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MEMORANDUM OF CALL

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OF (Organization)

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63-110 NSN 7540-00-634-4018 **STANDARD FORM 63** (Rev. 8-81)
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FPMR (41 CFR) 101—11.6

Pafford Ambulance Service, Inc.

FAX Transmittal

P.O. Box 130
214 Main Street
Hermitage, AR 71647

FAX Number (800)532-7571
(501)463-8591
Office Number (800)451-8036
Home 501-463-2807
463-2653

TO: Julie Denney

FAX Number: 202-456-2878

Date: 10-25-95

Number of Pages
(Including Header Page) 4

From: JAMIE PAFFORD-GRESHAM

Comments: Following is A Resolution PASSED By (today) NAT. ASSO. Of State EMS Directors At their ANNUAL Meeting today.
I ALSO HAVE a copy of the PROPOSED House Bill Reguarding Ambulances — I AM NOT SMART ENOUGH TO Disipher?? (READ thru) All of this — is Rural Protected & IS this the legislation I Need to Worry about — I will Be out of the office tomorrow But James (My DADDY) Will Be here — If we Should Be concerned — Contact us — Thank you For All of your Help — JPG

THE NATIONAL ASSOCIATION OF
State Emergency Medical Services Directors

NATIONAL ASSOCIATION OF STATE EMS DIRECTORS

Wednesday October 25, 1995
Bismarck, North Dakota

RESOLUTION 95-08

URGING ADEQUATE REIMBURSEMENT FOR AMBULANCE SERVICES

WHEREAS, ambulance service is an essential component of all *Emergency Medical Services (EMS)* systems, and

WHEREAS, EMS is a critical safety net that ensures all citizens timely emergency medical care and access into the entire health care system, and

WHEREAS, financing of ambulance services through reasonable and appropriate reimbursement policies is essential to sustain current levels of service, and

WHEREAS, EMS, representing less than 1% of overall national health expenditures, already represents an extremely marginal cost to ensure such a critical, population-based service, and

WHEREAS, Congress is currently enacting reductions and changes to the Medicare program that may cap ambulance fees at current levels well beyond the Year 2000 and *limit the overall amount* available to reimburse ambulance services on an annual basis,

NOW, THEREFORE, BE IT RESOLVED, that the National Association of State EMS Directors urges that Congress adopt a bill that contains specific language to reform ambulance reimbursement through the development of a *comprehensive, national fee schedule* and reject language which would freeze ambulance service rates into the future, and

BE IT FURTHER RESOLVED that the National Association of State EMS Directors encourages the President, Congress, the Health Care Financing Administration and other public and private *insurance officials to support adequate* reimbursement for emergency medical care and transportation, with particular attention to rural constraints, to ensure the vitality and full geographic distribution of these critical health services.

Adopted in this form by unanimous vote of the membership, October 25, 1995:

President, Dan Manz

Louise Gevette 10-25-95

Secretary, Louise Gevette

1947 Camino Vida Roble • Suite 202 • Carlsbad, CA 92008 • 619/431-7054 • FAX 619/431-6135

HOUSE MEDICARE PRESERVATION ACT
HR 2485

SEC. 15609A. ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.

(a) Payment in Accordance With Fee Schedule: Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended--

(1) by striking 'and (P)' and inserting '(P)'; and

(2) by striking the semicolon at the end and inserting the following: ', and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (in accordance with section 15608(b) of the Medicare Preservation Act),'.

(b) Requirements for Establishment of Fee Schedule:

(1) In general: , and in accordance with the requirements of this subsection

(2) Considerations: In establishing the fee schedule for ambulance services, the Secretary shall--

(A) establish mechanisms to control increases in expenditures for ambulance services under part B of the medicare program which fairly reflect the changing nature of the ambulance service industry;

(B) establish definitions for ambulance services which promote efficiency and link payments (including fees for assessment and treatment services) to the type of service provided;

(C) take into account regional differences which affect cost and productivity, including differences in the costs of resources and the costs of uncompensated care; Rural?

(D) apply dynamic adjustments to payment rates to account for inflation, demographic changes in the population of medicare beneficiaries, and changes in the number of providers of ambulance services participating in the medicare program, and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

(3) Savings: In establishing the fee schedule for ambulance services, the Secretary shall--

(A) ensure that the aggregate amount of payments made for ambulance services under part B of the medicare program during 1998 does not exceed the aggregate amount of payments which would have been made for such services under part B of the program during 1998 if the amendments made by this section were not in effect; and

(B) set the payment amounts provided under the fee schedule for services furnished in 1999 and each subsequent

Pafford Ambulance Service, Inc.

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P.O. Box 130
214 Main Street
Hermitage, AR 71647

FAX Number (800)532-7571
(501)463-8591
Office Number (800)451-8036

TO: Julie Nemec -
FAX Number: 202-456-2878
Date: 10-11-95
Number of Pages
(Including Header Page) 3
From: Jamie -

Comments: Thank you for all of your help and input yesterday - Here is a copy of what we figured out - See what you & Carol think -

P.S. True definition of RURAL (in the South): A town or city with ONE WALMART OR Less!!! ☺

Pafford Ambulance Service, Inc.
P.O. Box 130
214 Main Street
Hermitage, AR 71647

RURAL AMBULANCE SERVICES (DEFINED)

Rural EMS Providers are those providers who provide the only EMS service for a county or similar geographic region containing locales where transport times to major trauma centers (level 1) may routinely exceed 20 minutes due to terrain, distance or other contributing factors.

(Note: this definition was used in an EMS study prepared by the American College of Emergency Physicians to compare rural and urban EMS settings.)

A possibility would be to use the present definition of Rural as defined by the Office of Management and Budget and add a third option to the criteria.

Rural–meets any of the following **THREE** criteria:

1) located outside of a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget, **OR**

2) located in a rural census tract of one of the MSA countiest listed in Appendix I of the Federal Register notice, **OR**

3) areas which are designated by OMB as an MSA county which does not contain a level one trauma center within its boundaries.

(There are counties on the OMB's list as MSA counties which do not even have a hospital located in them but are considered due to proximity of a metropolitan area. Access to healthcare then becomes a problem in these areas.)

HCFA → HHS → OMB

Internal HHS clearance (November)
+ OMB

60 day comment period

Exception for ambulances that are sole supplier 40 mile area.
ALS BLS

Black Conservative for Village Voice

- Rep Controlled Congress as impacts on Domestic Policy

Greg Thomas

Next week
Mon Tues

10 min

(718) 789-3315
3325 (work)

(home) 718 816 7303

Oct. 3

Hone in definition of Rural

#of ambulances

Very developmental

To _____

Date _____ Time _____

WHILE YOU WERE OUT

M Jamie Pafford

of _____

Phone 1800 451- 8036
Area Code Number Extension

TELEPHONED		PLEASE CALL	
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WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

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Operator

FACSIMILE TRANSMISSION REQUEST

ADDRESSEE: (Name, Organization, Address)	FROM: (Name, Organization, Address)
Julie Demeo Phone: _____	Barb Wynn HCFA Phone: _____

TOTAL PAGES: (Without Cover)	ADDRESSEE'S FAX MACHINE PHONE NUMBER: (If Known)	DATE:
1	202-456-2878	9/15/95

REMARKS:
Attached is latest ~~staff~~ working version of the exception for rural ambulances. We are meeting with State EMS Directors next week + the exception may change based on their comments/concerns.
Please call if you have further questions.

IF FAX MACHINE RETRANSMISSION IS NECESSARY PLEASE CALL:

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Tom Ault or Barbara Winn

410-786-5635

1800 451 8036

Jamie Pofford

Sept. 29th

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

FACSIMILE

DATE AUGUST 16, 1995

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2249

ATTN: Julie Demeo

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: ( ) 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 12

COMMENTS:

Please replace this one with the old one.

Briefing Material
Ambulance Regulation
August 2, 1995

I. WHY THIS REGULATION IS NEEDED

There have been dramatic changes in the ambulance industry since this service was first authorized for Medicare beneficiaries in 1965. A huge array of equipment, supplies and vehicles plus increasingly well-trained staff have made ambulances more efficient at saving lives. These developments have also resulted in a rapid increase in Medicare expenditures. While total Medicare carrier payments grew by 50 percent between 1987 and 1992, carrier ambulance payments grew by 150 percent during that same period.

There are two types of ambulance services currently being delivered, Basic Life Support (BLS) and Advanced Life Support (ALS), which is a more sophisticated and costly service. Much of the growth in Medicare ambulance payments is the result of the increase in ALS services. For example, Medicare payments for ALS and BLS services increased by $72 million from 1988 to 1989. Of this amount, 73 percent was attributable to increased utilization of ALS ambulances. Also, the number of trips in ALS ambulances increased by 131 percent during this time period, while the comparable figure for BLS was 14 percent.

Medicare ALS payments have continued to increase in this decade, although at a slower rate than previously. For the period 1992 to 1994, ALS payments increased 15 percent annually from $500 million to $660 million. Total ambulance payments have experienced a similar pattern with annual increases of 15 percent and currently total $1.7 billion.

The growth of ambulance payments has been documented by three OIG Reports issued in 1992 to 1994. The OIG reports, along with the findings of the Project Hope Study of Payments for Ambulance Services under Medicare, have been the impetus of initiatives undertaken by HCFA to address the growth in ambulance spending while protecting beneficiary access to essential services. This issue has also received attention from Congress as evidenced by a December 1994 hearing by the Senate Appropriations Committee, Subcommittee on Labor, Health, and Human Resources.

Medicare's current policy bases payment for ambulance services on the type of vehicle dispatched to a beneficiary, i.e. if an ALS vehicle is used payment is made at the ALS rate. This proposed regulation would base payment on the level of ambulance service that is medically necessary.

We have reviewed ambulance utilization patterns and found that there is a small

number of regular users of this service. For some End Stage Renal Disease (ESRD) beneficiaries other forms of transportation to dialysis facilities is contraindicated; they need ambulance transportation to receive dialysis services on a regular basis, i.e. three times a week. This extremely small group of beneficiaries (less than 2 percent) account for 75 percent of all ESRD ambulance payments. Nevertheless, it is important that HCFA not foreclose access to medically necessary ambulance services for ESRD beneficiaries.

II. ISSUES

A. Basing Payment on Medical Necessity

Discussion

Medicare's current policy focuses on the type of vehicle used as determinative of the level of payment. The BLS/ALS issue is further complicated by the fact that there are an increasing number of local governments mandating, through ordinances or regulations, ALS ambulance service as the minimum level of ambulance transport.

Thus Medicare has paid at the ALS rate even when ALS services are not necessary. This has resulted in increased expenditures for the Medicare program and its beneficiaries who are subject to a 20 percent copayment on these services. While we do not dispute the value of the ALS services when they are needed, we also do not believe that Medicare should pay at the higher rate in cases where ALS services are not required. Under this proposal, an ALS ambulance company must bill the BLS code if only BLS services are furnished. Otherwise, the bill is incorrect and the Medicare carrier will downcode the claim to the BLS code with the corresponding lower payment allowance.

Impact on the Beneficiary

Ambulance companies file Medicare claims in one of two ways; accepting assignment or not accepting assignment. For assigned claims (which account for over 90 percent of all ambulance claims) the beneficiary is protected from any additional financial liability. Therefore, in the case where an ALS code is billed, but only a BLS payment is allowed, the beneficiary is liable only for coinsurance due on the lower BLS payment allowance. This protection is afforded in either of two ways. The most common circumstance will be that an ALS ambulance was used, but no ALS service was furnished. The new coding structure requires the use of a code that describes this situation. To bill for an ALS service when no ALS service was furnished is a false claim, and the beneficiary is not liable based on a false claim for services that were never furnished.

The other case, which we expect will be much less frequent, is the case in which

the ambulance company furnishes an ALS service which the carrier determines was not medically necessary. The carrier would then pay this claim at the BLS rate. The beneficiary will be protected by the "limitation on liability" provision (section 1879 of the law).

We are providing protection under section 1879 in the same manner as it applies to all other services, with this exception: the ambulance suppliers will not be required to give advanced written notices of the likelihood of non-coverage, nor to obtain the beneficiary's signed agreement to pay. Giving advance notice is not feasible with most ambulance patients, and their ability to make informed consumer decisions at such time is questionable. Likewise, the effectiveness of an agreement to pay signed by a patient in these circumstances also may well be questioned. Absent advance notices, providers will be held liable when the carrier finds they knew or should have known that Medicare would not pay; the program will pay when the providers are held not to have had such knowledge; a beneficiary will be liable only when there is clear and obvious evidence that the beneficiary knew that Medicare would not pay.

Regional Impact

In order to determine which geographical areas would be most impacted by basing Medicare ambulance payments on medical necessity rather than the level of ambulance used, we examined Medicare data, especially for those carrier areas that have a disproportionally high percentage of ALS care compared to national levels. If we assume that the regulation affected only the areas with a percentage of ALS charges greater than the national average percentage of ALS to total ambulance charges, the following five carriers out of 55 total carriers would account for 50 percent of the regulation's impact:

Northern California Texas
Florida Ohio
Mississippi

Also, eleven carriers (the additional 6 are Arkansas, Louisiana, Alabama, Georgia, Oregon, and Oklahoma) account for 76 percent of the regulation's impact. This effect is more pronounced when the data are viewed by locality. Of 235 localities, only 13 account for 50 percent of the impact, 36 localities account for 75 percent and 57 localities account for 90 percent of the total impact on ALS services. These regional patterns reflect a heavy use of ALS services and, while there are no national data identifying communities that mandate all ALS services, we believe the concentration of our data in specific areas reflects the communities with ALS mandates.

Savings

Savings associated with this regulation are $30 million for the first year; the five year savings total is $260 million.

Rural Area

A primary concern in basing payment on medical necessity is the issue of ambulance services in rural areas. We do realize that there are rural areas (where multiple ambulances, a mix of ALS and BLS, are not economical) that may be affected by our proposed change to base payment on medical necessity. To date, however, we have not come to closure on exactly how a rural exception should be effected.

Therefore, we are working with Department staff, including the Office of Rural Health, in an effort to establish a "rural exception" that will attempt to mitigate the possible negative impact on rural areas. A proposed exception under consideration is to continue to reimburse a rural ambulance supplier under the current policy if the State Emergency Medical Services Director certifies that the ambulance service meets one of the following criteria:

The ambulance supplier only offers an ALS level of service and is the sole provider of ambulance services in the county or comparable New England district.

When there is more than one ambulance supplier in the county, a supplier can be excepted if it offers an ALS level of service only and is located more than 40 miles from the nearest alternative provider.

Recommendation

If a locality decides to provide or require a level of service in excess of what is medically necessary, we recommend that Medicare should not be required to subsidize that decision. It should be the responsibility of the citizens of that locality to pay for the decision to support an ALS-only system.

Pros:

Potential cost savings for Medicare and the beneficiary.

Limitations on liability would provide beneficiary protection.

Identifying a rural exception would help to maintain access to services for beneficiaries in a rural area.

Cons:

Ambulance suppliers believe that the proposed policy change will lead to the collapse of many EMS systems in the U.S, including the probable elimination of ALS in rural communities and the layoff of EMS personnel.

Payments to some ambulance suppliers will be reduced.

B. Medical Condition Codes

Discussion

For several years the American Ambulance Association (AAA) has expressed an interest in the subject of the national medical condition indicator codes for ambulance services. Current Medicare guidelines indicate that, in order to be covered, ambulance services must be reasonable and necessary. This is usually established in part by the diagnosis of the patient's condition at the time of the transport. Physicians are required to use ICD-9-CM codes on Part B claims submitted for payment. However, no such national requirement exists for ambulance suppliers.

While suppliers have been encouraged to employ the use of the existing ICD-9-CM codes, many are reluctant to do so, because ICD-9-CM codes are diagnosis codes and, by law, ambulance suppliers not authorized to diagnose the patient's medical problem.

Currently, different carriers use local modifiers and ICD-9-CM crossovers to process claims. What is needed is a uniform method of coding that would simplify claims processing and provide ambulance personnel with the ability to accurately describe the condition of the patient.

The proposed condition indicator codes will describe the medical condition of the patient at the time ambulance services are provided and justify the medical necessity for BLS and ALS transportation, i.e., demonstrate that other methods of transportation are contraindicated.

Recommendation

Therefore, we are also proposing the promulgation of national medical condition indicator codes for ambulance services.

Pros:

Claims are easier to evaluate.

Comprehensive coding system would be consistent among carriers and conforms to the Medicare Transaction System.

The American Ambulance Association and American College of Emergency Physicians have reviewed the current list and submitted recommendations for consideration.

Cons:

The listing may need revision periodically.

AAA and ACEP believe the current listing should be expanded because the current list is too narrow and restrictive.

Monitoring the list by the carrier would require additional funding in addition to increasing the workload.

C. Ambulance Definition

Discussion
We also propose to publish rules clarifying the requirements for determining whether a vehicle qualifies as an ambulance for Medicare purposes.

In some States, an ambulance is defined, by State or local laws, as a vehicle that is intended for medical emergency transportation. There are, however, some suppliers that bill Medicare for providing transportation in vehicles that are not equipped to respond to medical emergencies as required by State or local law.
Transportation in such vehicles may be furnished to persons who need assistance in getting to care givers, for example, because of difficulty in ambulating, but who do not require medical emergency transportation. More specifically, their condition is such that transportation by means other than in a vehicle designed and equipped to respond to a medical emergency is not contraindicated. Typically, this level of transportation is less than ambulance services and is furnished to a person who has a scheduled medical appointment, using a vehicle such as an ambulette, ambu-van, medi-transport, or invalid coach. These services are not covered under Medicare law.

Some suppliers have been paid by Medicare for this type of transportation service. Suppliers have argued that their vehicles, despite not meeting State or local standards, still meet the definition of an ambulance contained in the regulations at 42 CFR 410.40, which does not explicitly require that an ambulance be designed and equipped to handle medical emergencies.

The AAA and ACEP have maintained that a separate definition of emergency should be included in the proposed regulation. While we initially agreed with this position, it was decided that the definitions contained in the statute adequately defined the term "emergency" and that we would include the concept of emergency in the context of definition of an ambulance. ACEP has submitted its "prudent layperson" *definition of emergency services*. This definition, according to ACEP, "accommodates an individual patient's judgement about their emergency symptoms and whether to seek emergency care." ACEP views HCFA's statutory definitions as inappropriate because ambulance personnel are not authorized to diagnose a patient's medical condition in addition to discouraging an individual from pursuing the care they deem appropriate; the prudent layperson definition would allow patients to determine whether they are in need of medical care.

Recommendation
We believe that the basic purpose of the ambulance benefit set forth in section 1861(s)(7) of the Act, which states that ambulance service may be covered by Medicare if the use of other methods of transportation is

distances than nearby freestanding facilities. Ambulance services must be reasonable and medically necessary. Generally, coverage of ambulance services is only available to a beneficiary whose condition is such that the use of other methods of transportation is contraindicated.

The first step in our effort to address this problem of inappropriate ambulance transport of ESRD beneficiaries involved the implementation of new origin and destination codes to be used when an ambulance supplier is billing for an ambulance trip to dialysis for ambulance services furnished to ESRD patients. Suppliers also have been instructed to use base billing codes that identify non-emergency (scheduled) transportation. These new codes will allow Medicare to distinguish between trips to hospital-based dialysis facilities and trips to non-hospital-based facilities as well as emergency and non-emergency transportation. These codes have been in full effect since April, 1995.

In addition to the implementation of the coding changes, HCFA worked closely with the ESRD Networks and facilities to clarify HCFA's coverage policy regarding ambulance transportation of ESRD beneficiaries. As a result we were able to assure that ESRD beneficiaries continued to receive dialysis treatment without disruption. The Networks were able to assure continued treatment by arranging for alternative transportation or, in the case of those needing ambulance transportation, making sure the patients were transferred to a hospital-based facility.

Recommendation

We propose to revise the current regulations to authorize coverage of medically necessary ambulance transportation of ESRD beneficiaries to the nearest freestanding outpatient dialysis facility capable of providing the necessary dialysis services. The purpose of the proposed revision is to make the existing regulation more consistent with our policy of transporting beneficiaries to the nearest appropriate facility.

In addition, we propose to revise the regulations to deal with the issue of whether the transport was scheduled or not. We would propose, in this instance, to base payment for ambulance services on a medical necessity criterion. We would require, in situations involving repetitive, scheduled ambulance runs (such as to a dialysis facility) where non-emergency BLS service is required, that the ambulance suppliers obtain advance written physician certification from the attending physician as documentation of the medical reason that transportation by other means is contraindicated. We also propose to specify that the certifications, while renewable, would be valid for a period not to exceed 60 days.

Pros:

Proposal makes the benefit more equitable to ESRD beneficiaries by

contraindicated by the individual's condition, but only to the extent provided in regulations, is to provide coverage for necessary transportation in emergency situations. The current definitions of "ambulance" contained in the regulation and manuals do not state specifically that ambulance services must be furnished in vehicles that are "equipped to respond to medical emergencies."

As a means of distinguishing an ambulance from other modes of medically related transportation, we are proposing to revise the regulation to define an ambulance in terms of the medical equipment, staffing requirements and the ability to respond to a medical emergency. We also propose to revise the regulation to establish definitions of BLS and ALS levels of ambulance service. We propose to use, with minor changes, the definitions contained in current manual instructions. While some may argue that we are overriding State or local law that may not be as strict as our proposal, these requirements would only apply to Medicare beneficiaries who, we believe, would benefit from receiving ambulance services from those suppliers meeting these vehicle, medical equipment, and staffing standards.

Pros:

Allows HCFA to distinguish between ambulances and lesser forms of medically related transportation.

Promotes consistency in interpretation of policy and adjudication of disputes.

Ensures a quality standard of care for Medicare beneficiaries.

Cons:

ACEP and AAA strongly believe that a separate definition of emergency that is appropriate for prehospital services is needed. The decision not to include separate definition of emergency, but to rely on the definitions contained in the statute are in conflict with ACEP's prudent layperson definition.

ACEP views the current definitions and proposed changes as establishing barriers to emergency medical care.

D. End Stage Renal Disease Beneficiaries

Discussion

Currently, the Medicare program may pay to have ESRD beneficiaries transported to hospital-based ESRD facilities that may be located at greater

eliminating unnecessarily long ambulance trips to hospital-based dialysis facilities when a freestanding facility is closer.

Potential cost savings to the beneficiary and Medicare.

Proposal is the direct result of working with the ambulance industry.

Cons:

Additional paperwork requirement for the attending physicians and ambulance suppliers.

Carrier costs for claims processing will increase because of physician certification requirement.

III. OTHER CONSIDERATIONS

Legislative Proposal in lieu of Regulatory Change

While we are proposing to change the regulations to effect the changes described above, another alternative is to seek a legislative proposal to change these policies. Since ambulance services are a politically sensitive issue, we may want a Congressional directive. On the other hand, problems in this area are well documented and the Medicare ambulance requirements that were originally set when the program began in 1965 need to be updated to reflect current conditions.

We have a legislative proposal to pay for ambulance services on a fee schedule. We would limit the payment allowance for ambulance services to the average allowed charge of each locality. An average allowed charge would be calculated for each locality (there are approximately 235 localities around the country). Payment would be made at the lower of the ambulance supplier's actual charge or the average allowed charge for that locality. This proposal is essentially budget neutral because by limiting the payment to the average allowed charge by locality, payment denied to a higher charger is added to the allowable charge of a lower charger. This proposal redistributes money within a locality rather than denying it.

We would also pursue legislation to protect the beneficiary's financial liability by requiring ambulance companies to accept assignment. Under the terms of Medicare assignment, Medicare pays its benefits only to the ambulance company (i.e., the beneficiary is not paid), the ambulance company accepts Medicare's allowable charge as its total charge, and ambulance companies may bill beneficiaries only for the Part B coinsurance (20 percent) and any unmet Part B deductible applied to Medicare's allowed charge for any Medicare

covered service. Historically, over 90 percent of ambulance claims are paid under assignment.

DEPARTMENT OF HEALTH & HUMAN SERVICES Chief of Staff
Washington D.C. 20201

FACSIMILE

DATE AUG 11 1995

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

Attn: Julie Demio

456-2249

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: ( ) 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 12

COMMENTS: Julie Demio:

Attached is the information you requested.

Mary Beth Donahue

Briefing Material
Ambulance Regulation
August 2, 1995

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on the lower BLS payment allowance. This protection is afforded in either of two ways. The most common circumstance will be that an ALS ambulance was used, but no ALS service was furnished. The new coding structure requires the use of a code that describes this situation. To bill for an ALS service when no ALS service was furnished is a false claim, and the beneficiary is not liable based on a false claim for services that were never furnished.

The other case, which we expect will be much less frequent, is the case in which the ambulance company furnishes an ALS service which the carrier determines was not medically necessary. The carrier would then pay this claim at the BLS rate. The beneficiary will be protected by the "limitation on liability" provision (section 1879 of the law).

We are providing protection under section 1879 in the same manner as it applies to all other services, with this exception: the ambulance suppliers will not be required to give advanced written notices of the likelihood of non-coverage, nor to obtain the beneficiary's signed agreement to pay. Giving advance notice is not feasible with most ambulance patients, and their ability to make informed consumer decisions at such time is questionable. Likewise, the effectiveness of an agreement to pay signed by a patient in these circumstances also may well be questioned. Absent advance notices, providers will be held liable when the carrier finds they knew or should have known that Medicare would not pay; the program will pay when the providers are held not to have had such knowledge; a beneficiary will be liable only when there is clear and obvious evidence that the beneficiary knew that Medicare would not pay.

Regional Impact

In order to determine which geographical areas would be most impacted by basing Medicare ambulance payments on medical necessity rather than the level of ambulance used, we examined Medicare data, especially for those carrier areas that have a disproportionally high percentage of ALS care compared to national levels. If we assume that the regulation affected only the areas with a percentage of ALS charges greater than the national average percentage of ALS to total ambulance charges, the following five carriers out of 55 total carriers would account for 50 percent of the regulation's impact:

Northern California	Texas
Florida	Ohio
Mississippi	

Also, eleven carriers (the additional 6 are Arkansas, Louisiana, Alabama, Georgia, Oregon, and Oklahoma) account for 76 percent of the regulation's impact. This effect is more pronounced when the data are viewed by locality. Of 235 localities, only 13 account for 50 percent of the impact, 36 localities account for 75 percent and 57 localities account for 90 percent of the total impact on ALS services. These regional patterns reflect a heavy use of ALS services and, while there are no national data identifying communities that mandate all ALS services, we believe the concentration of our data in specific areas reflects the communities with ALS mandates.

Savings

Savings associated with this regulation are $30 million for the first year; the five year savings total is $260 million.

Rural Area

A primary concern in basing payment on medical necessity is the issue of ambulance services in rural areas. We do realize that there are rural areas (where multiple ambulances, a mix of ALS and BLS, are not economical) that may be affected by our proposed change to base payment on medical necessity. To date, however, we have not come to closure on exactly how a rural exception should be effected.

Therefore, we are working with Department staff, including the Office of Rural Health, in an effort to establish a "rural exception" that will attempt to mitigate the possible negative impact on rural areas. A proposed exception under consideration is to continue to reimburse a rural ambulance supplier under the current policy if the State Emergency Medical Services Director certifies that the ambulance service meets one of the following criteria:

- The ambulance supplier only offers an ALS level of service and is the sole provider of ambulance services in the county or compareble New England district.

- When there is more than one ambulance supplier in the county, a supplier can be excepted if it offers an ALS level of service only and is located more than 40 miles from the nearest alternative provider.

Recommendation

If a locality decides to provide or require a level of service in excess of what is

medically necessary, we recommend that Medicare should not be required to subsidize that decision. It should be the responsibility of the citizens of that locality to pay for the decision to support an ALS-only system.

Pros:

- Potential cost savings for Medicare and the beneficiary.
- Limitations on liability would provide beneficiary protection.
- Identifying a rural exception would help to maintain access to services for beneficiaries in a rural area.

Cons:

- Ambulance suppliers believe that the proposed policy change will lead to the collapse of many EMS systems in the U.S, including the probable elimination of ALS in rural communities and the layoff of EMS personnel.
- Payments to some ambulance suppliers will be reduced.

B. Medical Condition Codes

Discussion

For several years the American Ambulance Association (AAA) has expressed an interest in the subject of the national medical condition indicator codes for ambulance services. Current Medicare guidelines indicate that, in order to be covered, ambulance services must be reasonable and necessary. This is usually established in part by the diagnosis of the patient's condition at the time of the transport. Physicians are required to use ICD-9-CM codes on Part B claims submitted for payment. However, no such national requirement exists for ambulance suppliers.

While suppliers have been encouraged to employ the use of the existing ICD-9-CM codes, many are reluctant to do so, because ICD-9-CM codes are diagnosis codes and, by law, ambulance suppliers not authorized to diagnose the patient's medical problem.

Currently, different carriers use local modifiers and ICD-9-CM crossovers to process claims. What is needed is a uniform method of coding that would simplify claims processing and provide ambulance personnel with the ability to accurately describe the condition of the patient.

The proposed condition indicator codes will describe the medical condition of the patient at the time ambulance services are provided and justify the medical necessity for BLS and ALS transportation, i.e., demonstrate that other methods of transportation are contraindicated.

Recommendation

Therefore, we are also proposing the promulgation of national medical condition indicator codes for ambulance services.

Pros:

- Claims are easier to evaluate.
- Comprehensive coding system would be consistent among carriers and conforms to the Medicare Transaction System.
- The American Ambulance Association and American College of Emergency Physicians have reviewed the current list and submitted recommendations for consideration.

Cons:

- The listing may need revision periodically.
- AAA and ACEP believe the current listing should be expanded because the current list is too narrow and restrictive.
- Monitoring the list by the carrier would require additional funding in addition to increasing the workload.

C. Ambulance Definition

Discussion

We also propose to publish rules clarifying the requirements for determining whether a vehicle qualifies as an ambulance for Medicare purposes.

In some States, an ambulance is defined, by State or local laws, as a vehicle that is intended for medical emergency transportation. There are, however, some suppliers that bill Medicare for providing transportation in vehicles that are not equipped to respond to medical emergencies as required by State or local law. Transportation in such vehicles may be furnished to persons who need assistance in getting to care givers, for example, because of difficulty in ambulating, but who do not require medical emergency transportation. More specifically, their condition is such that transportation by means other than in a vehicle designed and equipped to respond to a medical emergency is not contraindicated. Typically, this level of transportation is less than ambulance services and is furnished to a person who has a scheduled medical appointment, using a vehicle such as an ambulette, ambu-van, medi-transport, or invalid coach. These services are not covered under Medicare law.

Some suppliers have been paid by Medicare for this type of transportation service. Suppliers have argued that their vehicles, despite not meeting State or local standards, still meet the definition of an ambulance contained in the regulations at 42 CFR 410.40, which does not explicitly require that an ambulance be designed and equipped to handle medical emergencies.

The AAA and ACEP have maintained that a separate definition of emergency should be included in the proposed regulation. While we initially agreed with this position, it was decided that the definitions contained in the statute adequately defined the term "emergency" and that we would include the concept of emergency in the context of definition of an ambulance. ACEP has submitted its "prudent layperson" definition of emergency services. This definition, according to ACEP, "accommodates an individual patient's judgement about their emergency symptoms and whether to seek emergency care." ACEP views HCFA's statutory definitions as inappropriate because ambulance personnel are not authorized to diagnose a patient's medical condition in addition to discouraging an individual from pursuing the care they deem appropriate; the prudent layperson definition would allow patients to determine whether they are in need of medical care.

Recommendation

We believe that the basic purpose of the ambulance benefit set forth in section 1861(s)(7) of the Act, which states that ambulance service may be covered by Medicare if the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations, is to provide coverage for necessary transportation in emergency situations. The current definitions of "ambulance" contained in the regulation and manuals do not state specifically that ambulance services must be furnished in vehicles that are "equipped to respond to medical emergencies."

As a means of distinguishing an ambulance from other modes of medically related transportation, we are proposing to revise the regulation to define an ambulance in terms of the medical equipment, staffing requirements and the ability to respond to a medical emergency. We also propose to revise the regulation to establish definitions of BLS and ALS levels of ambulance service. We propose to use, with minor changes, the definitions contained in current manual instructions. While some may argue that we are overriding State or local law that may not be as strict as our proposal, these requirements would only apply to Medicare beneficiaries who, we believe, would benefit from receiving ambulance services from those suppliers meeting these vehicle, medical equipment, and staffing standards.

Pros:

- Allows HCFA to distinguish between ambulances and lesser forms of medically related transportation.
- Promotes consistency in interpretation of policy and adjudication of disputes.
- Ensures a quality standard of care for Medicare beneficiaries.

Cons:

- ACEP and AAA strongly believe that a separate definition of emergency that is appropriate for prehospital services is needed. The decision not to include separate definition of emergency, but to rely on the definitions contained in the statute are in conflict with ACEP's prudent layperson definition.

- ACEP views the current definitions and proposed changes as establishing barriers to emergency medical care.

D. End Stage Renal Disease Beneficiaries

Discussion

Currently, the Medicare program may pay to have ESRD beneficiaries transported to hospital-based ESRD facilities that may be located at greater distances than nearby freestanding facilities. Ambulance services must be reasonable and medically necessary. Generally, coverage of ambulance services is only available to a beneficiary whose condition is such that the use of other methods of transportation is contraindicated.

The first step in our effort to address this problem of inappropriate ambulance transport of ESRD beneficiaries involved the implementation of new origin and destination codes to be used when an ambulance supplier is billing for an ambulance trip to dialysis for ambulance services furnished to ESRD patients. Suppliers also have been instructed to use base billing codes that identify non-emergency (scheduled) transportation. These new codes will allow Medicare to distinguish between trips to hospital-based dialysis facilities and trips to non-hospital-based facilities as well as emergency and non-emergency transportation. These codes have been in full effect since April, 1995.

In addition to the implementation of the coding changes, HCFA worked closely with the ESRD Networks and facilities to clarify HCFA's coverage policy regarding ambulance transportation of ESRD beneficiaries. As a result we were able to assure that ESRD beneficiaries continued to receive dialysis treatment without disruption. The Networks were able to assure continued treatment by arranging for alternative transportation or, in the case of those needing ambulance transportation, making sure the patients were transferred to a hospital-based facility.

Recommendation

We propose to revise the current regulations to authorize coverage of medically necessary ambulance transportation of ESRD beneficiaries to the nearest freestanding outpatient dialysis facility capable of providing the necessary dialysis services. The purpose of the proposed revision is to make the existing regulation more consistent with our policy of transporting beneficiaries to the nearest

appropriate facility.

In addition, we propose to revise the regulations to deal with the issue of whether the transport was scheduled or not. We would propose, in this instance, to base payment for ambulance services on a medical necessity criterion. We would require, in situations involving repetitive, scheduled ambulance runs (such as to a dialysis facility) where non-emergency BLS service is required, that the ambulance suppliers obtain advance written physician certification from the attending physician as documentation of the medical reason that transportation by other means is contraindicated. We also propose to specify that the certifications, while renewable, would be valid for a period not to exceed 60 days.
Pros:

- Proposal makes the benefit more equitable to ESRD beneficiaries by eliminating unnecessarily long ambulance trips to hospital-based dialysis facilities when a freestanding facility is closer.

- Potential cost savings to the beneficiary and Medicare.

- Proposal is the direct result of working with the ambulance industry.

Cons:

- Additional paperwork requirement for the attending physicians and ambulance suppliers.

- Carrier costs for claims processing will increase because of physician certification requirement.

III. OTHER CONSIDERATIONS

Legislative Proposal in lieu of Regulatory Change

While we are proposing to change the regulations to effect the changes described above, another alternative is to seek a legislative proposal to change these policies. Since ambulance services are a politically sensitive issue, we may want a Congressional directive. On the other hand, problems in this area are well documented and the Medicare ambulance requirements that were originally set when the program began in 1965 need to be updated to reflect current conditions.

We have a legislative proposal to pay for ambulance services on a fee schedule. We would limit the payment allowance for ambulance services to the average allowed charge of each locality. An average allowed charge would be calculated for each locality (there are approximately 235 localities around the country). Payment would be made at the lower of the ambulance supplier's actual charge or the average allowed charge for that locality. This proposal is essentially budget neutral because by limiting the payment to the average allowed charge by locality, payment denied to a higher charger is added to the allowable charge of a lower charger. This proposal redistributes money within a locality rather than denying it.

We would also pursue legislation to protect the beneficiary's financial liability by requiring ambulance companies to accept assignment. Under the terms of Medicare assignment, Medicare pays its benefits only to the ambulance company (i.e., the beneficiary is not paid), the ambulance company accepts Medicare's allowable charge as its total charge, and ambulance companies may bill beneficiaries only for the Part B coinsurance (20 percent) and any unmet Part B deductible applied to Medicare's allowed charge for any Medicare covered service. Historically, over 90 percent of ambulance claims are paid under assignment.

Pafford Ambulance Service, Inc.

FAX Transmittal

P.O. Box 130
214 Main Street
Hermitage, AR 71647

FAX Number (800)532-7571
(501)463-8591
Office Number (800)451-8036

TO: Julie Demeo

FAX Number: 2024562878

Date: 8-11-95

Number of Pages
(Including Header Page) 17

From: Jamie & James Pafford

Comments:

I know its lengthy —
Please let me know if you have
to need further
Jamie

Pafford Ambulance Service, Inc.
P.O. Box 130
214 Main Street
Hermitage, AR 71647

August 11, 1995

Julie Demeo
The White House
Domestic Policy
Washington, D.C.

RE: HCFA proposed regulation changes for ambulance service (ALS vs BLS)

Attached please find letters we have received regarding the proposed changes in HCFA regulations pertaining to emergency ambulance services.

Here is a letter written to the President from our State Director of EMS. We do not know if he has received this letter. Although it is lengthy, it makes several important points.

Daddy and I both separately received a letter from Thomas Ault with HCFA. They were exactly the same. While we recognize the goal of the program is to reduce short term expenditures, there must be consideration given to the long term implications. We are especially concerned about the effect of these changes on rural ambulance providers.

The change proposed by HCFA would provide reimbursement based on patient need, rather that the level of service provided. This is feasible in urban areas where ambulance providers have sufficient transport volume to operate both ALS and BLS ambulances. However, in rural America, ambulance providers cannot afford to operate a "tiered" system. It will financially force these providers to operate only basic ambulance services, if any at all.

We would like to propose the question to Mr. Ault of HCFA as to what type of service he feels will be "readily available to Medicare beneficiaries" as he states in his letter, if this change is made.

Most small communities in America have limited hospital emergency room resources. Patients must travel great distances to reach major trauma centers. Providing less than ALS ambulance services to these patients at the onset of the emergency will result in much greater costs to the overall health care system. Many rural communities have recognized the need for this level of service and have adopted ordinances and local laws mandating ALS ambulance services in their respective communities.

The Office of the Inspector General's study emphasized this point in the report made part of HCFA's "Project Hope" dated October 21, 1991 (Section 7.3.1) In this study, it is noted there must be some consideration given to the reimbursement methodology for rural providers. Failure to recognize this fact will have a devastating impact on rural providers. Rural, in terms of this issue, would imply areas of approximately 30,000 population have sufficient volume to permit operating a tiered system.

It is our request that the current changes proposed by HCFA be amended to protect small rural ALS ambulance services. This could be accomplished by making the current changes applicable to services operating in urban areas. Rural areas should be permitted to continue providing ALS services in accordance will all current requirements (i.e. ordinances, mandates) of ALS reimbursement.

It should be further noted payment to rural ambulance providers constituted only twenty percent of the overall ambulance expenditures made by the Medicare program. It is estimated the savings from early ALS intervention in rural emergency medical situations will far exceed the cost to the program.

Failure to intervene in the proposed changes before HCFA will result in services leaving the rural areas. Rural residents will be left with little or no ALS emergency care. This will obviously have a catastrophic impact on the health and welfare of millions of Americans.

Your personal assistance in this matter is critical to the future of emergency medical care in rural America. Please contact me if we can be of further assistance to you and your staff on this matter.

Sincerely,

Jamie Pafford-Gresham
Vice-President

Lloyd D. (Doug) Darr
12201 Jacksonville-Cato Road
North little Rock, AR 72120
(501) 835-0741

June 25, 1995

President Bill Clinton
1600 Pennsylvania Avenue
Washington, DC

Dear President Clinton,

I am writing to request your help in preventing the Health Care Financing Administration (HCFA) from destroying our nations rural emergency medical services (EMS) through a well intended, but poorly researched, regulatory rule change. Specifically, they are attempting to reduce the nation's Medicare cost by quickly pushing through a package of changes which effect the reimbursement of pre-hospital emergency medical care by ambulance services. Overall this is a very good, well thought out package of changes. However, one change will only allow for reimbursement of transfers at the Advanced Life Support (ALS or paramedic level) rate when the patient actually needs the advanced level of care. At first look this appears to be a logical change, but it's effect will be to reduce the Emergency Medical Services available in our nation's rural and frontier areas back to the Basic Life Support (BLS or basic emergency medical technician) levels of the late 70s and early 80s.

The package of changes is already drafted and will be published in the Federal Register within the next month. My specific request for your help is for you to temporarily stop the promulgation process of these changes and direct HCFA to conduct an in-depth study to determine the impact of this change on the ability of the rural and frontier ambulance services to provide Advanced Life Support (ALS) for both emergencies and transfers after the changes are implemented.

To my knowledge the only input HCFA has had on these changes is primarily from large, urban ambulance services with high call volumes and numerous ambulances serving one urban region. These services can, and probably should, only be reimbursed for what they provide based on patient needs. The people HCFA has not heard from is the small, rural service with two or three ambulances who do not have the luxury of multiple ALS and BLS units on duty and do not have the large call volume required to effectively assign units to a request for service based on the patient's need. If these services are providing ALS level care, then ALS units are all they will have on duty, and their cost of transferring a patient will be the ALS cost, regardless of the patient's needs.

I realize that publishing in the Federal Register is the legal way of obtaining public comment. Having been Governor of our rural state, I am sure you realize that the typical rural ambulance service manager will never see or is even aware of the Federal Register. These people need to be heard from now, and HCFA needs to go to them, since they do not have the ability or method to be able to go to HCFA.

If your staff researches this issue, you will be told that the American Ambulance Association (AAA) has agreed to the transfer reimbursement change. What you need to keep in mind is that the AAA primarily represents the large, urban services who will not be effected by the change. If HCFA were to survey the rural state's ambulance associations and services, I believe they will find they oppose this change because of it's impact on rural services. The Arkansas Ambulance Association is opposed to this change.

If this change goes through, then rural services will loss the benefit of ALS level reimbursement on 70% of their transfers. With transfers (not emergencies) being the majority of a service's funding source, the services will be forced to reduce costs by only providing the less expensive BLS level of care on all emergencies and transfers. This will reduce the overall pre-hospital and between hospital patient care available. The overall result will be a drastic increase in morbidity and mortality in rural areas which presently have ALS care, with an associated increase in the downstream costs of patient care.

Until recently the highest level of pre-hospital care, ALS (paramedic), was only available in the urban area where the profit motive is greater due to increased call volume. However, in the urban areas transport times to major, well equipped hospitals is short, and the impact of advanced procedures before arrival at the hospital is less.

The rural areas is where the ALS (paramedic) level is needed most, and where it is the most effective in preventing morbidity and mortality. Frequently the rural patient's life is in the hands of the EMT or paramedic for over an hour before arrival at a rural emergency room. After arrival at a rural hospital the critical trauma or medical patient may only be stabilized before having to be transferred to a more well equipped and staffed urban tertiary care center for treatment. The patients care then reverts back to the paramedic, who must monitor and maintain the advanced procedure initiated during the one to three hour trip to the large urban hospital.

The basic life support (BLS) and advanced life support (ALS) levels are frequently misunderstood by the general public and many public officials. The BLS level of care is performed by an emergency medical technician-basic, commonly referred to as EMTs, who have completed at least 110 hours of training in accordance with curriculum established by the US Department of Transportation (DOT) and are certified/licensed by their state. They perform basic, non-invasive skills such as splinting, bleeding control and bandaging, administering oxygen, assisting a patient with the patient's own medications, extrication from vehicles, etc. The EMT has been the backbone of pre-hospital care since the late 1970s.

The ALS level is performed by an emergency medical technician-paramedic, commonly referred to as paramedics. After becoming EMT-Basics, these individuals continue their training by

completing a minimum of 700 hours of additional training established by the DOT paramedic curriculum. The average paramedic course in Arkansas is 900 hours long. Paramedics are frequently the difference between life and death for a critical patient. In addition to the EMT -Basic's skills, paramedics perform advanced procedures such as EKG monitoring, endotracheal intubation, chest decompression, treating shock with IV fluids, and administration of drugs for medical problems such as heart attack, insulin shock, acute high blood pressure, severe anaphylactic (allergic) reactions, severe asthma attacks, congestive heart failure, etc. The paramedics procedures are so effective that a recent study showed that if a paramedic cannot restore a heartbeat to a patient in cardiac arrest, that the statistical probability of the emergency room saving the patient is zero. Based on this study, some states are considering allowing paramedics (not EMT-Basics) to pronounce patients dead when resuscitative efforts in the field are unsuccessful.

The long term financial impact of proper paramedic level pre-hospital care is tremendous. Twelve lead EKGs performed in the field are reducing the time to diagnosis of heart attack and treatment with thrombolytic therapy. Rapid thrombolytic therapy can significantly reduce the damage caused by a heart attack, thereby reducing length of hospital stays, and allow the patient to return to productive life. The paramedic's advanced cardiac life support (ACLS) skills can prevent cardiac arrest, or even restart a stopped heart. Treating patients with acute high blood pressure can prevent them from having a stroke enroute to the hospital. Rapid treatment of unconscious patients in insulin shock prevents brain damage. IV fluids for victims of traumatic injury can keep them alive until they receive surgical care. Treating trauma victims with steroids can prevent the brain from swelling enroute to the hospital, preventing permanent brain damage or death. These are only a few examples of the numerous emergencies which require a paramedics skills.

A paramedic is also frequently required to maintain the standard of care when transferring trauma, heart attack, and other acute patients from the smaller rural hospital to an urban tertiary care facility. If a paramedic level ambulance is not available, then the hospital has to send a nurse or physician, drastically increasing the overall cost of the transfer.

One of the justifications given for the new regulations is that a study of Arkansas and a few other states showed that the amount of ALS claims by ambulance services has increased significantly between 1988 and now. The false conclusion derived from the study was that the increase was due to fraud. In 1988, Arkansas had only 20 paramedic level ambulance services. Since then 67 services have upgraded to the paramedic level so that they can provide better care. In fact, since your election to President, Cherokee Village, Walnut Ridge, Clinton, Maumelle, Cabot, Lonoke County, Grant County, Sherwood, and Newton County have advanced to the paramedic level. Columbia County, Hempstead County, and Yell County will reach the paramedic level in the next few months. If these new Medicare changes take effect, every one of these areas will probably have to revert back to the basic life support (BLS) level because they will not be able to support the increased cost of providing paramedic (ALS) care.

I hope that you can intervene to prevent the promulgation of these Medicare reimbursement changes before a study of their impact on rural America is conducted.

I am willing to volunteer my time to help your staff or HCFA in studying this issue. I was the Director of the Arkansas Department of Health's Emergency Medical Services and Trauma Systems Division until last week, when I voluntarily resigned to work in the private sector. I have served on the Executive Committee of the National Association of State EMS Directors where I represented the south central states. I am currently working as a paramedic and shift supervisor in Sherwood, Arkansas.

I appreciate your attention to this critical issue.

Sincerely,

Doug Darr

Lloyd D. (Doug) Darr, MS, NREMT-P
Captain, USAF Retired

cc: Governor Jim Guy Tucker
Senator David Pryor
Senator Dale Bumpers
Representative Ray Thornton
Dr. Sandra B. Nichols, Director, Arkansas Department of Health
Dr. Marvon Leibovich, Chairman, Arkansas EMS Advisory Council
Dr. John Cone, Chairman, Arkansas Trauma Advisory Council
Mr. David Jones, Member, Arkansas Trauma Advisory Council
Mr. Francis Carson, President, Arkansas Ambulance Association
Mr. Bob Williams, President, Arkansas EMT Association
Mr. Dan Manz, President, National Association of State EMS Directors

REPORT TO CONGRESS

A STUDY OF PAYMENTS FOR AMBULANCE SERVICES UNDER MEDICARE

Donna E. Shalala
Secretary of Health and Human Services
1994

provide total cost data. In the absence of an on-site audit, the accuracy of the reported cost data is less than ideal for research purposes.

These data problems point to the need for caution, also, in making recommendations based on inferences drawn from the data. Despite the coding differences, the overall quality of the 1987 Medicare claims data was adequate to provide insights into the use and spending patterns for ambulance services.

FINDINGS

Patterns of Ambulance Service Use and Costs

Analysis of Medicare claims data showed that of the almost $602 million in allowed charges incurred for ambulance services in 1987, about 20 percent were incurred by beneficiaries living in rural areas, though rural beneficiaries comprise about 27 percent of Medicare enrollees. The rate of use was higher among beneficiaries in urban areas (65 users per 1,000 beneficiaries) than among beneficiaries living in rural areas (57 users per 1,000 beneficiaries).

Urban residents also make more frequent use of ambulance services (about 110 runs per 1,000 beneficiaries) than rural residents (about 89 runs per 1,000 beneficiaries). Since the average allowed charge per run was higher for urban residents ($134 per run) than for rural residents ($110 per run), the rate of program allowed charges for urban beneficiaries ($14,818 per 1,000 beneficiaries) was 50 percent higher than for rural residents ($9,854 per 1,000 beneficiaries). While it is clear that charges are higher for ambulance services in urban areas, it is unclear whether the difference in the rate of use between urban and rural areas reflects differential access or different preferences as to the mode of transportation.

The charges allowed by Medicare in the 4 States surveyed covered the average costs of providing rural ambulance services, for both BLS and ALS services. In urban areas, the allowed charges were sufficient to cover BLS services, but were below the average costs of ALS services though exceeding marginal costs. The attached study by Project HOPE presents detailed data at Table 5-1. Nevertheless, a smaller proportion of rural providers than urban providers accepted assignment for Medicare claims. In the analysis of cost outliers, it was clear that in some sparsely-populated communities served by small firms, costs are significantly higher than the average of Medicare's allowed charges. In addition, mileage was shown to be a major contributor to higher average costs for these rural firms.

THIS IS WHAT WE ARE TALKING ABOUT — WE CAN'T AFFORD TO DO IT ANOTHER WAY —

The study of the claims file showed that services reimbursed in addition to an ambulance base rate (i.e., "add-ons") increased the average allowed charges for BLS and ALS runs by 42 and 74 percent, respectively. Mileage charges contributed the most to the price of a run, with oxygen second. The relative importance of these additionally-reimbursable services to the overall price of an ambulance run varied among the carriers. While most carriers reimbursed an all-inclusive rate for ALS services, some carriers predominantly used the non-inclusive rate.

Results from the Survey of Ambulance Providers suggest that mileage add-ons were considered essential for ambulance providers in rural areas. The analysis of payment adequacy suggested that, when including the add-on services, Medicare's allowed charges were roughly comparable to costs. However, the higher total charges allowed for bills in which the services are separately itemized may be providing an incentive to unbundle the services for billing purposes. This incentive is likely to be strong among providers who perceive that their costs would not be covered by billing an all-inclusive charge.

The analysis of national Medicare claims data underscored the geographic diversity of the ambulance industry. Average allowed charges for an ambulance trip varied widely both within and across Medicare carriers. Service mix also varied.

Basing reimbursement on the actual procedures performed and services rendered, rather than the type of vehicle used.

RECOMMENDATIONS

The findings in this report indicate that, overall, ambulance providers are receiving adequate payments for services to Medicare beneficiaries. However, HCFA has undertaken and plans further administrative, regulatory, and legislative initiatives for improving the consistency of carrier coverage determinations and payments for ambulance services. No new legislation is proposed at this time; however, we are considering proposing such legislation as part of the Fiscal Year (FY) 1996 budget.

Last page of Report

HCFA is mindful of Congressional concerns about assuring access to transport services in rural areas and equity in the payment for the services. The agency will be especially sensitive to these objectives in the proposed initiatives.

- Basing reimbursement on the actual procedures performed and services rendered, rather than the type of vehicle used.

RECOMMENDATIONS

The findings in this report indicate that, overall, ambulance providers are receiving adequate payments for services to Medicare beneficiaries. However, HCFA has undertaken and plans further administrative, regulatory, and legislative initiatives for improving the consistency of carrier coverage determinations and payments for ambulance services. No new legislation is proposed at this time; however, we are considering proposing such legislation as part of the Fiscal Year (FY) 1996 budget.

A STUDY OF PAYMENTS FOR AMBULANCE SERVICES UNDER MEDICARE

Final Report

October 21, 1991

Penny E. Mohr
Doug M. Brown
Mary Beth Fiske
Beth A. Owen

Project HOPE

The Office of the Inspector General (OIG) recommended that Medicare carriers apply inherent reasonableness criteria more stringently. These criteria allow carriers to adjust rates downward if charges do not appear to be economically justified. The use of these criteria would be particularly applicable in areas with unregulated rates served by one or a few providers.

These criteria could also be used to adjust rates upwards for areas that have legitimately higher costs. These adjustments could be made for sole community providers serving sparsely-populated areas, similar to payment adjustments made for sole community rural hospitals. (Recall there are economies of scale in the provision of ambulance services, and, ceteris paribus, the small providers will have higher costs per run.) Rates also could be adjusted if a strong case could be made that the decline in the use of volunteer staff, or changes in community standards has dramatically increased costs.

7.3.2 Scheduled Runs

A major finding of this study was that scheduled runs are provided at substantially lower cost than emergency runs. (Approximately 20 to 60 percent below the costs of providing an emergency BLS run and substantially below the cost of providing an emergency ALS run in the surveyed States.) Despite this fact, most

August 10, 1995

MEMORANDUM FOR CAROL RASCO

FROM: JULIE DEMEO

Subject: HCFA Regulation's Negative Effect on Rural Ambulance Service

The President requested that you follow-up on his conversation with Jamie Pafford-Gresham, regarding a ~~new~~ HCFA ~~proposed~~ regulation and it's negative effect on rural ambulance services. which may be proposed in the coming months
In response to this request, I spoke with Jamie and her father who own the Pafford Ambulance Service. Their company owns 25 ambulances which service eleven rural counties in Mississippi and Arkansas.

They are very concerned about such potential ~~a proposed~~ HCFA regulation ~~(currently in comment period)~~, ~~which~~ since it would alter the amulance reimbursement structure.

According to the Pafford's:

* Most ambulances (especially in rural areas) are mandated by the county to be "Advanced Life Support" (ALS) equipped, versus "Basic Life Support" (BLS) equipped.

* Equipping an ambulance at the ALS level costs approximately $70,000, versus $50,000 for a basic ambulance.

* In counties with this ALS mandate, HCFA currently reimburses all ambulance (Medicare) calls at the ALS rate, which is approximately $100 more that the BLS rate.

* The new regulation would reimburse only calls where ALS is used at the ALS rate and all other calls at the BLS rate.

The proposed HCFA change would disproportionately impact rural emergency service for the worse, at a time when rural hospitals are closing and rural health systems are struggling. For rural counties that only can only afford to be serviced by one ambulance -- that ambulance has to be ALS equipped! Yet, the lower volume of calls in rural areas means that to support an ALS ambulance they need to get paid at an ALS rate.

~~Unlike~~ Urban areas ~~which~~ have more ambulances to respond to more calls to respond to which often gives them greater flexibility of what type of ambulance to send

UNSCIENTIFIC CASE STUDY OF THE JEFFORD'S AMBULANCE SERVICE:

* 25 (ALS) ambulances
* Approx start-up cost of $70,000 per ALS ambulance
* 11 counties (all with an ALS-mandate law)
* Approximately 45 total calls per day
* Over 50% are emergency calls (911 or equivalent used)
* But only approx. 35% turn out to use the ALS equipment (and thus be ALS rate reimbursed under proposed HCFA regulation)

If the Jaffords are reimbursed for 45 calls a day, but now only 35% or the 45 calls are at the ALS rate - this means a daily decrease of ~~$250~~

$13.75/day ⇒ decrease of $310/day

45
.35
25
135
13.75

45
14
31

Lee County 14,000 17mi from means + Hospital

2 paramedic units

6.5 calls/day ⇒ decrease of $500/day

1.5 ALS