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AMBULANCE SERVICES

Changes Needed to Improve Medicare Payment Policies and Coverage Decisions

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Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss Medicare's payment and coverage policies for ambulance services. Currently, program payments are determined using a complex method based on reasonable costs for hospital-based providers or based on reasonable charges for ambulance providers not affiliated with a hospital or other health care facility (known as freestanding providers). This method has produced wide differences in payments across providers for the same services. In addition, there has been considerable variation in Medicare's determinations of what ambulance services are covered and what provider documentation is needed for ensuring claims are paid.

The Balanced Budget Act of 1997 (BBA) required the Medicare program to change its payment system for ambulance services.[1] In response, the Health Care Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), has proposed a fee schedule that will standardize payment rates across provider types based on national rates for particular services. As required by BBA, the proposed fee schedule was developed using a negotiated rulemaking process, and it involved a committee made up of officials from HCFA and representatives from various interested parties, including the American Ambulance Association and the American Hospital Association, among others.[2] In February 2000, the committee made recommendations to HCFA on elements of the fee schedule, which the agency used as the basis of its proposed fee schedule to the maximum extent possible. Under BBA, the fee schedule was to have applied to ambulance services furnished on or after January 1, 2000. HCFA published a proposed rule on September 12, 2000,[3] and has received public comment but has not issued a final rule to date.

[1]P.L. 105-33, Sec. 4531(b), 111 Stat. 251, 450-52.

[2]The other members of the Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule were from the American College of Emergency Physicians and National Association of EMS Physicians, Association of Air Medical Services, International Association of Fire Fighters, International Association of Fire Chiefs, National Association of Counties, National Association of State Emergency Medical Services Directors, and National Volunteer Fire Council.

[3]65 *Fed. Reg*. 55,078.

In July 2000, we reported on payments for ambulance services with an emphasis on rural providers. This was in response to congressional concerns about the circumstances facing some rural ambulance providers and about beneficiary access to these vital services. My comments today are based on our July 2000 report[4] and will focus on (1) the unique concerns of rural ambulance providers, (2) the likely effects of the proposed fee schedule on these providers, and (3) longstanding issues affecting the approval of claims made for payment of ambulance services.

In summary, many rural ambulance providers face a set of unique challenges, which may need consideration in implementing an appropriate payment policy. As noted in our July 2000 report, those serving large geographic areas with low population density, unless they rely on volunteers, tended to have high per-trip costs as compared to urban and suburban providers because of a lower volume of transports. Rural providers also tended to have longer ambulance transports than their urban counterparts, making the adequacy of reimbursement for mileage costs more central to their overall payments than for providers in more densely populated areas. Fewer alternatives for transporting rural residents to hospitals, a substantial reliance on Medicare revenues, and difficulty maintaining volunteer staff were among other challenges facing rural ambulance providers.

The proposed Medicare fee schedule will alter the way ambulance providers are paid. Much of the variation in payment rates among similar providers will be eliminated. Providers now receiving payments that are higher than the national average are likely to receive lower payments under the fee schedule, whereas those that are paid less than the national average, such as many rural providers, are likely to receive increased payments. The proposed fee schedule incorporates enhanced payments for providers that transport beneficiaries in rural areas. These payments are intended to help sustain essential ambulance service in sparsely populated areas. However, this adjustment does not sufficiently distinguish the providers serving beneficiaries in the most isolated rural areas and may not appropriately account for the higher costs of low-volume providers. In our July 2000 report, we recommended, and HCFA agreed, that the payment adjuster needed refinement to better address these problems.

[4] *Rural Ambulances: Medicare Fee Schedule Payments Could Be Better Targeted* (GAO/HEHS-00-115, July 17, 2000).

Not only does Medicare's current ambulance payment method produce wide and unexplained variation in rates, variation in approvals and denials of payments may have resulted in unequal coverage for Medicare beneficiaries. Different practices among carriers, which are the contractors that process claims for the Medicare program, may have contributed to the variation in claims denials. For example, in our 2000 review, we found that carriers made different decisions regarding the level of payment applied to similar claims for advanced emergency transport services. In addition, claims have been denied because providers did not properly fill out forms. Confounding consistency problems, the absence of a national coding system that readily identifies the beneficiary's medical condition at the time of the transport has impaired providers' ability to convey to carriers information that is needed to approve claims for payment.

Background

Medicare covers medically necessary ambulance services when no other means of transportation to receive health care services is appropriate, given the beneficiary's medical condition at the time of transport. Medicare pays for both emergency and nonemergency ambulance transports that meet the established criteria. To receive Medicare reimbursement, providers of ambulance services must also meet vehicle and crew requirements. Transport in any vehicle other than an ambulance—such as a wheelchair or stretcher van—does not qualify for Medicare payment.

Medicare pays for different levels of ambulance services, which reflect the staff training and equipment required to meet the patient's needs. Basic life support (BLS) is provided by emergency medical technicians (EMT). Advanced life support (ALS) is provided by paramedics or EMTs with advanced training. ALS with specialized services is provided by the same staff as standard ALS but involves additional equipment.

Currently, Medicare uses different payment methods for hospital-based and freestanding ambulance providers. Hospital-based providers are paid based on their reasonable costs. For freestanding providers, Medicare generally pays a rate based on reasonable charges, subject to an upper limit that essentially establishes a maximum payment amount. Freestanding providers can bill separately for mileage and certain supplies.

Between 1987 and 1995, Medicare payments to freestanding ambulance providers more than tripled, from $602 million to almost $2 billion, rising

at an average annual rate of 16 percent. Overall Medicare spending during that same time increased 11 percent annually. From 1996 through 1998, payments to freestanding ambulance providers stabilized at about $2.1 billion. BBA stipulated that total payments under the fee schedule for ambulance services in 2000 should not exceed essentially the amount that payments would have been under the old payment system. This requirement is known as a budget neutrality provision.

In 1997, 11,135 freestanding and 1,119 hospital-based providers billed Medicare for ground transports. The freestanding providers are a diverse group, including private for-profit, nonprofit, and public entities. They include operations staffed almost entirely by community volunteers, public ventures that include a mix of volunteer and professional staff, and private operations using paid staff operating independently or contracting their services to local governments. In our July 2000 report, we noted that about 34 percent were managed by local fire departments. In several communities a quasi-government agency owned the ambulance equipment and contracted with private companies for staff.

The majority of air ambulance transports are provided by hospital-based providers. An estimated 275 freestanding and hospital-based programs provide fixed-wing and rotor-wing air ambulance transports, which represent a small proportion (about 5 percent) of total ambulance payments.

Rural Ambulance Providers Face Multiple Challenges

In our July 2000 report, we noted that several factors characterizing rural ambulance providers may need consideration in implementing an appropriate payment policy. These include:

- *High per-transport costs in low-volume areas*. Compared to their urban and suburban counterparts, rural ambulance providers have fewer transports over which to spread their fixed costs because of the low population density in rural areas. Yet, rural providers must meet many of the same basic requirements as other providers to maintain a responsive ambulance service, such as a fully equipped ambulance that is continually serviced and maintained and sufficient numbers of trained staff. As a result, rural providers that do not rely on volunteers generally have higher per-transport costs than their urban and suburban counterparts.

- *Longer distances traveled*. A common characteristic of rural ambulance providers is a large service area, which generally requires longer trips. Longer trips increase direct costs from increased mileage costs and staff

travel time. They also raise indirect costs because ambulance providers must have sufficient backup services when vehicles and staff are unavailable for extended periods. Current Medicare payment policy generally allows freestanding providers to receive a payment for mileage. Nevertheless, mileage-related reimbursement issues, such as the amount paid for mileage, represent a greater concern to rural providers because of the longer distances traveled.

- *Lack of alternative transportation services*. Rural areas may lack alternative transport services, such as taxis, van services, and public transportation, which are more readily available in urban and suburban areas. This situation is complicated by the fact that some localities require ambulance providers to transport in response to an emergency call, even if the severity of the problem has not been established. Because of this situation, some providers transport a Medicare beneficiary whose need for transport does not meet Medicare coverage criteria and must therefore seek payment from the beneficiary or another source.

- *Reliance on Medicare revenue*. Medicare payments account for a substantial share of revenue for rural ambulance providers that bill Medicare. Among rural providers, 44 percent of their annual revenue in 1998, on average, was from Medicare, compared to 37 percent for urban providers, according to Project Hope Center for Health Services, a nonprofit health policy research organization. Additionally, for some rural providers, other revenue sources—such as subsidies from local tax revenues, donations, or other fundraising efforts—have not kept pace with increasing costs of delivering the services.

- *Decreasing availability of volunteer staff*. Rural ambulance providers traditionally have relied more heavily on volunteer staff than providers in urban or suburban areas. Some communities having difficulty recruiting and retaining volunteers may have had to hire paid staff, which increases the costs of providing services.

New Fee Schedule Will Alter the Way Medicare Pays for Ambulance Services

Medicare's proposed fee schedule, published in September 2000, reduces the variation in maximum payment amounts to similar providers for the same type of services. The considerable variation that exists in the current payment system does not necessarily reflect expected differences in provider costs. For example, in 1999, the maximum payments for two types of emergency transport—one requiring no specialized services and the other requiring specialized services—were the same in Montana at $231 for freestanding providers. In North Dakota, the maximum payment

was about $350 and also did not differ measurably for the two types of transport services. In contrast, South Dakota's maximum payment for the less intensive transport was $137, which was $30 lower than the payment for the transport requiring specialized services. Per-mile payments also varied widely. For example, in rural South Dakota, the payment was just over $2 per mile, compared to $6 per mile in rural Wyoming.

The shift to the proposed fee schedule would narrow the wide variation in payments to ambulance providers for similar services. The proposed schedule includes one fee for each level of service. This fee is not expected to vary among providers except for two possible adjustments—one for geographic wage and price differences and the other based on the beneficiary's location, rural or urban. As a result, a national fee schedule is likely to provide increased per-trip payments to those providers that under the current system receive payments considerably below the national average and decreased payments to providers with payments that have been substantially above the national average.

As part of its mandate, the negotiated rulemaking committee was directed to consider the issue of providing essential ambulance service in isolated areas. The committee recommended a rural payment adjustment to recognize higher costs associated with low-volume providers to ensure adequate access to ambulance services. Consistent with the committee's recommendation, the proposed fee schedule includes an additional mileage payment for the first 17 miles for all transports of beneficiaries in rural areas.

The mileage payment adjustment, however, treats all providers in rural areas identically and does not specifically target providers that offer the only ambulance service for residents in the most isolated areas. As a result, some providers may receive the payment adjustment when they are not the only available source of ambulance service, so the adjustment may be too low for the truly isolated providers.

In addition, the proposed rural adjustment is tied to the mileage payment rather than the base rate and, therefore, may not adequately help low-volume providers. Such providers may not have enough transports to enable them to cover the fixed costs associated with maintaining ambulance service. The per-mile cost would not necessarily be higher with longer trips. It is the base rate, which is designed to pay for general costs such as staff and equipment—and not the mileage rate—that may be insufficient for these providers. For that reason, adjusting the base rate rather than the mileage rate would better account for higher per-transport

fixed costs. In response to our 2000 report, HCFA stated that it intends to consider alternative adjustments to more appropriately address payment to isolate, essential, low-volume rural ambulance providers.

Policies for Approving or Denying Claims Payment Are Not Consistent Across Carriers

Whether or not a claim for ambulance transport is approved varies among carriers, and these discrepancies can translate into unequal coverage for beneficiaries. In 1998, between 9 percent and 26 percent of claims for payment of emergency and nonemergency ambulance transports were denied among the nine carriers that processed two-thirds of all ambulance claims. Different practices among carriers, including increased scrutiny due to concerns about fraud, may explain some of the variation in denial rates. Following are other inconsistencies in carrier practices cited in our July 2000 report that may help explain denial rate differences:

- National coverage policy exists only for some situations. Generally, Medicare coverage policies have been set by individual carriers rather than nationally by HCFA. For example, in 1998, the carrier covering ambulance providers in New Jersey and Pennsylvania reimbursed transports at ALS levels where local ordinances mandated ALS as the minimum standard of care for all transports. In contrast, the carrier for an ambulance provider in Fargo, North Dakota, reduced many of the provider's ALS claims to BLS payment rates, even though a local ordinance required ALS services in all cases. (The carrier's policy has since changed.)

- Some carriers were found to have applied criteria inappropriately, particularly for nonemergency transports. For example, for Medicare coverage of a nonemergency ambulance transport, a beneficiary must be bed-confined. In the course of our 2000 study, we found one carrier that processed claims for 11 states applied bed-confined criteria to emergency transports as well as those that were nonemergency. (The carrier's policy has since changed.)

- Providers were concerned that carriers sometimes determined that Medicare will cover an ambulance claim based on the patient's ultimate diagnosis, rather than the patient's condition at the time of transport. Medicare officials have stated that the need for ambulance services is to be based on the patient's medical condition at the time of transport, not the diagnosis made later in the emergency room or hospital.

- Ambulance providers are required to transport beneficiaries to the nearest hospital that can appropriately treat them. Carriers may have denied

payments for certain claims because they relied on inaccurate survey information specifying what services particular hospitals offer when determining whether a hospital could have appropriately served a beneficiary. However, the survey information does not always accurately reflect the situation at the time of transport, such as whether a bed was available or if the hospital was able to provide the necessary type of care.

- Some providers lacked information about how to fill out electronic claims forms correctly. Volunteer staffs in particular may have had difficulty filing claims, as they often lacked experience with the requirements for Medicare's claims payment process. An improperly completed claim form increases the possibility of a denial.

Claims review difficulties are exacerbated by the lack of a national coding system that easily identifies the beneficiary's health condition to link it to the appropriate level of service (BLS, ALS,or ALS with specialized services). As a result, the provider may not convey the information the carrier needs to understand the beneficiary's medical condition at the time of pickup, creating a barrier to appropriate reimbursement.

Medicare officials have stated that a standardized, mandated coding system would be helpful and the agency has investigated alternative approaches for implementing such a system. The agency contends that using standardized codes would promote consistency in the processing of claims, reduce the uncertainty for providers regarding claims approval, and help in filing claims properly.

Conclusions

Overall, the proposed fee schedule will improve the equity of Medicare's payment for ambulance providers. Payments will likely increase for providers that now receive payments that are lower than average, whereas payments will likely decline for those now receiving payments above the average. In our July 2000 report, we recommended that HCFA modify the payment adjuster for rural transports to ensure that it is structured to address the high fixed costs of low-volume providers in isolated areas, as these providers' services are essential to ensuring Medicare beneficiaries' access to ambulance services. HCFA agreed to work with the ambulance industry to identify and collect relevant data so that appropriate adjustments can be made in the future.

Concerns about claims denials need to be addressed separately from development of the fee schedule. In our view, policies across carriers should be made consistent. In addition, a uniform system for coding the

health condition of beneficiaries using ambulance transport services would likely improve the processing of ambulance claims and lead to more transparent decisions about claims payment.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or other Committee Members may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact me at (202) 512-7119. Jessica Farb, Hannah Fein, and Michael Kendix made contributions to this statement.