payment policies in Medicare.

The Medicare Payment Advisory Commission is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.

Introduction

As part of the Commission's Congressional mandate, each year MedPAC makes recommendations to the Congress on how payments to health care providers in Medicare should be updated or improved. Occasionally the Congress requests that the Commission review specific payment policies in Medicare, including temporary policies that require annual reauthorization at a budgetary cost to the taxpayer. In these instances, the Commission reviews the available data, policy options, and implications, and includes this analysis in our standing reports to Congress. In making our assessment of temporary policies, the Commission often uses a common set of questions:

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

The Commission's work may also include recommendations, as appropriate. In certain cases, the Commission has not made recommendations, but instead has developed a set of principles the Congress could use to evaluate payment policies

In what follows, I will review the Commission’s findings and recommendations (if available) on the following temporary Medicare payment policies:

- Rural hospital add-on payments
- Medicare floor for physician work (GPCI)
- Medicare therapy caps exceptions process
- Medicare ambulance add-ons
- Medicare Advantage special needs plans

Rural hospital add-on payments

A key objective of Medicare’s rural payment adjustments is to maintain access to care. Areas with low population density may have small, isolated, low-volume care providers. In these cases, costs may be above average because the low population density prevents economies of scale, and the low volume and high costs may be beyond a provider’s control. Special payments by federal or local sources may be needed to maintain access to care in these communities. However, in some cases, the special payments are not adequately targeted toward the hospitals needed for access.

Principles for evaluating rural add-on payments

One challenge for policymakers is that the current mix of rural payment adjusters is not guided by a coherent set of underlying principles. The adjusters evolved separately, and there is not a clear common framework for how they are intended to work together to preserve access without duplicative, overlapping adjustments. In addition, they are not always targeted to the areas with the greatest concerns about access to care. The lack of targeting stems in part from Medicare’s definition of “rural.” Medicare defines rural as all areas outside of metropolitan statistical areas, so many adjustments can apply to rural areas with a single local provider as well as rural areas with many competing local providers. The Commission has created a framework of principles for rationalizing rural add-on payments that includes targeting providers that are necessary for access, empirically justifying (and not duplicating) payments, and maintaining incentives for cost control.

Principle 1: Target payment adjusters to preserve access

Payment adjusters should be targeted to providers that are necessary to preserve beneficiaries' access to care. Currently, special adjustments often go to rural providers, whether they are critical to maintaining access or not. This practice ignores the wide variation in provider supply in different rural communities.

Principle 2: Focus low-volume adjustments on isolated providers

Many of the current adjustments focus on increasing payments to low-volume providers. However, there are two types of low-volume providers. One type is isolated providers who have low volumes because of low population density in their markets. These providers often have difficulty covering their fixed costs given their low volume of cases. For these providers, low volumes are inevitable and beyond their control. A second type of provider has low volumes because neighboring competitors attract patients away from the low-volume provider. These providers are not necessary for access, and it may be inappropriate to give a low-volume adjustment to two competing low-volume hospitals that are 5 or 10 miles from each other. By focusing low-volume adjustments on isolated providers, rather than making the adjustment available to all providers with low volumes, Medicare can best use its limited resources to serve Medicare beneficiaries.

Principle 3: Empirically justify the magnitude of payment adjustments

The magnitude of the adjustment should be determined empirically. For example, it is necessary to determine the degree to which a low patient volume makes it more difficult for a provider to cover its fixed costs. Patient volume should be measured as total patient volume rather than solely Medicare patient volume, because economies of scale depend on total volumes of patients.

Principle 4: Maintain incentives for cost control

It matters not only how much money is paid to rural providers, but also how it is paid. For example, Medicare's approach of paying prospective payment rates to providers puts stronger pressure on providers to control their costs. Cost-based payments reduce this incentive. Therefore, cost-based reimbursement could be limited to the most isolated providers with very low case volume and highly variable costs that are hard to predict.

Inpatient low-volume adjustment

In our 2001 Report to Congress on Medicare in rural areas, the Commission recommended that the Congress require the Secretary to create a low-volume adjustment for hospitals that are more than a specified distance from other facilities. The Congress enacted a low-volume adjustment in 2003 and the Secretary implemented it, determining that only hospitals receiving prospective payment (PPS hospitals) with fewer than 200 total discharges that are more than 25 miles from another hospital warrant such an adjustment. Because many of the smallest hospitals are already critical access hospitals (CAHs), which receive cost-based reimbursement, the low-volume adjustment applied to only 2 PPS hospitals in 2010. CMS has the regulatory authority to increase the number of hospitals that qualify for this adjustment by increasing the total discharge threshold from 200 up to 800, which would expand the number of hospitals that could qualify for the adjustment.

In 2010, the Congress enacted an additional temporary low-volume adjustment for hospitals that are 15 miles or more from another PPS hospital. Unlike the permanent low-volume adjustment which lets the Secretary determine the discharge threshold, the Congress mandated that inpatient payments increase for any hospital with fewer than 1,600 Medicare discharges. PPS payments are increased by 25 percent for hospitals with 200 or fewer Medicare discharges, with the adjustment declining linearly until it phases out for hospitals with 1,600 or more Medicare discharges. For example, a hospital with 200 Medicare discharges gets a 25 percent add on, a hospital with 900 Medicare discharges gets a 12.5 percent add on, and a hospital with 1,600 Medicare discharges receives no add on. The adjustment is not well targeted with over 50 percent of rural IPPS hospitals qualifying for the adjustment.

The Commission has raised several concerns about this adjustment:

- The program is not focused on isolated hospitals because low-volume hospitals are allowed to be any distance from critical access hospitals.
- The adjustment can be duplicative of sole community hospital (SCH) payments. A sole community hospital receives SCH payments based on its historical cost inflated forward, and then can receive a low-volume add-on payment in addition to the cost-based payments.

- The amount of the adjustment may be more than is empirically justified and may reduce incentives for cost control. Rural hospitals within the bottom quintile of Medicare volume (those that would receive the largest add-on payment) had 7.1 percent Medicare margins in 2012 compared to a –5.4 percent for all hospitals. The 12.5 percent higher profit margin at the lowest volume hospitals suggests that the adjustment is larger than is empirically justified.
- The adjustment is based on Medicare discharges rather than total discharges. Economies of scale depend on total discharges (not just Medicare discharges), so the adjustment has a weaker connection to a provider’s problem with economies of scale than an adjustment based on total discharges. Basing the adjustment on Medicare discharges also discriminates in favor of hospitals with large numbers of private-payer patients and against hospitals with larger shares of Medicare discharges.

Table 1. Low-volume policy favors hospitals with larger non-Medicare shares

Type of hospital	Medicare discharges	Private-payer and other discharges	Total discharges	Low-volume adjustment
Hospital A: high Medicare share (70%)	1,500	600	2,100	2% increase
Hospital B: low Medicare share (30%)	600	1,500	2,100	18% increase

Note: We rounded data from two hospitals that would have qualified for the low-volume payment based on their 2009 Medicare volume.

Source: MedPAC analysis of CMS data.

Table 1 shows the 2009 volumes of Medicare and total discharges for two hospitals and simulates how the low-volume adjustment would affect those hospitals in 2011. Hospital A, with a 70 percent Medicare share, receives only a 2 percent low-volume add-on due to having 1,500 Medicare discharges (the maximum number of discharges still eligible for the add-on). It has 2,100 total discharges. Like Hospital A, Hospital B has low economies of scale with the same number of total discharges (2,100), but it receives an 18 percent add-on because a smaller share of its patients are Medicare beneficiaries (600). Hospital B is unfairly advantaged under the current system, especially if a large share of its non-Medicare patients is highly profitable privately insured patients.

While the Commission did not make a recommendation about the temporary inpatient low-volume adjustment, the set of principles we advanced could be used as a guide to modify the policy to better target Medicare's assistance to low-volume, isolated providers.

Medicare floor for physician work (GPCI)

The fee schedule for physician and other health professionals 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 in which a service is furnished. The work GPCI is one of three geographic payment indexes. The other two adjust for practice expense and professional liability insurance. Together, they adjust payments for resource costs that are beyond providers' control and that vary geographically.

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 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.

One argument made against the work GPCI is that the data used to construct it are flawed. For example, differences across practices in return on investment (profitability of practices), geographic variation in the volume of services provided under fee-for-service payments, and the market concentration of insurers or providers limit the usefulness of data on physician earnings for creating an index. In addition, if data on the earnings of physicians and other health professionals were used to construct the work GPCI, there would be a circular relationship between the work GPCI and the data used to construct it.

Another argument against a work GPCI is geographic equality. That is, the work of physicians and other health professionals is the same in all areas, so there should be no difference in payment levels across different geographic areas. Still others cite the extra demands or costs of rural practice, such as greater on-call time and travel, and assert that physicians and other health professionals must be paid more to locate in rural areas. By contrast, the work GPCI tends to

lower payment rates in rural areas relative to urban areas because professional earnings in rural areas are lower.

Concerns about the work GPCI have led the Congress to put constraints on its application. First, the GPCI is limited to one quarter of the relative cost of professional work effort in a locality compared to the national average, which means that three quarters of the payment for work effort is not adjusted by the GPCI. Second, the GPCI is limited by a temporary floor that suspends it in localities with costs of living below the national average. Without further legislation, the floor will expire at the end of March 2014.

The Commission's findings are, first, that there is evidence of the 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 that we can measure geographic variation in physician earnings, those earnings vary geographically.

However, the current GPCI is flawed in concept and implementation. Conceptually, it is based on the earnings of professionals in a set of reference occupations (e.g., lawyers, architects, teachers), 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 health professionals of sufficient quality to validate the GPCI.

While the work GPCI is flawed, the Commission believes it does not warrant an immediate change in law. Under current law, the floor expires but only one quarter of the GPCI is applied. While we are unable to determine whether the work GPCI has an effect on the quality of care, there is no evidence that the GPCI affects beneficiaries' access to services. Moreover, the Commission believes that any access concerns would be better addressed through other targeted policies, such as the primary care bonus.

Weighing the need for some geographic adjustment, but recognizing that there is insufficient data in the short run to revise the work GPCI, the Commission made the following recommendation:

- **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 cost per unit of output across labor markets for physicians and other health professionals.**
- **Further, the Congress should allow the GPCI floor to expire as current law requires and adjust payments for the work of physicians and other health professionals only by the current one-fourth GPCI (because of uncertainty in the data) while the Secretary develops an adjuster to replace it.**

Because the recommendation follows current law, it will not directly affect program spending.

Outpatient therapy caps exception

The Medicare outpatient therapy benefit covers services for physical therapy, occupational therapy, and speech-language pathology. Medicare spent about \$5.7 billion in 2011 on outpatient therapy services for about 4.9 million beneficiaries. Medicare pays for outpatient therapy services through the fee schedule for physician and other health professional services.

There are annual per beneficiary spending limits (known as caps) on outpatient therapy; one for physical therapy and speech-language pathology services combined, and another for occupational therapy services. Each cap is set at \$1,920 in allowed charges for 2014. However, there is an exceptions process that allows beneficiaries to continue to receive outpatient therapy above these caps. A broad exceptions process allows providers to deliver services above either spending cap relatively easily, limiting the effectiveness of the caps. The exceptions process is scheduled to expire on March 31, 2014 under current law. Once the exceptions process expires, therapy caps would be enforced (in effect establishing hard caps) with no process to obtain coverage for additional services beyond those limits. We estimate that about 20 percent of beneficiaries receiving outpatient therapy would have their therapy truncated at the cap.

The Commission is concerned that on the one hand, hard caps would impede access to necessary and useful care for Medicare beneficiaries. For the right clinical indications, outpatient therapy services provide significant benefits. On the other hand, the automatic exceptions process is not

an effective mechanism to control volume. There is wide geographic variation in the use of outpatient therapy services, raising concerns about program integrity and unnecessarily high levels of Medicare spending. In addition, Medicare lacks basic information to evaluate the medical necessity of therapy services, such as patients' functional status and the outcomes of therapy services.

To balance these concerns the Commission makes three recommendations. The first is to improve physician oversight and program integrity, the second is to ensure access to care while managing Medicare's costs, and the third is to strengthen management of the therapy benefit in the long-term.

Ensure program integrity

The Medicare program currently lacks clear clinical guidelines as to who needs outpatient therapy, how much therapy they should receive, and how long they need services. In addition, there is limited physician oversight to determine a patient's clinical progress and whether services continue to be necessary. Data with which to judge the clinical necessity of therapy services are not collected by the Medicare program. Under these circumstances, Medicare has few tools to constrain excessive use of and spending for outpatient therapy services.

In addition, holding health status equal, use of outpatient therapy varies across the country, suggesting inappropriate use in areas where spending far exceeds the national average. Payment edits based on established national guidelines for appropriate therapy are needed to target aberrant therapy billers and identify geographic areas where abuse of the benefit is suspected.

The Commission's first recommendation aims to improve physician oversight over therapy services and restrain inappropriate use of therapy.

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 PPACA-granted authorities to target high-use geographic areas and aberrant providers.**

The current certification period for the outpatient therapy plan of care is 90 days, and during that period therapy users can use unlimited amounts of therapy without review by the ordering physician. However, a 90-day certification period is longer than the average therapy episode, which lasts for 33 days. Reducing the time frame to 45 days would increase physician engagement and potentially restrain the overuse of services that may otherwise occur during a 90-day period.

In some areas of the country where there has been excessive use of outpatient therapy, CMS's contractors have developed payment edits for high amounts of therapy, reviewed claims from therapy providers that exhibit unusual billing patterns, and conducted site visits to verify the presence and legitimacy of providers. CMS should extend those efforts. Focusing on outlier geographic areas and aberrant providers should reduce the burden on providers in areas where there is little evidence of inappropriate use.

Based on the experience of recent program integrity activities regarding outpatient therapy, we would expect that increased physician oversight of therapy and narrowing the gap between the highest spending areas and the nationwide average would reduce unnecessary program spending. Some of this reduction may be offset by an increase in the number of physician visits paid under Part B if beneficiaries who reach the initial 45-day limit want to continue with their treatment.

Ensure access while managing Medicare's costs

Under current law, the automatic exceptions process will expire at the end of March. At that time, the hard caps on therapy services will take effect—there will be no exceptions, even for necessary services over the cap. To strike a balance between maintaining beneficiaries' access to necessary services and managing spending on therapy services, the Commission recommends:

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 each 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; and**
- **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.**

Each cap is \$1,920 in allowed charges for 2014. Reducing each therapy cap to \$1,270 would accommodate the annual therapy needs of most beneficiaries, while restraining excessive utilization. The lower caps would allow for roughly 14 physical therapy and speech-language pathology visits and 14 occupational therapy visits before any requirement for medical review. Under a reduced cap, about two-thirds of therapy users could receive services before reaching the caps.

The manual medical review process for therapy claims that exceed cap limits should be streamlined. The contractors who manage the process should accept requests for review electronically, reviews should be completed and decisions should be issued within 10 business days, and beneficiaries should be allowed to have two visits during the review process for which the provider bears financial responsibility.

The recommendation also includes hospital outpatient departments (HOPDs) under therapy caps. The Commission believes Medicare should apply the policy of annual caps to all therapy settings—including HOPDs—to ensure that no setting has an unfair competitive advantage.

In the America Taxpayer Relief Act of 2012, the Congress adopted the portion of our recommendation to 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.

We expect that the parts of this recommendation that have not been adopted by the Congress will result in an increase in Medicare spending relative to the hard cap that will take effect after March 31, 2014, under current law. The Commission strongly believes that a manual review process is essential to ensuring beneficiaries' access to needed care; this process would permit additional utilization relative to current law. However, this recommendation should decrease Medicare spending relative to the automatic exceptions process that is currently being used.

In addition, we note that if spending on outpatient therapy services is projected to be above current law, and the Congress wishes to further constrain spending, it could lower therapy caps further and increase the number of services subject to medical review, reduce payment rates for longer episodes of care, or increase beneficiary cost sharing for longer episodes.

Improve management of the benefit in the long term

The Medicare program does not have adequate data with which to evaluate the medical necessity and outcomes of outpatient therapy. Medicare's primary source of information on therapy services is claims data, but the diagnosis information currently required for Medicare payment does not permit any meaningful assessment of how a given therapy regimen relates to a given diagnosis. Claims data also lack measures of functional status, which could help determine the impact of therapy services on the patient's functional ability. The Commission's third recommendation aims to improve the longer term management of the benefit, with specific focus on improving the quality of claims data and developing a tool to collect data on functional status.

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**

with 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.

In the first part of the recommendation, the Commission raises concerns about the use of a certain type of billing code, the V-code. V-codes describe the services beneficiaries receive rather than provide a description of their clinical condition. The Commission recommends that CMS deny claims which have V-codes as a principal diagnosis for therapy, which would require therapists to use more clinically relevant diagnosis codes.

The second part of the recommendation is for CMS to develop a single patient assessment instrument that measures functional status and the outcomes of therapy services over time. This streamlined tool should allow Medicare to categorize therapy users by severity of condition, track their improvement over time, and ultimately pay therapy providers for their performance. Better data could also help lay the groundwork for CMS to develop larger payment bundles that would include outpatient therapy services.

Medicare ambulance add-ons

Medicare spending for ambulance services in 2011 was \$5.3 billion, or about 1 percent of total benefits spending. Medicare pays for ambulance services under a fee schedule that uses relative value units (RVUs) to calculate a base payment, and the distance a patient is transported to calculate a mileage payment. Medicare also makes several add-on payments to certain ambulance providers; two are permanent and three are temporary. The temporary ambulance add-on payments Congress asked MedPAC to study have the following effects:

- increase payments for ambulance transports provided to beneficiaries in urban areas by 2 percent and in rural areas by 3 percent;
- increase payments for ambulance transports in “super-rural” areas by 22.6 percent; and
- designate certain counties as rural for purposes of applying a 50 percent increase in payments for air ambulance services provided in rural areas.

These three temporary add-on payment policies accounted for about \$192 million in Medicare spending and the two permanent add-on payment policies accounted for approximately \$220

million more, for total add-on payments of about \$412 million, or about 8 percent of total Medicare payments for ambulance services.

In the Commission's analysis, we found 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. Over the same period, Medicare ambulance volume grew by roughly 10 percent, 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 nonemergency BLS 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.

We were unable to independently evaluate the financial performance of ambulance providers in Medicare, since Medicare currently does not collect supplier or provider cost data to set or update ambulance payment rates. 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's estimate of the range of median margins in 2010 is -2.3 percent to 9.3 percent with the add-ons and -8.4 percent to 5.3 percent without the add-ons. GAO also found that higher costs were associated with lower volume, more emergency versus nonemergency transports, and higher levels of government subsidies. In addition, the Commission's analysis finding that for-profit suppliers and private equity firms have recently increased their entry into the ambulance industry suggests that profit opportunities in the industry have been available.

In examining the add-on payments, the Commission finds the current ground ambulance add-ons are not well targeted. For example, the permanent rural short-mileage add-on increases payments for all ground transports in any rural ZIP code. This is problematic because the criteria of

transports being rural and short mileage are not good indicators that a transport originates in an area that has the potential for generating a low volume of transports, is isolated, or whose transports have higher costs—a supplier could have a volume of transports well beyond any reasonable standard of low-volume and still receive the add-on. The costs of providing transports are higher in isolated, low-volume rural areas and add-ons should be directed to those areas, not others, as is now the case.

Extending any of the temporary add-ons would increase costs without improving access, quality, or advancing clinical integration, and as a result, the Commission would not recommend doing so. However, to ensure beneficiary access remains, the Commission suggests a two-step approach: (1) 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, and (2) 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.

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. Because payments for transports other than BLS nonemergency will be maintained at their current level (at which no access problems have occurred) access should be maintained for all those transports including all emergency transports.

The new, targeted adjustment would apply to transports originating in geographically-isolated, low-volume areas. An area, rather than a supplier or provider, would be considered low-volume based on the likelihood of that area generating less than a defined number of transports in the course of a year (discussed in detail in the June 2013 MedPAC Report to Congress). This would offset the expiration of the super-rural add-on and protect access in isolated, low-volume areas.

Thus, the Commission recommends that 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.**

Our analysis also suggests that greater focus on program integrity in this area is warranted. For example, we find that the number of dialysis-related transports has increased rapidly in recent years, about twice as fast as all other ambulance transports, and there is tremendous variation across the states in the use of and Medicare spending on dialysis-related ambulance transports. The HHS-OIG has found that many ambulance transports are not medically necessary, raising questions about the rapid growth and unwarranted variation in spending on BLS non-emergency transports such as those to dialysis facilities and transports to community health centers for partial hospitalizations.

As a first step to ensuring appropriate use of the ambulance benefit, there should be no ambiguity over medical necessity. There should be clear definitions and guidelines as to which nonemergency ambulance transport should be covered, and of the terms “recurring” and “nonrecurring” transports. Clear guidelines would enable the Medicare administrative contractors (MACs) to use uniform and complete pre-payment edits to review claims, and the recovery audit contractors (RACs) could expand their audits to include the medical necessity of Medicare Part B BLS nonemergency ambulance transports.

There is also a need for regular and periodic reviews of all nonemergency ambulance claims to search for unusual patterns of use, and to rapidly implement administrative safeguards and apply existing legal authorities to eliminate any identified excessive and fraudulent use. If these steps

are not enough to curb clinically inappropriate and potentially fraudulent use of ambulance transports to dialysis facilities and other nonemergency treatment settings, additional authorities to implement techniques such as prior authorization may be needed. We recommend that:

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.**

Reducing clinically inappropriate use of BLS nonemergency services should result in program savings.

Medicare Advantage special needs plans

In the Medicare Advantage (MA) program, special needs plans (SNPs) are a sub-category of coordinated care plans (CCPs). What primarily distinguishes SNPs from other MA plans is that SNPs limit their enrollment to one of the three categories of special needs individuals: dual-eligible beneficiaries, residents of a nursing home or community residents who are nursing-home certifiable, and beneficiaries with certain chronic or disabling conditions. In contrast, regular MA plans must allow all Medicare beneficiaries residing in their service area to enroll in the plan that meet MA eligibility criteria.

SNP authority expires at the end of 2015. In the absence of congressional action, on January 1, 2016, the SNP designation will sunset. SNPs that wish to continue in the MA program will have to operate as other MA plans in which all beneficiaries are eligible to enroll, not just beneficiaries with special needs. The current law Medicare baseline assumes that SNP authority will expire. If this occurs, some beneficiaries enrolled in SNPs will likely return to traditional

FFS. If SNPs are reauthorized and beneficiaries remain enrolled in SNPs, program spending will increase relative to the baseline because spending on beneficiaries enrolled in MA is on average higher than Medicare FFS spending for similar beneficiaries.

However, there may be reason to consider a more targeted approach to reauthorizing SNPs based on their relative value to the Medicare program. We evaluate each type of SNP on how well it performs on quality of care measures, whether it encourages a more integrated delivery system than is currently available in traditional FFS Medicare, and how SNP reauthorization would affect Medicare program spending.

I-SNPs

Institutional SNPs, known as I-SNPs, are plans primarily for beneficiaries residing in nursing homes. They perform well on a number of quality measures. In particular, I-SNPs have much lower than expected hospital readmission rates. This suggests that I-SNPs are able to reduce hospital readmissions for beneficiaries that reside in nursing homes. Reducing hospital readmissions for beneficiaries in nursing homes suggests that I-SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in traditional FFS.

Considering these factors, the Commissions recommends the Congress permanently reauthorize I-SNPs.

C-SNPs

Chronic condition SNPs, known as C-SNPs, are plans for beneficiaries with certain chronic conditions. In general, C-SNPs tend to perform no better, and often worse, than other SNPs and MA plans on most quality measures. The Commission recommended in 2008 that the list of conditions that qualify for a C-SNP be narrowed, and although the list of C-SNP conditions was reduced, we continue to believe that the list is too broad. It is our judgment that regular MA plans should be able to manage the majority of clinical conditions that currently serve as the basis for a plan to be established as a C-SNP and that the C-SNP model of care for these conditions should be imported into MA plans. This will move MA plans toward providing services that are more targeted to particular populations. This will also improve the integration of the delivery system in regular MA plans for chronically ill enrollees.

There has been recent movement in the MA plan industry in this direction of importing the C-SNP model of care into regular MA plans. There may be a rationale, however, for maintaining C-SNPs for a small number of conditions, including end-stage renal disease (ESRD), HIV/AIDS, and chronic and disabling mental health conditions. These conditions dominate an individual's health and may warrant maintaining separate plans for these conditions while innovations in care delivery for these populations are still being made. However, the ability of MA plans to adequately care for beneficiaries with these three conditions should be revisited in the future.

Considering these factors, the Commission recommends the Congress should:

- **Allow the authority for chronic care SNPs (C-SNPs) to expire, with the exception of C-SNPs for a small number of conditions, including ESRD, HIV/AIDS, and chronic and disabling mental health conditions;**
- **Direct the Secretary, within three years, to permit MA plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions;**
- **Permit current C-SNPs to continue operating during the transition period as the Secretary develops standards. Except for the conditions noted above, impose a moratorium for all other C-SNPs as of January 1, [2014.]**

D-SNPs

Special needs plans for beneficiaries dually eligible for Medicare and Medicaid, known as D-SNPs, generally have average to below average performance on quality measures compared to other SNPs and regular MA plans, with some exceptions. D-SNPs are required to have contracts with states. However, the contracts have generally not resulted in D-SNPs clinically or financially integrating Medicaid benefits.

We found exceptions under two D-SNP models in which an incentive exists to clinically and financially integrate with Medicaid benefits. Under one model, the D-SNP covers Medicare and some or all Medicaid long-term care services and supports (LTSS), behavioral health services, or both through a single plan and through its contract with the state. Under another model, a managed care organization administers the D-SNP and the Medicaid plan that furnishes some or

all of the LTSS or behavioral health services. Some of the same dual-eligible beneficiaries are enrolled in both plans. Under this model, integration occurs at the level of the managed care organization across the two plans.

A number of administrative misalignments act as barriers to integrating Medicare and Medicaid benefits and may hamper the D-SNPs' ability to integrate and coordinate benefits for dual eligible beneficiaries. Most of these barriers (the inability to jointly market the Medicare and Medicaid benefits that D-SNPs furnish, multiple enrollment cards, and lack of a model contract for states to use as a reference) can be alleviated by the Secretary of Health and Human Services. Aligning the Medicare and Medicaid appeals and grievances processes, however, would require a change in statute.

The Commission recommends the Congress should permanently reauthorize dual-eligible special needs plans (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D-SNPs to expire.