Pafford Ambulance Service, Inc.

FAX Transmittal

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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
Any questions
Jamie

Pafford Ambulance Service, Inc.
P.O. Box 130
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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. Marvun 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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

FKA-41

6325 Security Boulevard
Baltimore, MD 21207

AUG 2 1995

Mr. James Pafford
President
Pafford Ambulance Service, Inc.
P.O. Box 130
214 Main Street
Hermitage, Arkansas 71647

Dear Mr. Pafford:

The President and First Lady asked that I thank you for your letter which they are sharing with us because we administer health care programs, such as Medicare, within the Federal government. Although the President and Mrs. Clinton would like to personally answer all the mail they receive, their heavy schedule makes this impossible. Please excuse the delay in my reply.

I can surely understand your concern about changes in Medicare payment for ambulance services. The proposed revision to Medicare's ambulance regulations came about because of dramatic changes in the ambulance industry during recent years. No longer is emergency transportation limited to a quick trip to the hospital. En-route life-saving techniques have progressed from the elementary, such as giving oxygen and controlling bleeding, to the very advanced, such as intravenous administration of drugs and heart defibrillation.

In order to deal effectively with these changes, we are revising our regulations to make more explicit the conditions under which a patient is to be transported by ambulance, for Basic Life Support (BLS) transportation and Advanced Life Support (ALS) transportation. The charges for ALS transport are, on average, almost twice as high as for BLS transport. While we do not dispute the value of ALS services when they are needed, we wish to provide a strong incentive to curb excessive ALS billings when ALS services are not needed.

In this regard, we wish to assure you that reimbursement of ambulance services will be equitable for necessary covered services. Also, we are sensitive to your concern about the need to assure access to quality care. Accordingly, we believe that

WHAT Type

ambulance services will continue to be readily available to Medicare beneficiaries.

We welcome any additional comments you may have after the details of the proposed regulations are published for comment.

Sincerely yours,

Thomas A. Ault/jg

Thomas A. Ault
Director
Bureau of Policy Development

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 Finke
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

Barbara

410 786 0594

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

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 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.

January 1

Rural Arkansas
to keep rural ambulance

HCFA proposed new regulations
stating only pay ALS when ALS
service used

NOW: mandated to provide ~~ALS~~ to
~~rural areas~~ thus paid by ~~Medicare~~
ALS Rate

about $100 diff. in Rate

In urban areas
BLS vs. ALS
Not protection

Rural Areas

HCFA comment period August end

Voted

~~Lee Co~~

Lee County, Ark

14,000 people

17 mi from nearest hospital

2 paramedic

$60,000 community donated

Ambulances
ALS services

1½ calls %

6 or 7 calls %

$49,000 for Basic Ambulance

$70,000 are fully equipped

11 Counties

Mandate Rule is Counties

Inspector General's office
gave HCFA a Report
that this would be horrible

Kills EMS in Rural Health
Care

1½% of Medicare Budget

11 Counties

25 ambulance

45 total calls

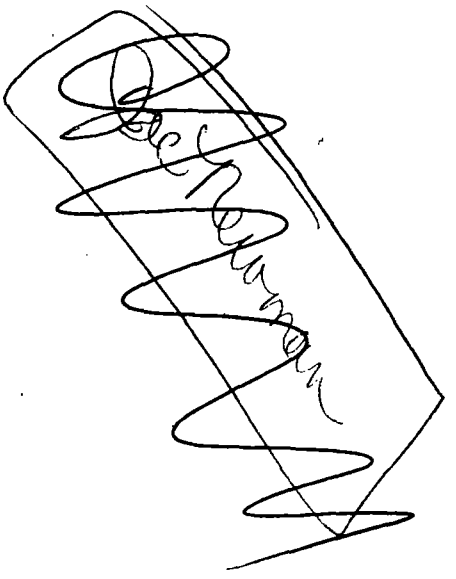
over 50% — Emergency calls
≈ 35% → turn out to be ALS
~~Medicaid~~ Medicare

- Ambulance Assoc. Amer
Says 911 call should be
fully reimbursed but even this is not
have provisions for protecting Rural America.

Arkansas EMS

North of Helena
South of Greenville

THE PRESIDENT HAS SEEN
7/6/95



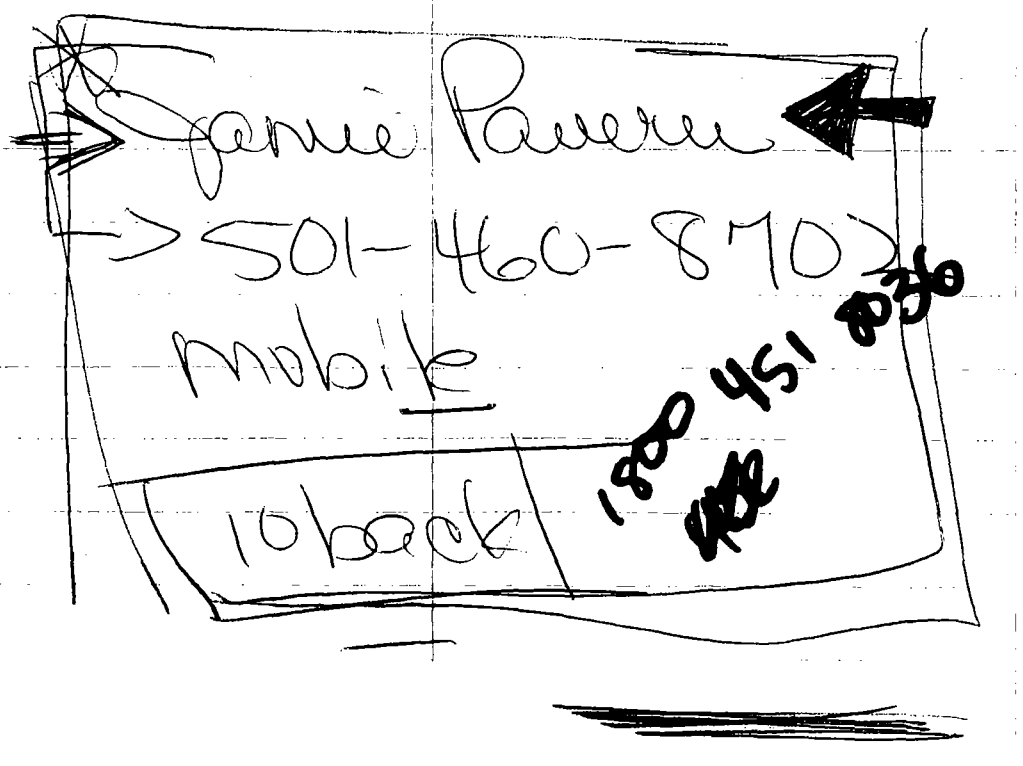
Pafford Ambulance Service, Inc.

Jamie Pafford - Gresham
Director of Operations

P.O. Box 130
214 W. Main St.
Hermitage, AR 71647

1-800-451-8036
Fax: 1-800-532-7571

Rural amb. services
out of Ars.



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FAX COVER SHEET

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FAX #: (410) 786-0594

FROM: JULIE DEMEO

NUMBER OF PAGES (including cover sheet): 3

COMMENTS:

If you have any problems with the fax transmission, please call Julie at (202)456-5392.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

FKA-41

3325 Security Boulevard
Baltimore, MD 21207

AUG 2 1995

Mr. James Pafford
President
Pafford Ambulance Service, Inc.
P.O. Box 130
214 Main Street
Hermitage, Arkansas 71647

Dear Mr. Pafford:

The President and First Lady asked that I thank you for your letter which they are sharing with us because we administer health care programs, such as Medicare, within the Federal government. Although the President and Mrs. Clinton would like to personally answer all the mail they receive, their heavy schedule makes this impossible. Please excuse the delay in my reply.

I can surely understand your concern about changes in Medicare payment for ambulance services. The proposed revision to Medicare's ambulance regulations came about because of dramatic changes in the ambulance industry during recent years. No longer is emergency transportation limited to a quick trip to the hospital. En-route life-saving techniques have progressed from the elementary, such as giving oxygen and controlling bleeding, to the very advanced, such as intravenous administration of drugs and heart defibrillation.

In order to deal effectively with these changes, we are revising our regulations to make more explicit the conditions under which a patient is to be transported by ambulance, for Basic Life Support (BLS) transportation and Advanced Life Support (ALS) transportation. The charges for ALS transport are, on average, almost twice as high as for BLS transport. While we do not dispute the value of ALS services when they are needed, we wish to provide a strong incentive to curb excessive ALS billings when ALS services are not needed.

In this regard, we wish to assure you that reimbursement of ambulance services will be equitable for necessary covered services. Also, we are sensitive to your concern about the need to assure access to quality care. Accordingly, we believe that

ambulance services will continue to be readily available to Medicare beneficiaries. WHAT Type!

We welcome any additional comments you may have after the details of the proposed regulations are published for comment.

Sincerely yours,

Thomas A. Ault

Thomas A. Ault
Director
Bureau of Policy Development

Party
Fri 10am

POTUS
asked CHR to
call & explain
POTUS asked
to call
Re Regulation
You discussed
W/ POTUS
that is pending
that will be harmful
to Small Rural ambulance
Services

Stofer Mayflower 202 347 3000

To Julie

Date 9/27 Time 3:20

WHILE YOU WERE OUT

M Jaime Afford

of Afford Ambulance

Phone (800) 451-8036

Area Code Number Extension

TELEPHONED		PLEASE CALL	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

Message

Stofer Waverly

Operator

AMPAD EFFICIENCY® 23-023 CARBONLESS

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: 202 456-2878

Date: 10-4-95

Number of Pages
(Including Header Page) 3

From: Jamie Pafford -

Comments: Enjoyed meeting with you - I received this information yesterday - We are going to "lobby" this issue as best we can - We will be asking for an Exemption as before on these two issues - this will have the same effect as the other HCFA issue we are working on - Pass the word on - Let me know if you have any news about any of this - PS. We have a few State Studies on what it costs to operate Rural Ambulance Services - Do you think they may look

SENATE MEDICARE REFORM LEGISLATION WILL CRIPPLE EMERGENCY AMBULANCE SERVICES

Two provisions in the Senate's Medicare reform legislation -- the seven-year freeze of rates and the introduction of so-called BELT (budget expenditure limit tool) tightening provisions -- are particularly devastating to the ambulance industry.

Drastic Effect on Emergency Ambulance Services (911)

The most frequent users of emergency ambulance services are the elderly. Therefore, Medicare dollars are critical to maintain emergency response systems to save lives. Our country's 911 emergency ambulance services are carefully designed partnerships between government agencies, emergency physicians and ambulance providers, where there is only one designated provider of ambulance service. The freeze and roll-back on that *single* provider will have a drastic effect on the level of emergency readiness in that system. Consequently, the destruction of emergency ambulance services throughout America will be set in motion:

1. **Crippling ambulance services will destroy life saving health care for all Americans.** The proposed cuts will effect all citizens, not just Medicare beneficiaries. To control costs, there would be:

   - **Longer response times.** For example, one ambulance provider estimated that response times would increase from 8 to 14 minutes, greatly diminishing patient survival chances.
   - **Fewer paramedics.** Lower-trained non-paramedic personnel will staff ambulances.
   - **Less advanced equipment.** An inability to keep up with technological advances in diagnostic equipment and communications systems.
   - **Reduced disaster response capability.** Severe reductions in America's ability to respond additional resources in natural or man-made disasters, such as to Hurricane Andrew or the bombing in Oklahoma City.

2. **Senate bill blows a gaping hole in the health care safety net.** Emergency ambulance service is already the last health care safety net for the nation's uninsured and underinsured. In fact, emergency ambulance services are the only health care provider group providing universal access to the poor and elderly. Our moral, ethical and legal obligation to respond to every 911 request will not diminish. Services must be sustained in a form which meets the public need.

3. **Accelerated collapse of rural ambulance services which are already in imminent danger.** The drastic consequences for emergency ambulance services will effect rural ambulance systems even more dramatically and with greater speed. Because there is only one ambulance

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Medicare Consultant: David Warfel, Esq. • One Rabro Drive, Hauppauge, NY 11788 • (516) 582-3282 • FAX (516) 582-3287

PAFFORD Ambulances — Also —

American Ambulance Association
Position Statement

provider in rural communities, once that service is eliminated, lives will be lost. Saving rural ambulance services is at least as critical as saving rural access hospitals.

4. **Bankrupting ambulance services across America will make the Medicare crisis worse, not better.** Because ambulance services operate on a very thin margin, and given spiraling operational cost increases, ambulance providers will face deficits and bankruptcy. To maintain existing services and standards, the only options for public and private providers to survive are: reduce services, raise taxes and/or increase beneficiaries' out-of-pocket-expenses. If these options are unavailable or exhausted, the result will be elimination of emergency medical services altogether.

5. **Fearing high out-of-pocket expenses, Medicare beneficiaries will be afraid to access 911 in an emergency.** Chronic underfunding of EMS systems will increase beneficiary out-of-pocket expenditures and will severly restrict access to essential emergency medical care.

6. **A freeze of ambulance rates will not control Medicare costs.** Medicare program expenditures will continue to rise because the bill does not take into account the large number of public providers and volunteer services which are beginning to bill Medicare as they have seen their own funding sources (ie., local taxes) shrink.

7. **Emergency ambulance rates are already inadequate according to a Congressional study.** The Project Hope Report authorized by Congress and released in 1994 found that Medicare rates for emergency and rural ambulance services are currently not adequate to offset costs. This study offers further proof that the combination of freezes and roll-backs will have immediate and severe consequences for emergency and all rural ambulance services.

A Better Alternative: Implement a New Reimbursement Method for Ambulance Services

The ambulance industry is the only Medicare provider group which has not been given the opportunity to reform its reimbursement system from the traditional *reasonable charge* methodology. This unique situation destroys the industry's ability to absorb the proposed combination of Medicare policy changes without life-threatening consequences. As an alternative, Congress should:

1. **Exempt Emergency Ambulance Services and all Rural Ambulance Services from the freeze and BELT provisions of the current legislative language.**

2. **Direct the Health Care Financing Administration to work with representatives from the ambulance industry to develop and implement an alternative reimbursement system designed to align the interests of patients, payors and providers.**

Save our communities from life-threatening cuts to emergency ambulance services.

States are the primary governmental divisions of the United States. The District of Columbia is treated as a statistical equivalent of a State for census purposes. The four census regions, nine census divisions, and their component States are shown under "CENSUS REGION AND CENSUS DIVISION" in this appendix.

The Census Bureau treats the outlying areas as State equivalents for the 1990 census. The outlying areas are American Samoa, Guam, the Northern Mariana Islands, Palau, Puerto Rico, and the Virgin Islands of the United States. Geographic definitions specific to each outlying area are shown in appendix A in the data products for each area.

Each State and equivalent is assigned a two-digit numeric Federal Information Processing Standards (FIPS) code in alphabetical order by State name, followed by the outlying area names. Each State and equivalent area also is assigned a two-digit census code. This code is assigned on the basis of the geographic sequence of each State within each census division; the first digit of the code is the code for the respective division. Puerto Rico, the Virgin Islands, and the outlying areas of the Pacific are assigned "0" as the division code. Each State and equivalent area also is assigned the two-letter FIPS/United States Postal Service (USPS) code.

In 12 selected States (Connecticut, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Wisconsin), the minor civil divisions also serve as general-purpose local governments. The Census Bureau presents

Samoa, Guam, the Northern Mariana Islands, Palau, Puerto Rico, and the Virgin Islands.

URBAN AND RURAL

The Census Bureau defines "urban" for the 1990 census as comprising all territory, population, and housing units in urbanized areas and in places of 2,500 or more persons outside urbanized areas. More specifically, "urban" consists of territory, persons, and housing units in:

1. Places of 2,500 or more persons incorporated as cities, villages, boroughs (except in Alaska and New York), and towns (except in the six New England States, New York, and Wisconsin), but excluding the rural portions of "extended cities."
2. Census designated places of 2,500 or more persons.
3. Other territory, incorporated or unincorporated, included in urbanized areas.

Territory, population, and housing units not classified as urban constitute "rural." In the 100-percent data products, "rural" is divided into "places of less than 2,500" and "not in places." The "not in places" category comprises "rural" outside incorporated and census designated places and the rural portions of extended cities. In many data products, the term "other rural" is used; "other rural" is a residual category specific to the classification of the rural in each data product.

Metro – non-metro (non-metro = rural)

Appendix definition:

~~Throughout this report, with the exception of the chapter on Asian and Pacific Islanders, rural people and places are defined as those outside the boundaries of metropolitan areas as defined by the Office of Management and Budget at the time of the census.~~ Metropolitan areas consist of one or more core counties containing an urbanized area of 50,000 or more people, together with surrounding suburban counties if they have a significant exchange of commuting workers with the metropolitan core and meet a set of conditions having to do with metropolitan character, such as population density and growth. Thus, (rural) counties do not have these qualifications and contain only open country, small towns, or small cities.

Technically, non-metro

THE WHITE HOUSE

WASHINGTON

FAX COVER SHEET

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(202)456-2878 FAX

TO: Jamie Pafford

FAX #: 1 800 532 7571

FROM: JULIE DEMEO

NUMBER OF PAGES (including cover sheet): 2

COMMENTS:

If you have any problems with the fax transmission, please call Julie at (202)456-5392.

SMSA

 Dick Long Rural Economy

219 0530

Non-metrop / Metro

2 Commonly

Urban

~~Rural~~ Any Place over 25,000 in incorporated area

Rural Non incorporated

SMSA (and metro stats area) city of 50,000 or more

Pafford Ambulance Service, Inc.

FAX Transmittal

P.O. Box 130
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Hermitage, AR 71647

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

TO: Julie Demeo –

FAX Number: 1-202-456-2878

Date: 11-21-95

Number of Pages
(Including Header Page) 15

From: Janice Pafford

Comments: Help me out with the meeting with Carol R.
Call me if I can be of further Help –
Be Careful & Have a Happy Thanksgiving

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

VIA FACSIMILE 1-202-456-2878

November 21, 1995

To: Julie Demeo

From: Jamie Pafford-Gresham

As per our phone conversation, here are the documents I discussed with you. I have also attached a letter to Carol Rasco, asking for a meeting as soon as possible. (Try to help me out on this one!!)

Senator Pryor and Bonnie Hogue of his staff, have agreed to help in any way possible and are willing to change their schedule to attend the meeting if we can get one set up.

We helped with the language on H.R. 2485 and were hoping to get this adopted. Instead they went with the senate bill S.1357. This freezes us, puts us in a BELT, and only allows us to receive ALS payments when ALS is utilized. NO rural exceptions!!

Please let me know something as soon as possible. I hope you have a safe and Happy Thanksgiving.

I

104TH CONGRESS
1ST SESSION

H. R. 2485

To amend title XVIII of the Social Security Act to preserve and reform the medicare program.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 17, 1995

Mr. ARCHER (for himself, Mr. BLILEY, Mr. BILIRAKIS, Mr. THOMAS, Mr. HYDE, Mr. GREENWOOD, Mr. HASTERT, Mrs. JOHNSON of Connecticut, and Mr. MCCRERY) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, the Judiciary, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XVIII of the Social Security Act to preserve and reform the medicare program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PURPOSE.

The purpose of this Act is to reform the medicare program, in order to preserve and protect the financial stability of the program.

NC

VOLUME 1

II

Calendar No. 216

104TH CONGRESS
1ST SESSION

S. 1357

To provide for reconciliation pursuant to section 105 of the concurrent resolution on the budget for fiscal year 1996.

IN THE SENATE OF THE UNITED STATES

OCTOBER 23, 1995

Mr. DOMENICI, from the Committee on the Budget, reported the following original bill; which was read twice and placed on the calendar

---

A BILL

To provide for reconciliation pursuant to section 105 of the concurrent resolution on the budget for fiscal year 1996.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Balanced Budget Reconciliation Act of 1995".

SEC. 2. TABLE OF TITLES.

The table of titles for this Act is as follows:

	Page
Title I. Committee on Agriculture, Nutrition, and Forestry	2
Title II. Committee on Armed Services	161
Title III. Committee on Banking, Housing, and Urban Affairs	181

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

VIA FACSIMILE 1-202-456-2878

November 21, 1995

Carol H. Rasco
Assistant to the President
for Domestic Policy
The White House
Washington, DC

Dear Ms Rasco:

Sorry we missed you on the South Lawn of the White House on the 29th of September. We were able to converse with Mrs. Clinton for a few minutes. She spoke highly of you and your capabilities to help with our ambulance issues. She informed my father and I to keep in touch with you on any changes we felt necessary for the President to know about.

Congress has adopted Senate bill S.1357. This bill kills all work we have done on the rural issue, and will devastate the ambulance industry nationwide. House bill H.R. 2485, contains language pertaining to the ambulance industry that we helped develop. I have faxed several things to Julie Domeo, of your office staff to be reviewed. She has been a great help to us and is asset to your staff.

At this time, on behalf of the Arkansas Ambulance Association and American Ambulance Association, We would like to set up a meeting next week with you at your earliest convenience. Bonnie Hogue, of Senator Pryors Office, is willing to attend and help out in any way possible. She mentioned that the Senator would also try to make the meeting. I feel that there will be six attendees, representing both, the Arkansas and American Ambulance Associations, with an emphasis on rural providers.

Please contact us at 1-800-451-8036 if you or your staff have any questions.
We will be anxiously awaiting your reply. Have a safe and Happy Thanksgiving!!

Sincerely,

Jamie Pafford-Gresham
Vice-President
Pafford Ambulance Service, Inc.

encloseures

JPG/jlp

AMERICAN AMBULANCE ASSOCIATION

Executive Offices
3800 Auburn Blvd., Suite C
Sacramento, CA 95821-2102
(916) 483-3827
FAX (916) 482-5473

Ambulance Savings Proposals

There are two areas of ambulance service under the Medicare program where significant savings could be achieved if HCFA would immediately implement changes. Both areas were the subject of recent HHS Inspector General reports. The American Ambulance Association (AAA) has studied both areas, developed recommendations, presented these reform proposals to HCFA, and testified before Congress, yet no changes have been made.

The following policy changes would yield over **$2 billion in savings** to the Medicare program over seven years – greater savings than those achieved by the Senate plan to eliminate ambulance updates (see attached chart). Even more importantly, this proposal would not jeopardize the emergency and rural-based ambulance services in this country. The AAA urges your consideration of these proposals:

I. Advanced Life Support (ALS) Services versus Basic Life Support (BLS) Services

Background

There are two types of ambulance transportation approved by Medicare for payment: Advanced Life Support (ALS) and Basic Life Support (BLS). ALS services cost more due to a variety of factors such as skill level of personnel, sophistication of equipment, etc. Medicare currently allows coverage of ALS when provided, if (1) it is medically necessary; (2) the provider is mandated by local law to provide ALS; or (3) no BLS is available.

Recommendations

The American Ambulance Association believes significant savings can be achieved, without sacrificing patient care or EMS systems, by covering ALS *only* if one of the following criteria is met:

1. If ALS is medically necessary.

2. When mandated by local law, but only:
   a. for emergencies, based on the perceived need of the patient.
   b. in rural areas, as defined by the Secretary.

In all other situations, only BLS rates would be allowed.

Savings

Savings to the Medicare program by making this change in coverage have been estimated by the Inspector General's Office. In her testimony before the Senate Appropriations Committee on December 16, 1994, June Gibbs Brown, Inspector General of the Department of Health and Human Services, estimated that "policies which allowed payment at the ALS level when it was not needed amounted to $47 million in 1993" lost to the Medicare program. Based on the growth of ALS reimbursement reported by the HCFA Bureau of Data Management and Strategy from 1989 to 1994, the American Ambulance Association estimates the total savings to be $670 million over seven years (1996-2002).

Inspector Brown then "recommended that HCFA revise its policy to require that payment for non-emergency ambulance service at the ALS level be allowed only when medically necessary." The American Ambulance Association's recommendation is consistent with the IG's testimony.

II. Repetitive Patients

Background

The largest area of abuse in ambulance transportation involves repetitive non-emergency patients (e.g., dialysis, radiation therapy). For the most part, the problem involves dialysis patients. For example, the average End Stage Renal Disease patient requires six transports per week. This can result in legitimate per patient costs well in excess of $30,000 annually. The potential for abuse occurs due to criteria for coverage known as "medical necessity." With this patient population, medical necessity is often difficult to determine because the patient's condition may change daily. Thus, there is a large gray area, leaving significant room for multiple interpretations. Because of this uncertainty, overpayments are often made which have resulted in significant dollars lost to the Medicare program. These overpayments were the subject of a recent HHS Inspector General Report.

While the medical necessity issue concerns dollars lost to the Medicare program, a second issue -- destination -- concerns dollars lost to beneficiaries. Because of a restriction in the current regulations, medically necessary ambulance transportation for ESRD patients is covered only when the destination is a hospital-based dialysis facility. This restriction applies despite the fact that Medicare-approved freestanding dialysis facilities have been established that are often less costly than those affiliated with hospitals. It is the opinion of the American Ambulance Association that any Medicare-approved dialysis center should be covered as an appropriate

destination facility. If this change were made, additional out-of-pocket expenditures by beneficiaries would be eliminated, relieving them of a costly burden due to a "quirk" in the regulations.

Recommendations

The American Ambulance Association recommends the following:

1. A system of prior authorization should be implemented for repetitive non-emergency patients (i.e., dialysis, radiation therapy) in which the ambulance provider gives the Medicare carrier the medical documentation, origin and destination information. The carrier would then be required, perhaps within a 7-10 day period, to advise the provider if the trips would be authorized and, if so, for a specific period of time (e.g., 60 days) after which the process repeats. (This would eliminate the problem of varying interpretations of "medical necessity.")

2. Ambulance transportation to any Medicare-approved dialysis center should be covered regardless of the origin, if an ambulance is medically necessary.

Savings

The Inspector General report, Ambulance Services for Medicare ESRD Beneficiaries: Medical Necessity, August, 1994, found that 70 percent of the ambulance transports did not meet medical necessity guidelines, resulting in approximately $44 million in overpayments in 1991. Using Medicare Trustee projected ESRD expenditures, the American Ambulance Association estimates the total savings to be $1.5 billion over seven years (1996-2002).

Summary

The American Ambulance Association estimates that implementing these two proposals will yield over **$2 billion in savings** to the Medicare program over seven years -- greater savings than those proposed by the Senate plan to eliminate ambulance updates (please refer to the attached charts).

Medicare Savings, Part B Ambulance Service
(billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	7-Year Total
Current Senate								
Eliminate Ambulance Update	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.3	-0.8
American Ambulance Association								
Limit ALS Reimbursement Levels to Medically Necessary	-0.00	-0.06	-0.07	-0.09	-0.12	-0.15	-0.19	-0.67
Require Prior Authorization Repetitive Non-emergency Patients	-0.00	-0.06	-0.17	-0.22	-0.22	-0.35	-0.49	-1.50
Total:	-0.00	-0.11	-0.24	-0.31	-0.33	-0.50	-0.68	-2.18

Note: Savings from ALS reimbursement limitations are calculated by taking IG (1992) estimated savings of $15.98 million in 1989, and projecting future amounts for the years 1997-2002 by the rate of growth in ALS total reimbursement (HCFA, 1994) from 1989 to 1994. Savings resulting from requiring prior authorization for ESRD non-emergency trips are calculated by taking the IG (August 1994) estimated overpayments of $44 million or 2.43% of total payments for all ESRD services in 1991, and applying this percentage to the Medicare Trustee projections of total ESRD payments for the years 1997-2002 (Trustee Report, 1995).

Sources:

Senate Finance Committee, Chart 2 - Medicare, September 26, 1995.
Board of Trustees, Report for Supplementary Medical Insurance Trust Fund, 1995.
HCFA, HHS, 1994 Part B Extract and Summary System (BESS) Procedure Report (Bureau of Data Management & Strategy).
IG, HHS, Review of Medical Necessity for Ambulance Services (October, 1992).
IG, HHS, Follow-Up to Review of Medical Necessity for Ambulance Services (June, 1995).
IG, HHS, Ambulance Services for Medicare ESRD Beneficiaries: Medical Necessity (August, 1994).
IG, HHS, Ambulance Services for Medicare ESRD Beneficiaries: Payment Practices (March, 1994).

AMERICAN AMBULANCE ASSOCIATION

Executive Offices
3800 Auburn Blvd., Suite C
Sacramento, CA 95821-2102
(916) 483-3827
FAX (916) 483-5473

MEDICARE REFORM
THE POSITION OF THE AMERICAN AMBULANCE ASSOCIATION

BACKGROUND

Ambulance services are covered under Medicare Part B. Both the House and Senate-passed versions of the Budget Reconciliation bills contained provisions which affected ambulance reimbursement. However, there were key differences between the House and Senate approaches. The Senate bill contained a blanket 7-year freeze on ambulance rates. The House bill did not contain a freeze but instead contained language which would place ambulance service on a fee schedule. Because the Senate freeze provision was "scorable" and was estimated to produce $800 million in savings over the next 7 years while the House fee schedule provision was not "scorable" (although it could yield far greater savings), the Senate provision was accepted in conference and ambulance rates are frozen under the bill for the next 7 years. The President, however, is expected to veto this measure shortly and a new version will be crafted. It is this new version to which the American Ambulance Association has now turned its attention.

AMERICAN AMBULANCE ASSOCIATION POSITION

The American Ambulance Association feels that a 7-year freeze on ambulance rates as contained in the current bill would be devastating to ambulance service in general and would be particularly devastating to rural and emergency service. The most frequent users of emergency ambulance services are the elderly. Therefore, Medicare dollars are critical to maintain this country's emergency response systems. Our country's 911 systems are carefully designed partnerships between government agencies, emergency physicians and ambulance providers, where there is only one designated provider of ambulance service. The rate freeze on that *single* provider will have a drastic effect on the level of emergency readiness in that system. Consequently, the dismantling of emergency ambulance services throughout America will be set in motion. The consequences of this have so alarmed the EMS community that the National Association of State EMS Directors, the people responsible for setting up and overseeing EMS

Government Relations: Fleishman-Hillard, Inc. • 1301 Connecticut Ave. NW, Washington, D.C. 20036 • (202) 296-5390 • FAX (202) 296-6119
Medicare Consultant: David Werfel, Esq. • One Rabro Drive, Hauppauge, NY 11788 • (516) 582-3285 • FAX (516) 582-3387

systems in the states, recently passed a resolution condemning the blanket freeze approach. A copy is attached. There is a better way to go.

THE PROPOSED SOLUTION

There is a solution which is better for the Medicare system, better for Medicare beneficiaries, and better for all those Americans who rely on available high-quality ambulance service in a time of need. That solution is to reform the ambulance reimbursement system from the bottom up - comprehensive reform - through the establishment of a fee schedule. This would likely save more money ultimately than a freeze and it allows the 30-year-old reimbursement system which the ambulance industry operates under to be brought up-to-date to reflect current health care trends. For instance, currently the Medicare regulations require that in order for reimbursement to be made to an ambulance company that responds to an emergency call, the patient must be transported to an emergency room. The process of putting the ambulance industry on a fee schedule would allow options such as "treat and release" to be considered thereby potentially saving millions of dollars in unnecessary emergency room admissions. But a 7-year blanket freeze as contained in the current measure simply freezes in place the distortions which are present in the ambulance reimbursement system today. This seems contrary to the spirit of making rational and beneficial changes to the Medicare system. Finally, all other provider groups have already been placed on a fee schedule. Ambulance is the last to go. This is the right time and the right way to correct this disparity, to achieve rational and meaningful savings, and, most importantly, to preserve our fragile EMS systems.

For questions or comments please contact Wendy Ruhlin at (202) 296-8390.

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:

Chair, Constitution, Bylaws, &
Resolutions Committee

Current Law

No provision

House Bill

The provision would require the Secretary to treat the State of Wisconsin as a single fee schedule area for physicians services beginning in 1997. The provision would be implemented in a budget neutral fashion. Nothing in the section is to be construed as limiting the availability to the Secretary, the contractor or the physicians in the State of otherwise applicable administrative procedures for subsequently modifying the fee schedule areas.

Senate Bill

No provision

Conference Agreement

The conference agreement does not include the House provision.

10. Payments for Ambulance Services (Sec. 15609A of House bill; Sec. 7049 of Senate bill)

Current Law

Payments for ambulance services are based on reasonable charge screens developed by individual carriers based on local billings (which may take a variety of forms). Based on these local billing methods, carriers develop screens for one or more of the following main billing methods: (i) a single all-inclusive charge reflecting all services and supplies, and mileage; (ii) one charge reflecting all services and supplies, with separate charge for mileage; (iii) one charge for all services and mileage, with separate charges for supplies; and (iv) separate charges for services, mileage, and supplies. Within each broad payment method, additional distinctions are made based on whether the service is basic life support or advanced life support service, whether emergency or nonemergency transport was used, and if specialized advanced life support services were rendered.

House Bill

a. Payment Amount. The provision would specify that beginning January 1,1998, payment for ambulance services would equal 80% of the lesser of the actual charge for the service or the fee schedule amount.

b. Fee Schedule. The provision would require the Secretary to establish a fee schedule through a negotiated rulemaking process. In establishing a fee schedule, the Secretary would be required to: (i) establish mechanisms to control increases in expenditures which fairly reflect the changing nature of the ambulance service industry;

(ii) establish definitions for ambulance services which promote efficiency and link payments (including fees for assessment and treatment services) to the type of services provided; (iii) take into account regional differences which affect cost and productivity, including differences in the costs of resources and the costs of uncompensated care; (iv) apply dynamic adjustments to payment rates to account for inflation, demographic changes in the population of Medicare beneficiaries, and changes in the number of participating providers; (v) phase-in the application of the payment rates in an efficient and fair manner.

The provision would require the Secretary to implement the provision in 1998 in a budget neutral fashion. Beginning in 1999, the payment amounts under the fee schedule would equal the previous year's payment amount updated by the increase in the consumer price index for the 12-month period ending the previous June.

The provision would require the Secretary to regularly consult with the following groups when establishing the fee schedule: American Ambulance Association, the National Association of State Medical Directors, and other national organizations representing individuals and entities who furnish or regulate ambulance services. The Secretary in establishing the fee schedule would be required to share with the associations and organizations the data and data analysis used in establishing the fee schedule, including data on variations in payments for years prior to 1998 among geographic areas and types of providers.

Senate Bill

a. Payment Amount. The provision would provide that when determining the reasonable cost or charge of ambulance services for fiscal years 1996 through 2002, the Secretary could not recognize any costs in excess of those recognized as reasonable in fiscal year 1995.

b. Fee Schedule. No provision

Conference Agreement

a. Payment Amount. The conference agreement includes the Senate provision.

b. Fee Schedule. The conference agreement does not include the House provision.

11. Standards for Physical Therapy Services Furnished by Physicians (Sec. 15609B of House Bill)

Current Law

No provision.

House Bill

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 Kenney

FAX Number: 202 - 456-2878

Date: 1-23 96

Number of Pages
(Including Header Page) 5

From: Jamie —

Comments: Here My Resume' —
let Me Know if you need anything
Else —
Ill be in Federal Court the next 2 days
So just leave a Message & Ill Check back in —

PS Have you or Jennifer found anything
out about Presidents Plan (last fyi

January 23, 1996

Dena S. Puskin, Sc.D.
Executive Secretary,
National Advisory Committee on Rural Health
5600 Fishers Lane, Rm 9-05
Rockville, MD 20857

Dear Ms. Puskin:

I am interested in obtaining a position on the National Advisory Committee on Rural Health. I understand there are five vacancies to be filled.

As a rural ambulance provider, serving twelve areas in rural Arkansas and Mississippi, we are the first to provide healthcare to the sick and injured, regardless of their ability to pay. Presently, I serve on the Arkansas Ambulance Association Board of Directors, and the American Ambulance Association Governmental Affairs Rural committee. (Both of these Associations will be sending letters of recommendations on my behalf).

I am very concerned with rural healthcare. In July, I played a vital roll in obtaining a "rural exemption" for ambulance services on a proposed HCFA regulation change. This change would have had a detrimental affect on rural ambulance services across America. Your office was a part of this effort. At this time, I am involved in finding an appropriate definition for "rural" ambulance services to be submitted to HCFA.

Since this time, I have been in direct contact with our legislative advocate, keeping up to date with proposed legislative changes that would effect rural providers across America.

As a rural ambulance provider, with insight and input from colleagues across the United States, I would be an asset to this committee.

Any support or assistance from you or your staff would be greatly appreciated. Please contact me at 1-800-451-8036 if you have any questions.

Sincerely,

Jamie Pafford-Gresham
Vice President/Director of Operations
Pafford Ambulance Service, Inc.

Jamie Pafford-Gresham

PO Box 130
Hermitage, AR 71647
1-501-463-8590 (W) 1-501-463-2807 (H)

Objective

Obtain a seat with the National Advisory Committee on Rural Health. Providing the committee insight from a rural ambulance provider.

Functional summary

At present, I am the Vice President and Director of Operations for the oldest and largest privately owned ambulance service in Arkansas, with branches in Mississippi. This includes, but not limited to, overseeing payroll, collections, employee benefits, and the overall day to day operation of our service. I am active with both the American and Arkansas Ambulance Associations, keeping abreast of the latest reimbursement developments and legislative changes on both the state and national level.

Employment

Pafford Ambulance Service, Inc. *1987 to present*
PO Box 130
Hermitage, Arkansas 71647
1-800-451-8036

Emergency Medical Technician-ambulance	*1987*
Manager- Louisiana Division	*1988*
Office Manager, Director of Operations, Jacksonville, AR	*1989-1994*
Vice President/Chief Financial Officer	*1994-present*

Education

Warren High School *19xx - 19xx*
Warren, Arkansas

Pines Vo-Tech 1987
Monticello, Arkansas

Phillips County Community College 1988
Helena, Arkansas

Petit Jean Vo-Tech 1990
Morrilton, Arkansas

Texas Tech 1990
EMS/MTI Program
Ambulance Service Management

References

Francis Carson
President,
Arkansas Ambulance Association
1-501-354-8181

David Nevins
Executive Vice President
American Ambulance Association
1-800-523-4447

Sharon Allen
Executive Vice President
Blue Cross & Blue Shield of Arkansas
1-501-378-2145

William Earl
President/CEO
Metro/AMR Ambulance Service
Monroe, Louisiana
1-800-456-2542

Summary of qualifications

I am a rural ambulance provider, who has worked in the field of EMS for the last eight years. I am knowledgeable of all aspects of the business. I am chairperson and co-founder for the Arkansas Ambulance Association's scholarship committee. This committee was developed to assist financially disadvantaged students, most from rural areas, the chance to further their education. This year I have become very involved with HCFA's efforts in changing the present ambulance legislation. Most changes are meant to improve services, but sometimes all things are not considered beforehand, like rural ambulance services. I have devoted a majority of my time this year lobbing new and proposed legislative changes on both, the state and national level.

Professional memberships

Arkansas Ambulance Association

Past Secretary	*1991-1993-*
Boardmember	*1995-present*
Scholarship Committee, (co-founder)	*1992-1995*
Scholarship Chairperson	*1995-present*

American Ambulance Association

Active member since	*1987*
Governmental Relations Rural Task Force	*1995-present*

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: 202-456-2878

Date: 1-18-96

Number of Pages
(Including Header Page) 6

From: Jamie —

word Ambulance
is this still current

Comments: Please see how your staff reads this - If it is out what plans the President following now?
Thanks —

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

VIA FAXMILLE 1-202-456-2878 1-17-96

Jennifer Klein
Domestic Policy
The White House
Washington, DC

> Julie Denver

Dear Jennifer:

Attached please find the American Ambulance Association's interpretation of Section 11461 of the President's plan for Medicare reform under Budget Reconciliation. If our interpretation is correct, this section of the President's plan would have a significant impact on ambulance services covered under Medicare. My last conversation with you was on the eleventh of December, at this time you concluded that the President's plan did not impact current Medicare law for ambulance services, I would appreciate your reviewing this matter to resolve the different interpretations.

As we have discussed before, the American Ambulance Association does not object to ambulance services being put under a fee schedule. However, we believe that fee schedule language which specifically addresses the areas of coverage and reimbursement that needs reform should be included. Additionally, we believe that the process of negotiated rulemaking should be required as this would provide an opportunity for all affected parties (e.g. ambulance providers, State regulators, and the emergency physician community) to have direct input into a rulemaking adoption process. I have attached such language passed by the House of Representatives as an example of the type of language we believe is important.

Relative to the issue of inherent reasonableness, there are grave concerns that if this provision is eliminated it will remove an important safety net that ambulance providers have utilized, under unusual circumstances, to correct grossly deficient rates where they exist.

Please contact me at your earliest convenience so the apparent discrepancies of opinion can be resolved. Thanks again for your help in this matter.

Sincerely,

Jamie

Jamie Pafford-Gresham
Vice-President
Pafford Ambulance Service, Inc.

American Ambulance Association

VIA FAX

TO: Board of Directors
Joe Paolella, Government Affairs Committee Chairman
Wendy Ruhlin, Government Relations Representative
David Nevins, Executive Vice President

FROM: David Werfel

SUBJECT: Administration's Provisions Relating to Part B

DATE: January 12, 1996

In reviewing §11461 of the Administration's provisions for Medicare Part B, there are two major changes that will impact ambulance services, if I am reading the sections correctly.

These two changes, and the reasons for my conclusions, are as follows:

1. Fee Schedule - Section 11461(a) amends Section 1833 of the Social Security Act by eliminating the reasonable charge methodology and placing services described in Section 1832(a)(1) under a fee schedule. Section 1832a(1) refers to "medical and other health services". §1861s defines "medical and other health services". Ambulance is listed at subdivision 7. Therefore, ambulance services would be placed under a fee schedule.

It is important to note that ambulance services provided by hospitals reimbursed on a reasonable cost basis would not be affected by this provision, creating a discrepancy in how ambulance services are reimbursed by Medicare.

The proposed amendment of 1833a(1) strikes the "reasonable charge" methodology and replaces it with payment that is the lower of the actual charge or a fee schedule.

Ambulance services (other than those provided by a Part A provider) do not meet any of the exceptions in 1833a(1). Therefore, Part B ambulance services would be allowed the lower of the actual charge or "applicable fee schedule developed by the Secretary". Of course, no ambulance fee schedule has, as yet, been developed. However, once it is, ambulance services would be on it.

Executive Offices • 3800 Auburn Blvd., Suite C, Sacramento, CA 95821-2182 • (916) 483-3027 • FAX (916) 482-5477
Government Relations: Fleischman-Hillard, Inc. • 1301 Connecticut Ave, NW, Washington, D.C. 20036 • (202) 296-8380 • FAX (202) 296-6119
Medicare Consultant, David Werfel, Esq. • One Ribas Drive, Hauppauge, NY 11788 • (516) 582-3283 • FAX (516) 582-3287
Labor Law Consultant, Jeff Tannenbaum • 450 California Street, 20th Floor • San Francisco, CA 94108-2693 • (415) 433-1940 • FAX (415) 399-8490

2. Inherent Reasonableness - Subdivision (b)(9)(A) of the proposed section 11461 strikes paragraphs (8) and (9) of 1842(b). These are the inherent reasonableness sections.

1842(b)(9) - This section is for the publication of adjustment to rates for physicians' services. Thus, its being deleted does not affect ambulance services. However, 1842(b)(8)(A) states that the Secretary shall describe in Regulations the factors used for determining when inherent reasonableness adjustments should be made. While 1842(b)(8)(B) and (C) specifically reference physicians services, 1842(b)(8)(A) does not and has been used as the basis for inherent reasonableness adjustments for ambulance.

Thus, we would have no methodology in place for correcting grossly deficient rates.

White House Proposal

(h) EFFECTIVE DATES.—

(1) The amendments made by subsection (c) apply to contracts whose periods end at, or after, the end of the third calendar month that begins after the date of enactment of this Act.

(2) The amendments made by subsections (a), (b), (d), and (e) apply to contracts whose periods begin after the third calendar month that begins after the date of enactment of this Act.

Subpart C—Provisions Relating to Part B of Medicare

SEC. 11461. REPLACEMENT OF REASONABLE CHARGE METHODOLOGY BY FEE SCHEDULES.

(a) IN GENERAL.—The matter in section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) preceding clause (A) is amended by striking "the reasonable charges for the services" and inserting "the lesser of the actual charges for the services and the amounts determined by the applicable fee schedules developed by the Secretary for the particular services".

Proposed New Section: 80% of the lesser of the actual charges for the services and the and/(or?) the amount determined by the applicable fee schedule developed by the Secretary for the particular se

(E) by redesignating clauses (ii) and (iii) as subparagraphs (B) and (C), respectively, and

(F) by redesignating subclauses (I), (II), and (III) of subparagraph (A) (as redesignated by subparagraph (D) of this paragraph) as clauses (i), (ii), and (iii), respectively.

(9)(A) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking paragraphs (8) and (9).

(B) The first sentence of section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10(B)) is amended by striking everything after "is authorized to" up to the period and inserting the following: "describe by regulation the factors to be used in determining the cases (of particular items) in which the application of this subsection results in the determination of an amount that, by reason of its being grossly excessive or grossly deficient, is not inherently reasonable, and to provide in these cases for the factors that will be considered in establishing an amount that is realistic and equitable".

(10) Section 1842(b)(10) (42 U.S.C. 1395u(b)(10)) is repealed.

(11) Section 1842(b)(11) (42 U.S.C. 1395u(b)(11)) is amended—

(A) by striking subparagraphs (B) through (D),

(B) by striking "(11)(A)" and inserting "(11)", and

THE WHITE HOUSE
WASHINGTON

FAX COVER SHEET

OFFICE OF THE ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY
SECOND FLOOR, WEST WING
THE WHITE HOUSE
WASHINGTON, DC 20500
(202)456-5392 PHONE
(202)456-2878 FAX

TO: Jamie Rafford

FAX #: 1-800-332-7571

FROM: JULIE DEMEO

NUMBER OF PAGES (including cover sheet): 4

COMMENTS:

If you have any problems with the fax transmission, please call Julie at (202)456-5392.

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THE WHITE HOUSE

WASHINGTON

FAX COVER SHEET

OFFICE OF THE ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY
SECOND FLOOR, WEST WING
THE WHITE HOUSE
WASHINGTON, DC 20500
(202)456-5392 PHONE
(202)456-2878 FAX

TO: Jamie Rafford

FAX #: 1-800-532-7571

FROM: JULIE DEMEO

NUMBER OF PAGES (including cover sheet): 4

COMMENTS:

If you have any problems with the fax transmission, please call Julie at (202)456-5392.

Mail letter + Resume directly

to: The Honorable Donna Shalala
Secretary for Health + Human Services
200 Independence Ave, SW
Washington, DC 20201

[redacted] letter + resume

mail

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

TO: Julie Demeo

FROM: Jamie Pafford-Gresham JPG

DATE: December 29, 1995

SUBJECT: National Advisory Committee on Rural Health

Hope you had a Merry Christmas! Thank the Lord it's overwith for another year! No, I really enjoyed it. I heard about this committee, Can you enlighten me on how to get on it?

On December 5, 1995 a notice appeared in the Federal Register stating that the Health Resources and Services Administration (HRSA) is requesting nominations to fill five vacancies on the Secretary's National Advisory Committee on Rural Health.

I am very interested in this position, Especially for my Daddy. We understand rural inside and out. (How can we help not to understand rural living in chicken scratch, Arkansas! Just a joke!!)

Do you think it's possible to get us a seat on this committee through Carol Rasco or the President? I think either one of us would be an asset to this committee. If you have any information on how we can obtain a seat on this, please let me know. I am very anxious to find out about this issue.

Give me a call as soon as you know something @ 1-800-4518036.

Thanks again for all your help!

1 800 532-7571

Feb 2nd New deadline

American Insurance Associations of this could help me

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

09-Jan-1996 11:33am

TO: Julie E. Demeo

FROM: Carol H. Rasco
Domestic Policy Council

SUBJECT: RE: Hi!

a. Pafford: Tell her to submit name with resume to Shalala. Then do a note in my POTUS briefing file that I should ask POTUS if this is someone I should flag on his behalf.

b. Balkan: See if Greg Simon is willing to talk to this guy since I won't know much to say.

c. I believe the sign up sheet I put together with Steve Warnath is on my desk....has about six veggies on it and I'm not sure what I put about dressings but it was the sheet I was going to take to meeting yesterday if we had met. Is it there?

Thanks!

It is snowing heavily here again...there too?

Peg Clark
62866

Betsy 690-6625
HHS (WH Liaison)

Nov. 29

EXECUTIVE OFFICE OF THE PRESIDENT

26-Nov-1995 01:47pm

TO: Jennifer L. Klein

FROM: Carol H. Rasco
Domestic Policy Council

CC: Julie E. Demeo
CC: Patricia E. Romani

SUBJECT: Pafford Ambulance Service folks

I understand Julie has given you these materials along with the letter asking me to meet ... she has explained to them I am out on travel for the better part of the coming week. WIll you simply follow up with a quick phone call to them stating you work with me, have the materials, we're watching it, etc. Let me know if anything significant transpires.....I'll then drop a quick note to them on Wednesday when I return.

Thanks!

Pat: put on Wed. agenda for me to do quick note. Source document in outbox directed to you to put with Wed. book.

Pat R -
See E Mail for Wed. task.

MEETING REQUEST/TRACKING FORM

CAROL H. RASCO

DOMESTIC POLICY

Name of Requestor: Jamie Pafford Date: 11/21/95

Affiliation: Pafford Ambulance Service, Inc.

Nature of Request: meeting to discuss impending cuts to rural ambulance services

Contact Person: Jamie @ 1-800-451-8036 Phone Number: _____

Meeting Data: A. Date: at your earliest convenience

B. Time: _____

C. Place: Washington (WH)

D. Purpose: Discuss impending cuts to ambulance Services

E. Conflicts: ~~N~~

DECISION

_____ Accept _____ Regret

_____ Forward To: OK Rein _____ Pending

Comments: (already done)

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

VIA FACSIMILE 1-202-456-2878

November 21, 1995

Carol H. Rasco
Assistant to the President
for Domestic Policy
The White House
Washington, DC

Dear Ms Rasco:

Sorry we missed you on the South Lawn of the White House on the 29th of September. We were able to converse with Mrs. Clinton for a few minutes. She spoke highly of you and your capabilities to help with our ambulance issues. She informed my father and I to keep in touch with you on any changes we felt necessary for the President to know about.

Congress has adopted Senate bill S.1357. This bill kills all work we have done on the rural issue, and will devastate the ambulance industry nationwide. House bill H.R. 2485, contains language pertaining to the ambulance industry that we helped develop. I have faxed several things to Julie Demeo, of your office staff to be reviewed. She has been a great help to us and is asset to your staff.

At this time, on behalf of the Arkansas Ambulance Association and American Ambulance Association, We would like to set up a meeting next week with you at your earliest convenience. Bonnie Hogue, of Senator Pryors Office, is willing to attend and help out in any way possible. She mentioned that the Senator would also try to make the meeting. I feel that there will be six attendees, representing both, the Arkansas and American Ambulance Associations, with an emphasis on rural providers.

NOTE: Julie has background materials on this

Please contact us at 1-800-451-8036 if you or your staff have any questions. We will be anxiously awaiting your reply. Have a safe and Happy Thanksgiving!!

Sincerely,

Jamie Pafford-Gresham
Vice-President
Pafford Ambulance Service, Inc.

encloseures

JPG/jlp