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OVERSIGHT OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES: MEDICARE PAYMENT POLICIES FOR AMBULANCE SERVICES

HEARING

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

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THURSDAY, NOVEMBER 15, 2001

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:19 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Joseph I. Lieberman, Chairman of the Committee, presiding.

Present: Senators Lieberman, Dayton, Carnahan, and Collins.

OPENING STATEMENT OF CHAIRMAN LIEBERMAN

Chairman LIEBERMAN. The hearing will come to order. Good morning. I am delighted to welcome everyone to this oversight hearing on the proposed changes in Medicare reimbursement of ambulance services and the impact the changes will have on the beneficiaries who rely on them.

I am pleased to open this meeting of our Committee as Chairman of the Committee, but I will in a few moments turn the gavel happily over to Senator Mark Dayton of Minnesota, whose interest and energy in this important subject has led to, facilitated, and enabled this hearing. For that, I thank him.

Let me start out by saying that the provision of ambulance transport in emergency situations is a critical aspect of access to medical care that must be preserved and protected. When Medicare beneficiaries call 911 in a medical emergency, they have every right to expect that an ambulance will arrive in a timely manner. It is our responsibility to ensure that this right is honored and that our national health care policy does nothing to jeopardize it.

That said, problems with Medicare's ambulance service reimbursement system are, unfortunately, longstanding and in dire need of reform. In the last decade alone, the General Accounting Office and the Department of Health and Human Services have issued 10 separate reports detailing these problems, specifically with regard to payment structure, the claims review and adjudication processes, and coding practices.

Under the Balanced Budget Act of 1997, ambulance requirements were supposed to move to a fee schedule instead of a reimbursement system based on medical diagnosis, and the Centers for Medicare and Medicaid have been working on that shift for quite some time. It now sounds like the rule on the fee schedule will be

issued, hopefully, early next year. The reimbursement levels presented by the proposal have, nonetheless, raised concerns among a number of our witnesses today, although I gather that the International Association of Firefighters supports the fee schedule as negotiated last year.

So we all want to avoid any situation that jeopardizes the livelihood of ambulance providers and employees or that will disrupt services for Medicare beneficiaries. We also want to avoid continuing problems with claims denials, inconsistent application of standards and adjudication process, and prolonged delays in claims processing that have led to unnecessary stress for patients.

This is a critically important subject and I am very grateful that Senator Dayton has taken the lead on it and Senator Collins is here as an expression of her interest in this, as well.

If I may say, just on a personal note, when I first came on this Committee in 1989 as a freshman, the then-Chairman John Glenn surprised me by telling me that if I had an interest in any subject and I wanted to do a hearing on it, to let him know and he would enable me to do that. I am happy that I told that story to Senator Dayton. [Laughter.]

So in fairness, and I guess some kind of validation of the, what is it, what goes around comes around, or what comes around goes around, or one good deed definitely should engender another, I am really proud to turn the gavel over to an outstanding freshman Member of the Senate for whom I think this will be the first of many hearings he will conduct, Senator Mark Dayton. There ought to be a ceremony of some kind. Take care.

OPENING STATEMENT OF SENATOR DAYTON

Senator DAYTON [presiding]. It is certainly a first for me. Thank you, Mr. Chairman. Thank you.

I certainly want to thank the departing Chairman for this opportunity. They say freshmen are meant to vote the way the leadership tells them to and not be heard otherwise, so I am pleased that Senator Lieberman was true to his word, and Senator Collins, I thank you for joining me here. I know you said you have to go on to another hearing, so why do I not let you go ahead, if you have any opening remarks.

OPENING STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you very much, Mr. Chairman. That is very kind of you, and thank you for chairing this oversight hearing on Medicare's payment policies for ambulance services.

I am particularly concerned about the effects that the new fee schedule will have on our rural ambulance providers, and I know this is a central concern of yours, as well. Payment under this new fee schedule will preclude providers of ambulance services from recouping their actual costs. For the average high-volume urban provider, this should not pose a significant problem.

For ambulance providers in rural areas, however, it is a different story. Ambulance services in rural areas tend to have higher fixed costs and low volume, which means that they are unable to take advantage of any economies of scale. I am, therefore, very con-

cerned that the proposed rule failed to include a meaningful adjustment for rural low-volume ambulance providers.

Several ambulance providers in my home State of Maine have expressed their concerns to me about the impact of the proposed fee schedule. Let me just give one example of the impact that this change will have on one of Maine's hospital-based ambulance providers, Franklin Memorial Hospital in Farmington, Maine.

Logging, tourism, and recreational activities are central to the economy of this region and good emergency transport is essential. Franklin Memorial owns and operates five local ambulance services that cover more than 2,000 square miles of rural Maine. They serve some of the most remote areas of our State and ambulances frequently have to travel more than 80 miles to reach the hospital. Moreover, these trips frequently involve backwoods and wilderness rescues, which require a highly trained staff. Since there are only 30,000 people in Franklin Memorial's service area, however, volume is very low.

Under the current Medicare reimbursement system, Franklin Memorial has just managed to break even on its ambulance services. Under the proposed fee schedule, however, these services stand to lose up to $500,000 a year systemwide. While the small towns served by Franklin Memorial have helped to subsidize this service, there is simply no way that they can absorb a loss of this magnitude.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act did increase the mileage adjustment for rural ambulance providers driving between 17 and 50 miles by $1.25. While this is helpful, it does not begin to adequately compensate low-volume ambulance services like Franklin Memorial Hospital.

Congress has required the General Accounting Office to conduct a study of the costs in low-volume areas, but any GAO recommendations for adjustments in the ambulance fee schedule would not be effective until 2004. I have, therefore, joined with Senator Russ Feingold in introducing the Rural Ambulance Relief Act, S. 1367, to provide a measure of immediate financial relief to rural providers, and I know that our Chairman also has legislation.

Our legislation establishes a "hold harmless" provision allowing both hospital-based and freestanding rural ambulance providers to elect to be paid on a reasonable cost basis until the Centers for Medicare and Medicaid Services is able to identify and adjust payments under the new ambulance fee schedule for services provided in low-volume rural areas.

Mr. Chairman, as we review Medicare's payment and coverage policies for ambulance services, I believe that it is critical that we take the unique needs of rural providers into account. I, therefore, hope that we can have some change in the fee schedule or perhaps legislative action to provide relief and ensure that those of our constituents who are living in rural areas still have access to the ambulance care that they need.

In closing, I would note that Mr. Scully told me this was an issue that was coming up in his town meetings. When I was traveling throughout the State of Maine and visiting several hospitals in the month of August and since then, it came up repeatedly. It is very much of a problem and I am concerned that if we do not rectify and

come up with a reasonable fee schedule, that we really will jeopardize ambulance service to many of our constituents.

So thank you for your leadership and I do very much appreciate your allowing me to proceed so that I can go on to an education conference. Thank you.

Senator DAYTON. Thank you, Senator Collins. Minnesota and Maine share many characteristics, including a wide expanse in our rural areas, and those are very much the same concerns that my ambulance providers in Minnesota expressed to me.

We are very pleased that Administrator Scully is here today and is able to not only speak, but as I understand, to be here until shortly before 10:30 a.m., when you need to go on to meet with Senator Stevens of Alaska, who as the ranking member of the Appropriations Committee is certainly someone you want to be timely to meet with.

Mr. SCULLY. He is not really happy with me on another issue, so it is a bundle of joy in this job. [Laughter.]

Senator DAYTON. That is right, and there are 100 of us and only one of you, so I am going to forego my opening statement. I am going to put it into the record.

[The prepared statement of Senator Dayton follows:]

PREPARED STATEMENT OF SENATOR DAYTON

Mr. Dayton. Reliable ambulance service is often a matter of life and death. There are growing problems that are putting ambulance providers in Minnesota and across the country in financial jeopardy and affecting their ability to deliver emergency services to patients.

This summer my staff in Minnesota met with ambulance providers and Medicare beneficiaries in Hibbing, Duluth, Moorhead, St. Cloud, Bemidji, Marshall, and Harmony, Minnesota to listen to their concerns over Medicare ambulance services. In every part of the state the stories were the same. The biggest concern was Medicare's denial of ambulance claims. Medicare has denied claims for such medical emergencies as cardiac arrest, heart attack, and stroke.

The family of a deceased woman was charged for an ambulance trip between a rehabilitation facility and a short-term care facility. Medicare denied that the ambulance transfer was medically necessary. My staff obtained notes from two doctors, one which documented the need to discharge the patient to a facility that could closely monitor her medical condition. The other letter explained the need for an ambulance as the patient required oxygen during the entire trip. Only after these efforts did Medicare agree to reopen the case and paid the initial ambulance charge and the mileage to the next closest facility (the family paid the rest of the bill).

The date of her transport was on October 29, 1999. The constituent died soon after, and her daughter contacted my campaign office on July 30, 2000. My staff contacted the rehabilitation facility she was transported from, the short-term facility she was transported to, the family on multiple occasions. In addition, my staff had her two doctors document why she needed ambulance transportation. As a result, the ambulance contractor, Noridian agreed to re-open her case on November 11, 2000, and subsequently pay for part of the bill on April 9, 2001.

In another instance, an elderly woman experienced nausea, vomiting, chest and abdominal pain. She was taken to the emergency room, where she was admitted to the hospital for a 3-day stay.

Medicare denied the claim because "Ambulance service is not covered when other transport could be used without endangering the patient's health. This rule applies whether or not such other means of transport is actually available." Medicare representatives felt the ambulance was a convenience and asserted that the patient's daughter (who lives over 200 miles away) should have driven her to the ER.

After months, the claim was finally paid. But the elderly woman from Duluth, Minnesota was so upset with the Medicare process, that when she needed an ambulance again she called a taxi. This is unacceptable.

To make matters worse, when Congress enacted the Balanced Budget Act of 1997 it required that ambulance payments be moved to a fee schedule on a cost-neutral

basis. Moving to a fee-schedule makes sense, but not on a cost-neutral basis for a system that is already underfunded. The proposed fee-schedule is especially unfair to rural areas and will mean the end of small ambulance providers in Minnesota and throughout the country.

Medicare beneficiaries deserve more from the health insurance system than additional anxiety in an emergency situation for a system into which they have paid. When people in Minnesota and across the country have an emergency requiring an ambulance, they want to know that they will quickly and reliably get the care they need. However, current Medicare policies and procedures are putting quality ambulance service at risk and are forcing many ambulance providers to struggle to stay in business—especially in rural communities.

Senator DAYTON. I just want to say that, obviously, the issues that Senator Collins has raised and others are of great concern to me and to Minnesota, as well, and would ask you to proceed, then, with your opening statement. Then we will have a chance to hopefully hear from other panelists who can give you their first-hand experience with some of the difficulties they have encountered. Please proceed.

TESTIMONY OF HON. THOMAS A. SCULLY,[1] ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. SCULLY. Sure. Thank you, Senator. Thank you for having me here today. As you will find in this statement, I have spent a lot more time on ambulance issues than I could have ever imagined 6 months ago when I decided to take this job.

I think we have all been sensitive to the vital role that emergency service providers play in care for all patients, including Medicare beneficiaries, but I think the events of the last 2 months have even raised and heightened the awareness of all of us to that, certainly what is going on all across the country, but in New York City as recently as the other day in Queens. So we have always been extremely aware of the importance that ambulance providers provide to the country with their services, but even more so now.

We are in the very final—very, very final stages of putting this regulation out. It is already a couple of years late, as you know, and I think it will be out before the end of the year. Our goal is to have it be effective April 1, and I think most of the ambulance community is aware of that.

The current ambulance payment system, as I think you probably found out, is very outdated and has led to huge discrepancies in the payments between geographic regions, between different providers. It is also incredibly burdensome from an administrative basis and requires substantial record keeping.

Congress has generally, since 1981, been moving towards what is called prospective payment and towards modernized fee schedules all across the board. The ambulance sector was really one of the very few places we were actually still paying on costs or charges, which are kind of amorphous terms, and I think it was a wise move for Congress to direct HCFA, now CMS, to move towards up with an ambulance fee schedule.

These systems generally, whether it is PPS or a fee schedule, are much more accurately reflecting the resources that are used in providing services. They generally reflect regional cost differences

[1] The prepared statement of Mr. Scully appears in the Appendix on page 35.

much better. And overall, I think almost every move we made to prospective payment or to a fee schedule, whether it is the physician fee schedule, hospital prospective payment, nursing home prospective payment, and home health prospective payment, every one of these—and I just left the hospital business—was greeted with great fear and skepticism ahead of time, and after they are actually phased in and folded in, I believe in almost every case they have turned out to be much more appropriate, much better payment systems, and have worked that much better. So that is certainly our goal with the ambulance fee schedule.

I certainly understand the concern people have any time you make a change and transition to a new fee schedule and I am sure those fears are appropriate, but I hope we are going to find in a couple years that the transition will have turned into a much better payment system, as it has with all the other payment systems.

Over the last 10 years, and I think I was going to put a chart up here,[1] the Medicare fees for ambulances have increased by nearly $1 billion, and the point of this chart is really, and I will get to it in a minute, is to show that the goal here when you go to PPS is to take what you would have spent under the old Medicare ambulance system and pay exactly the same amount under an improved and more appropriate and more adequate ambulance system. So that trend line that keeps going up, we are expecting about $2.3 billion in ambulance spending this year, going up to, I think it is $2.5 billion and $2.7 billion.

Our goal here is to restructure the ambulance payment system so it works better but we pay the ambulance providers exactly the same under the new law as they would under the old law. That is one of the major concerns the ambulance providers have expressed to me, and I will get into that in a minute, and it is a very legitimate one and I have done everything we can to make sure it works more appropriately.

In 1997, the BBA, Congress mandated that we switch to a national fee schedule, and in mandating that fee schedule, they suggested—Congress directed us to have a negotiated rulemaking. This was obviously in the last administration. Under the Clinton Administration, every major party in the ambulance world was involved in a very long and detailed negotiated rulemaking process that took a year, and in addition to CMS, then HCFA, the American Ambulance Association, the American Hospital Association, the Association of Air Medical Services, the International Association of Firefighters, the Association of Fire Chiefs, the Volunteer Fire Council, the Association of Counties, the State Emergency Medical Services Directors, on and on, basically every major group was involved in this, and having been involved in a number of negotiated rulemakings when I was running a hospital association, I can tell you they are complex agreements, but generally at the end of them, everybody signs on the dotted line, which is what happened in this case and everybody agrees to go forward.

So there was under the Clinton Aministration a year-long negotiated rulemaking. Everybody agreed to it. It was basically done and it had been put out as a notice of proposed rulemaking. It was

[1] Chart referred to by Mr. Scully appears in the Appendix on page 87.

finished. And so when I came in in May, I found that we had still many controversies going on. So we have reopened the rule, but there was an agreed-upon negotiated rulemaking that was completed in February 2000 and there was a consensus agreement.

As I have gone around the country, I have personally spent many hours on this, hundreds of hours looking at ambulance regulations, and I have also been to town hall meetings with Senator Hutchinson and Senator Lincoln in Arkansas, where this probably took most of the day, with groups of ambulance providers driving in from many States to express their unhappiness with the ambulance regulation. I did town hall meetings in Tennessee, Alabama, Kentucky, North Carolina, spent a day largely on ambulance issues in Montana with Senator Baucus, so there is no shortage of people concerned about this rule and I am intensely aware of the concerns and have spent a lot of time trying to fix it.

As I said, I have spent hundreds of hours on this rule. Secretary Thompson has personally spent dozens of hours with me on this rule, so there is nobody at HHS at any level that has missed the importance of this rule, and I would say that $2 billion is a relatively small piece of the Medicare program, about less than one percent, but it is taking a disproportionately enormous amount of our time, as it deserves, in the last few months.

I am confident that we are very aware of most of the providers' concerns. I cannot get into the details under the Administrative Procedures Act of everything that is in the rule that is coming out, but I do think that we have addressed most of them and that the rule that comes out will be a significant improvement over what was in the notice of proposed rulemaking.

There are a lot of concerns, certainly, about rural providers. As I mentioned in this chart, one of the most appropriate concerns, since I spent many years at OMB—in the last Bush Administration, I was at OMB and the White House for 4 years—one of the concerns when people switch from an old fee schedule to a new fee schedule is that we make hundreds of actuarial judgments about what the payment fee schedule should look like so $2.3 billion of spending under System A works out to $2.3 billion under System B, and their concern is that we make all these assumptions and instead of spending $2.3 billion, we spend $1.8 billion and the money is gone, and I think that was one of the major concerns the ambulance providers had in the assumptions we made about our initial regulations.

I have gotten into that process in great detail. I think in the draft regulation that is coming out, we made a number of adjustments that will assure that, in fact, the new system spends what was projected to be spent under the old system. I think the system is a substantial improvement over the old system. It is also phased in over a number of years, and I am confident there is no doubt that any time you have one of these systems, whether it is skilled nursing facilities or hospitals or physicians, somebody is always unhappy because there is a redistribution of funds.

But I do think the impact on the redistribution has been minimized. I think the rule is a much more rational payment system and I am confident that in a couple of years that the ambulance

community will find out that this is a much better payment system that is fair for everybody, so I hope you find that, as well.

But anyway, Senator, thank you for having me here today and I am happy to answer any questions.

Senator DAYTON. Thank you, Administrator Scully.

We are pleased to be joined here today by Senator Jean Carnahan of Missouri. Senator Carnahan, do you have an opening statement you would care to make.

OPENING STATEMENT OF SENATOR CARNAHAN

Senator CARNAHAN. Thank you, Mr. Chairman. The events of September 11 have certainly reinforced the importance of emergency medical services. They are among our first responders and they are on the front lines of the war on terrorism. It is important to remember that their services are not only needed during major medical incidents, they are oftentimes needed other times, as well. They are ready and required to serve all Americans on a 24-hour basis, 7 days a week, when any person has a medical emergency.

When someone is having a heart attack, they call an ambulance. When there is a car accident, they call an ambulance. Ambulance providers and emergency personnel need the financial resources to perform their job well and to provide the quality of services that Americans expect.

I commend Senator Dayton for calling for today's hearing. The purpose of the hearing is to examine the new fee schedule for ambulance services. Recently, I have heard from both urban and rural ambulance providers in Missouri who are opposed to the level of reimbursement under the new fee schedule. They are concerned about the impact the decrease in Medicare reimbursement would have on their ability to provide services.

Missouri would be hit particularly hard by the changes, since the State provides advanced life support services and the proposed fees are significantly below the cost of providing this high-quality care. The Metropolitan Ambulance Services Trust, also known as MAST, serves 17 municipalities in Missouri and Kansas, including the Kansas City metropolitan area. MAST estimates that it would lose $2 million due to lower Medicare reimbursements the first fiscal year that the new schedule is implemented. This loss would increase to $2.9 million annually when the fee schedule is fully phased in.

The impact on rural areas is also significant. The Ambulance District Association of Missouri represents tax-supported medical and service transports in Missouri. Its members are predominantly rural and must rely on third-party payers—insurance, Medicare, and Medicaid—to provide the majority of its revenues. The Ambulance District Association has informed me that the proposed changes in Medicare funding would shift the financial burden from the Federal to the local level. But the many rural districts in Missouri do not have the tax base to replace the lost Federal revenue.

Other Missouri organizations have expressed concern about the reimbursement level under the new fee schedule for ambulance services. Mr. Chairman, I would like to insert for the record testimony that has been submitted by the following organizations: The Metropolitan Ambulance Services Trust, the Ambulance District

Association of Missouri, the Missouri Emergency Medical Services Association, the Missouri Ambulance Association, the State Advisory Council on Emergency Medical Services, and the Kansas Emergency Medical Services Association.[1] I take the concerns of these organizations seriously because of what they could mean, a reduction in the availability and quality of emergency response services. Lives are at stake.

I think that CMS should be very cautious not to implement changes that would harm the country's emergency medical services. This is particularly true given the increased demands that are being placed on emergency personnel since the September 11 attacks. I look forward to hearing from Mr. Scully about what steps CMS has taken or plans to take to ensure that these cuts do not do irreparable harm. Thank you.

Senator DAYTON. Thank you, Senator Carnahan, and without objection, the additional testimony will be submitted for the record. Thank you.

Mr. Scully, there seems to be a disconnect between the assurances that you have given this Committee and expressed in all good faith in terms of the proposed new fee schedule and its fairness and its sufficiency and what Senator Carnahan has heard from her constituents, what Senator Collins expressed before, and what I have heard from people in Minnesota, especially in greater Minnesota, the more rural area of our State where the ambulance services are increasingly dependent upon Medicare and Medicaid reimbursements for their livelihood. The impact of this and the potential catastrophic effect—literally ambulance services going out of business if there is a shortfall that cannot be made up from any other source—have the providers and me seriously alarmed. Can you explain why there seems to be this gap between what the rates that you are proposing and where you think the equity lies and these concerns?

Mr. SCULLY. Well, I do not want to promise you that they will love it. Someone is not going to. But the process was that there was a negotiated rulemaking from February 1999 to February 2000 that came out with—the result was a negotiated rulemaking by the government. The Clinton Administration, Nancy Ann DeParl, who was my predecessor and a good friend, was negotiated actually by the National Mediation Service, I think, and all the various groups. The Department adopted it, put it out as an NPRM for comment, got 340-some comments, not all of them happy, as you can tell from what you have heard, and basically, I did not get involved in the process until I was confirmed in May.

So we basically have been in the process of taking the comments and the proposed rule, and under the negotiated rulemaking, because it theoretically is an agreement among all the parties and all the hospital groups in the country and the administration agreed to it, it is a little more difficult to make changes. But I have gotten into the details of every nook and cranny of the regulation and we have made changes. We spent a lot of time with all the ambulance providers and made changes where appropriate.

[1] The information submitted by Senator Carnahan appears in the Appendix on pages 88 thru 103 respectively.

So I cannot tell you that the regulation is perfect. It still is based on the notice of proposed rulemaking that was negotiated 2 years ago. But I think it is substantially better or will be substantially better. Again, I do not want to have my lawyers tell me I am violating the APA again, because the regulation will not be out for probably a couple more weeks or maybe longer.

But our goal is to have it in effect on April 1. It will be phased in over multiple years. And I think that most of the major concerns that I have heard from the ambulance community have been addressed fairly substantially. That does not mean they are all going to like it.

I mean, coming into it initially—I used to run a hospital association and sign on the dotted line of many negotiated rules I did not like, but the process of a negotiated rulemaking is you sit around for a year and you pound out your differences with the government and you either agree or you do not agree, and so there was a basis that, theoretically, everybody agreed to, and so when the new administration came in, as any group of providers would, they wanted to reopen it, and they did, and I think we have responsively reopened the——

Senator DAYTON. And I am not questioning the process, but the people that provide the services are going to have to live with the result, not the process. I guess my concern—I have a couple of concerns, and we are all concerned about cost controls for these large systems, but in some cases, the cost control has been seen to be driving the process and the product. Are you satisfied that these reimbursement levels are appropriate for the actual services being provided or do you see this as being used as a way of spreading the pain or the funding gap perhaps equitably and up to date, but effectively reducing these payments below levels that the services are actually providing?

Mr. SCULLY. I am comfortable that this is a responsible level of payment across the board. I think when you look at the variation in costs and charges State by State—for instance, if you look at West Virginia, over Tennessee or North Carolina, all of whom, I think, have sued us at various points for being underpaid under the old system and are very anxious to have the new system come in, they were vastly underpaid, arguably, and other States, arguably, in some places, there were things being overcharged.

Any time you move to a new payment system, there are going to be some winners and losers. I am comfortable the system is going to work much better. I have also spent a lot of time with the ambulance providers, including a good part of the day yesterday, telling them that as this rule goes forward, we will continue to work with them to tweak it to make it work better.

It is phased in over multiple years so there will not be an immediate harsh impact, I do not believe, on anybody. It is a mix of the new system and the old system for multiple years, more than 4 years, at least, and I am comfortable that—I have been through this in the hospital business when we went to outpatient PPS last year, which, when I used to run a hospital association, including 40 hospitals in Missouri, we all thought that the outpatient hospital system was going to be a disaster when it phased in last year,

and there were certainly difficulties, but I think it is a much better payment system.

I think, in the long run, this is a better payment system. There will be people that will not be happy with it, but I think it is very equitable and it makes much more sense as a much more rational payment system.

Senator DAYTON. My time for my first round of questions is up. Senator Carnahan.

Senator CARNAHAN. Ambulance and emergency medical service providers in Missouri have raised some concerns about the use of 1998 data to calculate the reimbursement levels. The concern is that these numbers are outdated and do not adequately reflect the current costs. How would you address this concern?

Mr. SCULLY. I think we already have addressed it. Again, I do not want to get punched by one of my attorneys here, but the issue for the NPRM was the best data we had at the time was 1998 data, and that was updated and inflated up to current terms. The concern I think that some of the people in the provider community had was that there were not as many services provided in 1998 as 2000 and that data might skew or throw off the numbers.

I think we have adjusted it to do it appropriately. The negotiated rulemaking was based on 1998 data. The 2000 data really is not clean enough to use yet, so if we had to use it, it would probably delay the rule by a year, and there are some people that are very unhappy that the rule is already a year and a half late.

So I think we have taken the 1998 data, which is the best data available, inflated it and updated it for 2000, and I am comfortable that the data is appropriate.

I think the biggest issue from the first day, and this is a little bit of budget wonkish stuff, that the ambulance community had, their number one concern is that we are going to spend $2.3 billion this year on ambulance spending under the old system. As we move to the new system, when you make all these assumptions about the level of services, that when you throw all the services up in the air and recalculate them, we might come back under conservative administration assumptions and only spend $1.9 billion or $2 billion, and the way the budget system works, you have a new base and the money evaporates forever.

That was a very legitimate concern. I think I have gone to great lengths in the rule to take care of that and I am very confident that the money we spend under the new system will be virtually as close as is humanly possible to the money that would have been spent under the old system, and I think that was the basis of their—the fundamental core of their concern and I think that has been addressed.

Senator CARNAHAN. When it comes to providing for rural services, what is CMS doing about the unique needs of emergency medical service providers in these rural communities, and how has CMS responded to GAO's concern that the new fee schedule does not adequately address the needs of these providers in the most isolated areas?

Mr. SCULLY. There are a number of changes we made in the rule that is coming out to address those things. I think of the seven or eight major concerns that the ambulance sector has raised to us,

we have addressed, I think, all of them. A couple of them, we did not agree on, but there are a number of changes that will help rural areas.

And I think if you look at the distribution tables that eventually come out, you will find that, for the most part, it is not necessarily every rural area of every rural State, but the rural States generally actually do considerably better under this rule, and I think we have taken virtually everything that we can, within reason, into account to make the rural payments more appropriate.

Senator CARNAHAN. You say they will be doing considerably better?

Mr. SCULLY. I can tell you, when you look through the tables, which I have been able to do and they will be out at some point in the regulation, it is not direct rhyme or reason, it is not that always the urbans do better than the rurals, but a lot of rural States do significantly better and I think in a lot of cases the rural payment will be more appropriate.

Senator CARNAHAN. The negotiations that led up to the creation of the new fee schedule took place before September 11. What is CMS doing to ensure that the new fee schedule addresses the increased demands that are going to be placed on ambulance providers?

Mr. SCULLY. Well, the payments are based essentially on the services, so if the volume of services go up, and obviously, in a lot of cases there will be many more calls to ambulance services for things, the payments go up. So, essentially, if the volume of services this year went up 10 or 12 percent, there is no cap over all the payments, so the actual volume of services go up. So if you have an advanced life services call in St. Louis or Kansas City and they just happen to have more, they will get paid more. So there could be significant inflation in the ambulance sector.

So the payments are set to the per visit, per service, and if there happens to be a greater volume, then the payments go up, so there is not really any limit on it. If there is more volume, they will get paid for more volume.

Senator CARNAHAN. Thank you, Mr. Chairman.

Senator DAYTON. Thank you, Senator Carnahan.

The two main categories of concern I have—one is the amount of payments and their sufficiency and the second is the timeliness of the payments and the difficulty that a lot of ambulance providers in Minnesota report to me they have getting their legitimate claims processed by the CMS. Why are such a significant number of ambulance claims being denied by Medicare contractors in Minnesota on the first submission and paid on the first appeal?

Mr. SCULLY. Senator, I cannot tell you that I am totally familiar with the Minnesota situation, but I spent a whole day in Montana with Senator Baucus, most of that day spent in an interesting debate between the air ambulance and ambulance people and Blue Cross of Montana, and it is a pretty small State so they know each other pretty well, at least population-wise.

And part of it, I think, is due to the fact that it is one of the few places we still pay based on costs and charges, so it is very difficult. The ambulance providers have to do a significant amount of documentation for what are actually costs or charges, depending

whether they are hospital-based or independent, and the Blue Cross plans, who are the Federal Government contractors—largely Blue Cross, there are others around the country—are obviously protectors of the trust funds to spend money appropriately are tasked with asking tough questions about whether the services were appropriate.

When you are under basically a heavy paperwork, heavy documentation system, which the old one is, where you have to justify your costs and charges for every visit, there is just a lot more controversy before it gets paid and I think it slows up the system.

I believe the new system, which will be much clearer on what the allowable fees are and charges, it will be a lot easier to implement and a lot less paperwork, a lot less controversy over what gets paid and probably will speed up the payment process. That is certainly one of the goals.

But I can tell you, having sat there with Blue Cross of Montana, which is a pretty community-friendly organization, and the tension between them and the ambulance providers over the many unpaid bills was—I think that is going on in every State. Some of that is the complexity of the system, and to be honest with you, I hope—in many cases, I do not want to discourage our local Medicare contractors from questioning bills anywhere, as long as it is appropriate. But I think the new system is going to be a lot better as far as making the payment simplified and clear.

Senator DAYTON. Medicare's claim processors often deny claims as "not medically necessary" based on the codes provided by ambulance personnel, even though a patient had an obvious emergency and needed an ambulance. A more appropriate "condition code" has been developed with the involvement of Medicare officials. Is this something that you can implement administratively to reduce the number of denials?

Mr. SCULLY. Well, I talked to some ambulance folks about this yesterday. The condition code thing—again, I was not here, this was 2 years ago—was apparently a kind of side group of the negotiated rulemaking that went up and talked about condition codes, which is a good idea. Apparently some then-HCFA, now CMS, staff were involved in that and were aware of it, but it was not part of the negotiated rulemaking as it went forward.

There really is not a direct tie between the payments and the condition codes. The condition codes can help, but it is something that we are very interested in moving forward and working with the providers on. But if we had adopted those condition codes, they are just not technically ready and I think that is pretty clear and it would have delayed the rule at least a year and it is something I think we need to keep working on.

The concept of the condition codes is a good concept, but it is just not ready to put in this regulation and there was no way to implement it in this regulation. So there really is not a crosswalk between the condition codes and the payment codes and we are anxious to work on that and I think a lot of the providers think that would simplify their lives, and it may well do it, but it is just not—it was not ready to put in this regulation.

Senator DAYTON. But do you support it in concept? Are you willing to proceed to work with the providers to develop that in the months ahead?

Mr. SCULLY. Yes, and I think it is important because there has been some controversy in the past where the hospitals were not wild about condition codes because they do not bill on that. They bill on ICD–9 codes and hospital-based codes and I think there is some evidence that they are interested in sitting down and working that out, too. So we are very interested in working it out, but it just was not possible to do it in this regulation unless we delayed it another year, and there are plenty of people that are not happy with the current delay, so——

Senator DAYTON. Thank you very much.

I would like to call in the second panel of witnesses. I would like to invite you, Mr. Administrator, if you would, to remain at the table, if we can add another chair. I know you have to leave at 10:25.

Mr. SCULLY. I will have to sneak out at 10:25.

Senator DAYTON. All right. But I would like to have you hear from these people directly. Two of them are from Minnesota, so rather than give you another trip to the upper Midwest, we will let you do so here. I think it is also symbolic that all of you are all on the same side after all anyway, and I know share that goal.

So I now call the second panel, Dr. Mark Lindquist, who is the Medical Director of the Emergency Department at St. Mary's Regional Health Center; Gary L. Wingrove, EMT with Gold Cross Ambulance Service; Mark Meijer, President of Life EMS Ambulance; and Dr. James Pruden, Chairman of New Jersey EMS Coalition. Welcome, gentlemen.

Dr. Lindquist, we will begin with you. Welcome.

TESTIMONY OF MARK D. LINDQUIST, M.D.,[1] MEDICAL DIRECTOR, EMERGENCY DEPARTMENT, ST. MARY'S REGIONAL HEALTH CENTER

Dr. LINDQUIST. First of all, I wish to thank Chairman Lieberman and Ranking Member Thompson for inviting me to appear before this Committee to discuss the proliferation of Medicare denials of ambulance claims and the inconsistent application of standards with regard to claim adjudication. I also would like to thank you, Senator Dayton, for your hard work on the issues that we are talking about today. I am honored to be present for this hearing.

I am an emergency physician practicing in Detroit Lakes, Minnesota. I am the Medical Director of four advanced life support air and ground ambulance services and eight police, fire, and rescue departments in Minnesota. I am also the co-owner of an air ambulance service, an ambulance billing and consulting company, and until just recently, two ground life support ambulance services.

On July 17 of the year 2000, my 69-year-old father suddenly collapsed while painting a gazebo in the backyard of his home in Moorhead, Minnesota. My mother was trapped inside the gazebo for a short time as my father was lying unconscious against the door, bleeding from a head wound. She was eventually able to push

[1] The prepared statement of Dr. Lindquist appears in the Appendix on page 43.

the door open, moving him away enough to go to a phone and call 911. Fargo-Moorhead Ambulance Service paramedics arrived quickly. My father began to regain consciousness. He had marked post-concussion confusion and agitation. Whether he also had neck or other injuries was unknown at that time.

He was brought by ambulance to the emergency department at a Fargo hospital, where an evaluation showed the presence of a large complex brain aneurysm. My father's sudden collapse had been caused by a small leakage of blood from the aneurysm, which is usually followed within a month by a catastrophic aneurysm rupture and massive brain bleeding.

Because of the size, location, and complexity of the aneurysm, he was referred to a neurosurgeon at the University of Minnesota who specializes in aneurysm repair and he underwent surgery on July 28. The long, complex surgery resulted in a serious secondary brain injury. He subsequently developed serious infections and respiratory failure and he died on August 13, 2000.

Medicare initially denied payment of the $500 911 ambulance call to his home where he had collapsed. The explanation from Wisconsin Physicians Services (WPS), the CMS contracted carrier, stated that the ambulance transfer from his home to the hospital was not medically necessary. Apparently, according to WPS, my 67-year-old mother should have been able to load his 190-pound body into a car and drive him to the hospital.

Upon being informed that the claim had been denied, my mother promptly paid the ambulance bill. It was only when I asked her several weeks later whether my father's medical bills were being covered that she told me the claim had been denied by Medicare. Like most non-medical laypersons, she was unaware that 20 percent or more of all Medicare ambulance claims are denied by this CMS contracted carrier. I urged her to obtain a letter explaining medical necessity from the attending physician and appeal the denial.

The bill was resubmitted to Medicare along with a letter from my father's attending neurologist explaining why the ambulance transport had been necessary. The explanatory letter was returned to the neurologist by a WPS customer service employee who stated he did not understand the reason for the letter. The bill was resubmitted a third time and was finally partially paid by Medicare after the third submission.

Needless to say, my mother was perplexed. She did not understand why the ambulance claims were denied, as she strongly felt that skilled emergency medical care was required when my father collapsed. I have been unable to give her a logical explanation and am, frankly, disgusted by the disregard shown by WPS for the competent medical judgment of my father's physicians.

As an owner of ambulance services and an ambulance billing company in Minnesota, I am very aware of these frequent claim denials, including cases where payment has been denied for patients in complete cardiac arrest, the explanation being given that an ambulance transport was not necessary, even though the patient's heart had stopped beating.

This summer, the mother of one of my employees was brought by ambulance to a hospital in Fargo after developing pneumonia

while recovering from a broken hip. The 1-year mortality rate for patients recovering from a fractured hip is as high as 50 percent because of such complications. The woman was short of breath, had low blood oxygen levels and a build-up of fluid in her chest and she died 16 hours after being brought to the hospital. WPS stated the ambulance transfer was not medically necessary and denied payment of that claim, also. The patient's daughter, who is a flight nurse, resubmitted the claim with a harsh letter and it was ultimately partially paid.

The prudent layperson standard contained in S. 1350, the Medicare Ambulance Payment Reform Act of 2001, states that if a prudent non-medically-trained layperson has reason to believe that a medical emergency exists when calling for an ambulance, Medicare would be required to pay the claim. Currently, an ambulance claim filed by a patient who suffered chest pain can be denied if he or she is eventually found to have a non-cardiac source of pain. Of course, at the time of initial symptoms, it is impossible for the patient, paramedics, and even emergency physicians to know that the source of pain is not an emergency condition.

I ask you to carefully consider implementing the prudent layperson standard as part of S. 1350, the Medicare Ambulance Payment Reform Act of 2001. The standard would eliminate much of the inconsistency currently found in the payment or denial of Medicare claims.

Thank you for the opportunity to address this Committee and I would be happy to answer any questions you may have.

Senator DAYTON. Thank you, Dr. Lindquist. We will have questions after all the panels have had a chance to make their presentations. Thank you. Dr. Pruden.

TESTIMONY OF JAMES N. PRUDEN,[1] M.D., FACEP, CHAIRMAN, NEW JERSEY EMS COALITION

Dr. PRUDEN. As a member of the New Jersey Statewide EMS Coalition, we cannot thank Senator Dayton enough for his initiative in identifying shortcomings in the proposed ambulance reimbursement fee schedule and we applaud and support his efforts to effect remedies. We also appreciate the opportunity to speak before this Committee.

The proposed fee schedule threatens to dismantle EMS in the State of New Jersey. In the Balanced Budget Act of 1997, the Secretary was directed to consider appropriate regional and operational differences. One of the differences not considered is the non-police, non-fire EMS constituency. Eighty percent of the EMS squads in the State of New Jersey are such squads. Additionally, in the State of New Jersey, we have a unique system for delivery of ALS care, and that, too, was not recognized in the negotiated rulemaking process. Let me describe that system briefly.

When a 911 call goes to an ambulance, a basic life support unit, BLS unit, is dispatched. Again, 80 percent of the time, those calls are answered by volunteer squads that do not charge the patient nor the insurance for the services they provide. Last year, 400,000 ambulance transports were accomplished by volunteers. This saved

[1] The prepared statement of Dr. Pruden appears in the Appendix on page 46.

Medicare $48 million in charges and, at an 80 percent reimbursement rate, saved them $39 million in costs. In the State of New Jersey, only BLS units are allowed to provide a transport.

The BLS component—when your 911 call suggests a more serious illness—crushing chest pain, severe allergic reaction, breathing difficulty—the paramedics are dispatched simultaneously with the BLS squad, two rigs responding to the same call. Is this inefficient? Well, nationally, 30 percent of the time a patient goes to the hospital by pre-hospital transport, they are accompanied by paramedics. In the State of New Jersey, only 13 percent of the time are they accompanied by paramedics. If you get there, and you do not need medics, they can leave. This allows us to cover the entire State with advanced life support capability.

So what? Medics are expensive, take 2 years of additional training. They have additional skills and equipment. The average charge for a paramedic-accompanied call in the State of New Jersey is $525. With implementation of the base reimbursement rate at $152 and the mileage and the gypsy considerations, the average reimbursement would be about $373 per ALS call, a loss of $150. That is if it is accompanied by volunteers. If you have the proprietary ambulance accompany the ALS squad, they are entitled to their cut, which takes away an additional $200 per call, on average. Paramedics are based at hospitals in the State of New Jersey and the hospitals would stand to lose about $19.5 million a year on ALS runs if this is implemented.

So what would happen? Well, the hospitals would either get out of the ALS business or the hospitals would start transporting, and then if the hospital starts transporting, there will be turf wars between proprietary and hospital transport units. The volunteers who get their greatest sense of reward by responding to people in the greatest need would get to a scene, an ALS transport unit would be there, they (the volunteers) would have no role to play, they would go home. It would not be long before the volunteer system would disappear in the State of New Jersey.

Now, what would that mean? That would mean that the $48 million in charges and $39 million in costs that Medicare does not have to pay right now, they will have to pay when this reimbursement takes place.

Additionally, disasters—in the events of 9/11, in the first few hours, 450 ambulance squads from New Jersey reported to assist. Ninety percent of those squads reporting were volunteer squads. Additionally, the entire New Jersey Congressional delegation has supported the efforts of this coalition, every member of the House, every member of the Senate, Democrats and Republicans, have supported our efforts to avoid implementation of this process.

So what are the options? The options are, leave it alone, let it be as it is. Other options are to establish a carve-out. The Secretary is entitled to establish a carve-out or waiver for different States to cover the cost of pre-hospital care. CMS has the legal authority to grant this carve-out waiver. Whatever options are addressed; whether your bill goes through or they choose to leave us alone, or they implement a waiver, it is imperative that the implementation of the present reimbursement design by HCFA CMS, does not go

through as it is now or we stand to lose significantly in the State of New Jersey.

Senator DAYTON. Thank you very much, Dr. Pruden. Mr. Wingrove.

TESTIMONY OF GARY L. WINGROVE,[1] EMT–P, MINNESOTA AMBULANCE ASSOCIATION

Mr. WINGROVE. Senator Dayton and Members of the Committee, thank you for having me here today. This is a big day for me because I am here with you and the Committee and the other panelists and Administrator Scully.

My name is Gary Wingrove. I am a paramedic. I represent the Minnesota Ambulance Association and MAA President Buck McAlpin is also present today.

There are two major problems facing the ambulance industry and these include an increase in the number of denied Medicare emergency ambulance claims and the impact of the proposed fee schedule.

In the written testimony that I submitted, I told you about four Minnesotans—I would like to describe two of them today—that have used ambulance service. A woman had an implanted defibrillator that failed to function. She was in cardiac arrest. The paramedics were summoned and successfully resuscitated her using an external manual defibrillator.

A woman was moving a mattress in her apartment. She lost her balance. The mattress fell on top of her and she could not breathe. She screamed for help and a neighbor called 911. The paramedics arrived and removed the mattress. She had excruciating back pain and could not move and was transported to the hospital.

These people have a few things in common. They are all over 65. They have Medicare as their primary health care insurance. They were transported to hospitals for physician evaluation, diagnosis, and treatment. Medicare paid all of their hospital, physician, lab, and diagnostic bills, yet their ambulance claims were denied. The reason given by the contractors was that the ambulance was not medically necessary. We disagree, and like the beneficiaries, are outraged that this occurred.

We find that 90 percent of the denied claims are paid on the first appeal attempt. One of our members reports that they frequently have to fax pages from the carrier's own ambulance billing manual back to them because they give wrong information over the telephone, both to us as providers and to beneficiaries.

In January of this year, the Medicare contractor processing hospital-based ambulance claims in our State put the ambulance services on focused review. This means they suspended 100 percent of the claims submitted by the provider and required the provider to submit both the ambulance run form and hospital records before they would process the claims. By the middle of 2001, one hospital-based ambulance provider had over 1,500 unpaid Medicare claims totaling over $6 million.

Mr. Chairman and Members of the Committee, we submit that the only person who should be allowed to determine whether a

[1] The prepared statement of Mr. Wingrove appears in the Appendix on page 48.

medical emergency exists is the person who decides whether or not to dial 911. Congress should establish a prudent layperson standard for the payment of emergency ambulance claims and Congress should direct CMS to adopt a condition coding system for use in ambulance claims.

The average Minnesota ambulance service has a payer mix that is 50 percent Medicare. We predict a 50 percent decrease in reimbursement in our State as a result of the combination of mandatory Medicare assignment and the implementation of the proposed fee schedule. This means the average Minnesota ambulance service will lose 25 percent of their total revenue. The ambulance industry in Minnesota bills approximately $140 million per year, and we are predicting a decline in revenue of $37 million.

While the anticipated payment rates are inadequate for urban providers, the situation is much worse for rural providers. Many rural government-operated ambulance services predict financial insolvency. Some ambulance services are anticipating reduction in service provided to Medicare beneficiaries from paramedic level ALS to EMT level BLS.

Even though the fee schedule has not yet been implemented, some ambulance services are already in dire financial straits. According to the January 2001 edition of the EMS Insider, East Texas Medical Center, which provides EMS to dozens of rural communities in West Texas, notified residents of Honey Grove, Texas, that it would cease providing 24-hour coverage to the town, and beginning December 1, 2000, they would station a unit at Honey Grove only from 7 a.m. to 4 p.m. on Tuesday through Saturday. At all other times, it sends an ambulance from a town 20 miles away. Then this town has no first responder service.

To illustrate the difficulties in providing rural ambulance service, the cost per hour to provide ambulance service is almost identical in greater Minnesota as urban Minnesota, but compared to urban revenue, the greater Minnesota revenue per day must either cover three units instead of one, or the ambulance service must make 1 day of urban reimbursement last the entire week.

The problem of underfunding Medicare ambulance reimbursement is disproportionately rural. Congress must recognize the fundamental flaw in this historical way that ambulance service has been reimbursed. Payments for rural ambulance services must be higher than urban payments. We urge Congress to set the urban ambulance payment rates at a level consistent with the national average cost of providing service and require CMS to adopt rural payment adjustments next year in a manner yet to be determined by the General Accounting Office. The proposed 4-year implementation plan works well for Minnesota, since we are a State that will see substantial revenue declines.

And finally, I would like to address the issue of cost versus charge. Ambulance service is a health care service that is delivered in the public safety environment, and when other sectors of health care have moved to fee schedules, as Administrator Scully mentioned, and we think that is a good thing, too, they have always started from a different model. Physicians, hospitals, physical therapists are all full-time providers and they are not tax subsidized. Our industry is different because we have some full-cost

providers. We have some very heavily taxed subsidized providers. and then we have volunteers.

So ambulance service charges have nothing to do with the cost, and because we have been on a historical charge payment system, unlike the other segments that moved to fee schedules, the $2.3 billion that you hear about has nothing to do with what the actual cost of providing the service is. It is average charges.

Thank you for the opportunity to address the Committee and I would be happy to answer any questions you might have.

Senator DAYTON. Thank you, Mr. Wingrove. Mr. Meijer.

TESTIMONY OF MARK D. MEIJER,[1] OWNER AND CEO, LIFE EMS AMBULANCE SERVICE

Mr. MEIJER. Good morning, Senator Dayton.

Senator DAYTON. Good morning.

Mr. MEIJER. Thank you very much for allowing me to be here this morning. I appreciate Gary's comments on his twins and their upcoming birthday. Being a fairly new first-time father, I could talk all morning about our new daughter. [Laughter.]

Mr. MEIJER. At any rate, I appreciate the staff and the guests here at the Senate Committee on Governmental Affairs for allowing us to be here. It is an honor to provide testimony this morning on behalf of the American Ambulance Association as well as on behalf of all of those across the country that may have to call 911 in the event of a medical emergency, as well as those of us that are entrusted with their care on a daily basis.

I am Mark Meijer and I am the immediate Past President of the American Ambulance Association and also a paramedic and President of Life EMS Ambulance, where our medics serve a combination of urban and rural areas throughout Western and Central Michigan.

Ambulance responders are often the first point of entry for patients in our Nation's health care system. Good emergency medical care not only saves lives, it also saves money. It saves money by providing immediate treatment of sudden illnesses and injuries and thus reducing the amount of hospital time and rehab time to deal with a patient's final outcome. In many respects, ambulance service can be described as the ultimate preventative medicine, which sometimes people think, how can that be, because we react to existing illness or injury occurrences. But, in essence, by preventing that illness or injury from becoming worse, we save a tremendous amount of dollars as well as lives for the country.

Due to the fact that Medicare beneficiaries make up a large portion of those patients needing ambulance treatment and transport, it is critical to the availability of the Nation's emergency medical safety net that Medicare provides an appropriate level of reimbursement in an efficient manner. Since Congress directed Medicare to cover ambulance transport years ago, it has often been difficult for many providers to be fully participating, in other words, to bill Medicare rather than the beneficiary for services provided, because of the program's historic low-cost payments and erratic claims processing history.

[1] The prepared statement of Mr. Meijer appears in the Appendix on page 54.

Just to recount a bit of history, when we first started Life EMS Ambulance, my first encounter with directing our company to begin participating with Medicare was an outgrowth of a patient that we transported, an elderly woman who had a hip fracture and happened to be friends of my parents. I was called by her husband to come over to the house and essentially sit down at their kitchen table to look at this pile of invoices and paperwork to do with this one hip fracture occurrence where he had claim forms and bills and what have you, and it was at that point in time that I decided that there is no way that the beneficiaries can be expected to bill for these services, that we have to be able to bill those and know how to do it efficiently as a provider of service, even though we were not happy with the payment levels or the process at that time, but we could not expect our patients to deal with that quagmire of paperwork.

Decades later, we are here today discussing below-cost payment levels, more specifically to do with the upcoming fee schedule, as well as erratic claims processing.

I appreciated Mr. Scully's comment at the outset, and those of us from the American Ambulance Association certainly appreciate Mr. Scully and Mr. Patel and all the folks at CMS for their generous amount of time in meeting with us, as well as being very candid in trying to work through some of the issues.

Some of the things that we would like to stress, and Mr. Scully referenced the negotiated rulemaking process being a consensus effort, it certainly was. I was President of the American Ambulance Association at that time and was involved in every one of those meetings, as were some of the folks in this room. And clearly, the American Ambulance Association stands behind the agreement that we entered into in the consensus making process in the negotiated rulemaking.

However, the issues that we have brought forth to CMS regarding the proposed rule and fee schedule have to do with things that then-HCFA, now CMS, did not allow us to address in the negotiated rulemaking process, that being primarily the proposed rate as well as getting into things like the condition codes that Gary has mentioned, which are critical to the success of any new national fee schedule. To move forward with the national fee schedule without having the condition codes in place would be an extremely dangerous move for this country's ambulance providers.

In addition to that, we certainly would like to mention that the American Ambulance Association has provided the basis for a crosswalk, as Mr. Scully identified one of the challenges of moving from the current payment coding situation to the condition codes. We have provided a basis for that and we certainly will work with CMS to make that condition code process happy.

Finally, I certainly would like to thank you, Senator Dayton, for introducing S. 1350. It certainly would address a lot of these issues in a very up-front manner and we appreciate the opportunity to describe some of our challenges here today.

Senator DAYTON. Thank you, Mr. Meijer.

Mr. Scully, I know you have to leave. Thank you very much for staying and listening to this panel and we look forward to working with you and your staff as you implement the new regulations and

also to make, hopefully, some of these other improvements, as well. So thank you very much. Will someone in your operation be able to stay here, then, for the balance of this testimony?

Mr. SCULLY. Yes. Hopefully, she will be here quickly. I can stay for a couple more minutes. Linda Fishman, who is the Policy Director at CMS and the former chief health care staffer for the Ways and Means Committee for a number of years, who is pretty familiar with a lot of these issues and has worked a lot on this regulation, is going to come in a minute.

I would just say one thing. I know it is frustrating. In the, for instance, Wisconsin Physician Services, the contractor, believe it or not, is actually one of our better contractors. It is a huge program, $240 billion a year, and we make lots of mistakes and do lots of dumb things and we are doing the best we can to fix it. Obviously, the situation with your parents and a lot of other problems, it is just the nature of having a massive program.

One of the things we are trying to do, which I have mentioned, is contractor reform, which I hope is going to pass the Senate and looks like it is going to pass the House, which would take the 51 contractors we have nationally and try to cull them back to a smaller, more manageable group of our better contractors, and generally what I have seen, believe it or not, Wisconsin Physician Services is one of our better contractors and does a pretty good job.

But it is just a very big program and a lot of people do not realize that when they get mad at Medicare, it is generally done through the 51 Blue Cross plans, Mutual of Omaha, and some others around the country that are our carriers and contractors, and getting everything right in the context of the program group, a little over 10 percent last year, in the context of an enormous program that is growing very fast, and probably too fast to be sustained in the long run, is not easy.

So we are doing the best we can, and obviously, you are going to find in a program that big a lot of indefensible things, and we do and they are certainly not intentional, but we are doing the best we can to fix them. Thank you.

Senator DAYTON. I appreciate that, and obviously, we all look for perfection that is not achievable in a big system. I would just make the observation that I think Dr. Lindquist's testimony was pretty compelling. As both a physician, a provider, and a person whose father and mother were directly involved by the nature of an ambulance service, each one is a crisis that involves someone's life or death situation. I think the impact of any of these denials, or the emotional effect of them are compounded by the nature of the milieu in which you and they are operating.

I would also say—and you are probably aware of this—I was particularly struck in Minnesota by the percentage of the costs of these, in many cases, small businesses and close-to-the-margin providers—the percentage of their operating cost that have to go into claims administration and refiling and the like. I certainly support what you said to the Administrator about the need for vigilance on the part of the payer, but also anything that can be done to make this whole process more efficient and, therefore, less costly and improves the quality of the service that can be provided and that serves everybody's purpose.

Mr. SCULLY. I do think, Senator, it will eventually be a better payment system and we will do everything we can to work with people like New Jersey who have some unique issues to make sure it works.

Senator DAYTON. And I look forward to being involved with you in that as well. Thank you very much for being with us today.

Let me ask a few questions here and invite each member of the panel then to respond in turn. Going back to the point I raised with Administrator Scully just a moment ago, can you give me an estimate of what percent of the claims that you believe, either in your service or in the system you are representing here today, that are denied at the first submission? Dr. Lindquist?

Dr. LINDQUIST. Well, the numbers vary greatly, anywhere from 20 percent all the way up to 85 percent. I believe in our system, our initial denial on the first submission of the bill is somewhere around 30 percent.

Senator DAYTON. OK. Dr. Pruden.

Dr. PRUDEN. We have no reason to dispute those numbers that were just reported by Dr. Lindquist. What would happen to our system, though, is we are presently reimbursed under Part A and reconciled at the end of the year and that would go away with initiation of the reimbursement process.

May I make a clarification on your condition statement?

Senator DAYTON. Please, yes.

Dr. PRUDEN. People may not understand what the condition statement versus an ICD–9 code means, but if you imagine a mother with a 2-year-old child who has a history of allergies to bee stings, severe allergic reactions, and the child gets stung by an insect. She is afraid the child is going to die. She calls 911. They send out paramedics and they get him to the hospital and they find out it was not a bee, it was something else. The ICD–9 code would reflect insect bite. That does not require a 911 call, but the paramedics and the BLS crew that were responding were responding to what they thought was a life-threatening condition, and that is why implementation of the condition codes is a critical component of this implementation process.

Senator DAYTON. That is an excellent example. That clarifies my understanding as well, so thank you. Mr. Wingrove.

Mr. WINGROVE. The numbers that Dr. Lindquist said represent Minnesota, but I think that the striking thing that I would like to point out is that of those claims that get denied, 90 percent of them are paid on appeal. We are wondering where the QA loop is on the other end, because the same claim keeps getting denied and denied and denied.

Senator DAYTON. Exactly. Thank you. Mr. Meijer.

Mr. MEIJER. Just briefly, from a national level, Senator, it varies wildly, and that is the challenges with all of the carriers in that in some States, providers are on 100 percent prepayment review and it has literally put operations out of business. It seems to kind of cycle around through carriers and through States. We went through this in Michigan a number of years ago, that actually put a number of ambulance services out of business.

Senator DAYTON. Thank you. Going to the other part of my comment, then, could you give me an estimate of what percentage of

you operating costs are associated with claims management, with the administrative side of that?

Dr. LINDQUIST. I personally cannot tell you with my companies. I leave that to the operations director and I pretty much stay with the medical direction of the company, so I cannot tell you.

Senator DAYTON. All right. Dr. Pruden?

Dr. PRUDEN. Again, I do not have specific numbers. I would venture to guess, based on other similar components of the system, as much as 20 percent to 30 percent of your office overhead is related to making claims.

Senator DAYTON. Thank you.

Mr. WINGROVE. I think that is in the ballpark. It is certainly the only part of our business that is growing. We are cutting to prepare for the fee schedule, but we are increasing staff in the business office.

Mr. MEIJER. And one of the critical aspects of that is not just the overhead of processing the claims but the timely payments. That is really what can be a disaster for, as you mentioned, Senator, ambulance services that operate on a low margin and the biggest part of our costs, of course, are payroll for our medics, and in order to make payroll, ambulance services need that consistent reimbursement, quite frankly. So it is the timely reimbursement that can be a huge cost to services and impact lives.

Senator DAYTON. Any closing remarks any of you would like to make, any point that was not made or you want to elaborate on for the record? Dr. Lindquist.

Dr. LINDQUIST. One thing that struck me when we were talking about the urban versus rural mileage differences, I realize that determining the nature of a community can be a little bit difficult, but if you are familiar with Crookston, Minnesota—Crookston is a small town of 7,000 people in Northwestern Minnesota. Its nearest town of any size is Grand Forks-East Grand Forks, which is probably around 60,000 or 70,000. But because of the county proximity to that metropolitan area, Crookston, Minnesota, is classified as an urban area for purposes of reimbursement, and under no circumstances could anyone visiting Crookston possibly confuse Crookston with an urban area. I think the nature by which these determinations are made needs to be readdressed, as well.

Senator DAYTON. Thank you.

Dr. PRUDEN. I think Congress and HCFA/CMS are to be commended for making an effort to get some control of the situation, but it is a very difficult animal to understand, and to pretend that a one-size-fits-all solution is going to solve the problem is difficult.

As Mr. Wingrove pointed out, to base your reimbursement on charges when charges do not adequately identify the costs, when you have a large volunteer system that does not generate any charges and then you are trying to reimburse based on that, on an average, it becomes very compounded. So I think we have to look more closely at identifying some of the difficulties that will accrue when this is implemented.

Senator DAYTON. Thank you. Mr. Wingrove.

Mr. WINGROVE. Senator, thank you. I would just like to mention that we think that implementation of these condition codes is very critical to solving this problem for beneficiaries of their claims

being denied and for providers who have to help them through that process when that happens.

I do not understand how it is so complex. There are 93 of them. It seems that someone could number them 1 through 93 and make a small change in the computer program, or just put a number in a field in a computer, in a field that we have for text, and someone on the other side could see that, and if one of the codes is there, they know it is medical necessary and the claim gets paid. If the code is not there, we can send that one in by hand if something did not match up into that system. So I do not understand that point and perhaps someone from CMS could delve into that a little deeper with us later.

Senator DAYTON. Well, I think your point is well made. It occurs to me that Administrator Scully committed to working with myself, with you, and others to undertake that process. Let them publish the final rules and then we will proceed on that immediately, because I think, as you say, this is one step either forward or backward, depending on your point of view, but we have got to take some other steps forward.

Mr. Meijer.

Mr. MEIJER. Thank you, Senator. Just to amplify the condition code aspect again, should the fee schedule move forward without the condition codes in place April 1, I think it will be a disaster for emergency ambulance services across the country, and we are committed to assisting that process happening and are confident, just as Gary described, that it can be done by then.

I think, as the Administrator mentioned, the spirit of the consensus process of negotiated rulemaking was very strong. A lot of us in this room spent a lot of time there, and clearly one of the resounding things that came out of that process was the overall support for condition codes from all areas of providers and how everybody identified that that is critical in making this work, and I think very consistent with CMS's mission, as we heard earlier, of simplifying the coding process in the claims processing scenario that we all encounter, the condition codes would clearly do that. Thank you very much.

Senator DAYTON. Thank you very much. Thank you all, gentlemen, for being here today, for your testimony. If you would like to submit any additional testimony for the record, please do so by November 21. Otherwise, again, I assure you that I will be working with you and others in the industry with CMS to try to minimize whatever damage is done by these new regulations, and also moving with you to work on some of these other areas as quickly as possible. Thank you very much.

Our next panel, we have Laura Dummit, the Director of Health Care-Medicare Payment Issues for the U.S. General Accounting Office; Lori Moore, Assistant to the General President for EMS Services for the International Association of Firefighters; and Chief John Sinclair, Secretary of the Emergency Medical Services Section of the International Association of Fire Chiefs. Welcome to all of you.

Let us begin with you, Ms. Dummit. Welcome.

TESTIMONY OF LAURA A. DUMMIT,[1] DIRECTOR, HEALTH CARE-MEDICARE PAYMENT ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Ms. DUMMIT. Thank you. Senator Dayton, I am pleased to be here today to discuss Medicare's payment and coverage policies for ambulance services.

We all understand the important role of ambulance transports in a locality's system of emergency medical services. Providers must be ready to provide emergency transport services rapidly and at all times. However, maintaining this ready stance may be difficult for rural providers because of their special geographic and economic circumstances.

In our July 2000 report on rural ambulances, we note the need to consider these circumstances in developing appropriate payment policies. Rural ambulance providers, which may serve sparsely populated areas, typically have fewer transports than their urban counterparts. Thus, they have fewer trips over which to spread fixed costs, such as staff salaries and vehicle maintenance. In addition, rural providers tend to have longer trips and, therefore, log greater mileage and staff time. Longer distances translate not only into higher fuel costs, but also the higher costs of maintaining backup capacity as emergency equipment and staff may be unavailable for lengthy periods.

Rural providers can also find themselves to be the only means of transportation in areas lacking taxis, van services, or public transportation. This can be a particular problem when a State or local government requires an ambulance provider to respond to all emergency calls, even if the patient's condition does not warrant payment under Medicare's criteria.

Finally, questions have been raised about the continued availability of volunteer staff. When volunteers cannot be recruited, providers have to hire salaried staff, which increases the cost of providing services.

Vagaries in the way Medicare now pays for ambulances have added to the challenges facing rural providers. Medicare's current payment method has produced wide variation in payments for the same service. For example, Medicare paid providers in North Dakota about $120 more per service than providers in Montana for the same service. Similarly, it paid providers in Wyoming about $4 more per mile of ambulance transport than providers in South Dakota.

About 2 months after our report was issued, CMS, then called HCFA, published a proposed ambulance fee schedule specifying preset payment rates. This schedule is expected to reduce payment variations. Fees will vary by the type of service provided and account for geographic cost differences. The fee schedule will raise payments for providers now receiving payment below the national average. Thus, many rural providers will actually see an increase in Medicare payments under the fee schedule.

In addition, there will be a payment adjustment for providers that transport beneficiaries in rural areas. This adjustment is intended to recognize the higher costs of essential, isolated ambu-

[1] The prepared statement of Ms. Dummit appears in the Appendix on page 67.

lance providers. We are concerned, however, that the increased payment applies to an excessively broad set of providers, so it may not adequately target essential providers in isolated areas. Further, the increased payment is tied to the mileage reimbursement rather than the preset rates for services, so it may not adequately help those providers with too few transports to cover their fixed costs. In responding to our 2000 report, HCFA stated that it plans to work with the ambulance industry to develop an alternative adjustment.

What ambulance services Medicare will cover is also important in ensuring access. Providers have noted inconsistent treatment of claims, leading to concerns about the fairness of claims payment decisions. In the past, claims approval and denial decisions have been problematic as, among other things, ambulance providers lack standard documentation methods for reporting a patient's condition at the time of pick-up. CMS has taken steps to clarify Medicare coverage criteria and educate providers on aspects of the claims process.

In conclusion, we believe that Medicare payment policy for ambulance services is moving in the right direction in that the proposed fee schedule seeks to link providers' payments to the resources required to provide those services. Nevertheless, we all know that Medicare's payment rates are only as sound as the data supporting them. Thus, we believe that ongoing data gathering and analysis are critical to enable Medicare to revise rates as needed.

Most importantly, attention needs to be given to the refinement of the rural payment adjustment so that it appropriately targets providers that most need it. The consequences of paying inappropriately for ambulance services can result in limiting access to some of Medicare's most vulnerable beneficiaries or introducing opportunities to exploit the benefit.

Senator Dayton, as we move forward with the General Accounting Office's forthcoming study of the costs of providing ambulance services, particularly in rural areas, we look forward to working with you and the Congress, and also, undoubtedly, we will be speaking with many of the organizations that are represented here in this hearing. Thank you.

Senator DAYTON. Thank you, Ms. Dummit. Thank you.

Chief Sinclair, welcome.

TESTIMONY OF DEPUTY CHIEF JOHN SINCLAIR,[1] SECRETARY, EMERGENCY MEDICAL SERVICES SECTION, INTERNATIONAL ASSOCIATION OF FIRE CHIEFS

Chief SINCLAIR. Good morning, Senator. Mr. Chairman and Senate staff, my name is John Sinclair and I am the Deputy Chief of Operations for Central Pierce Fire and Rescue in Takoma, Washington, and I am also the Secretary of the EMS Section of the International Association of Fire Chiefs. I represented, along with other team members, the International Association of Fire Chiefs on the negotiated rulemaking body that drafted several components of the Medicare ambulance fee schedule.

[1] The prepared statement of Chief Sinclair appears in the Appendix on page 80.

I represent the fire chiefs and other senior managers of the more than 31,000 fire departments across the United States. While prehospital emergency systems are noted for a wide range of organizations that provide emergency medical care and ambulance transport, there is one unifying force in nearly all EMS systems nationwide: The critical role of local fire departments.

In over 80 percent of America's communities, fire departments are the provider of EMS of first response. In addition, the fire service is the single largest provider of ambulance transport, comprising over one-third of the Centers for Medicare and Medicaid Services ambulance transport services.

Mr. Chairman, before turning over to the business of the hearing, I would like to thank you for your efforts on behalf of emergency and medical services everywhere. Recent events have certainly demonstrated the critical importance of local EMS systems in the event of a natural or manmade disaster.

The issues this Committee is hearing about today, timely and adequate reimbursement for ambulance transport services, are tremendously important to ensuring that local EMS systems have the necessary resources to serve their communities in times of great need.

In 1997, Congress passed a Balanced Budget Act that mandated a single fee schedule for ambulance reimbursement in the United States. The new fee schedule, created through negotiated rulemaking process, reflects the consensus of our industry on a wide variety of issues. There are, however, several issues that were designated as being off the table by, at that time, HCFA. We view two of these issues as being the most critical to successful implementation of the new fee schedule.

First, the proposed reimbursement rate must be raised to reflect the actual cost of providing ambulance transport.

Second, CMS should implement the system of condition codes that have been talked about by several other people. The implementation of these codes will reduce the number of denied and delayed claims that are a result of current practices and minimize the substantial administrative burden of seeking reimbursement from Medicare patients.

The issue of determining the cost of ambulance transport is notoriously difficult. The structure of EMS systems varies widely across the United States, which makes it difficult to estimate costs around the industry. However, we believe it is critical that Medicare reimbursement reflect, to the maximum extent possible, the actual cost of providing the service.

Mr. Chairman, you recently introduced a bill, the Medicare Ambulance Payment Reform Act of 2001, S. 1350 that would require CMS to set the reimbursement rates based on the average cost of service. We strongly encourage Congress to direct CMS to set reimbursement rates on that basis.

Of great concern to all ambulance providers is the extremely uneven and seemingly arbitrary manner in which claims are accepted for or denied payment by the Medicare carriers. The General Accounting Office report on rural ambulance payment under the proposed fee schedule notes that there are significant and somewhat inexplicable disparities in denial rates across the carriers. The re-

port states that difficulties with claims review and subsequent denial levels are exacerbated by the lack of a national coding system that easily identifies the beneficiary's health condition and links it to the appropriate level of service.

Let me provide the Committee with a very short example. One of the most frequent calls received by EMS providers is for a patient with severe chest pain. Given the possibility of a life-threatening cardiac event, EMS providers will aggressively treat the patient as they rapidly transport to the hospital. Upon arrival, the patient is ultimately diagnosed not with a heart attack but with a case of severe indigestion. While it is impossible for the firefighters in the field to know the patient's actual condition, CMS would refuse to reimburse the transport, deeming it medically unnecessary.

Mr. Chairman, this situation is simply unacceptable. Firefighters in the field need to make rapid decisions based on the best interest of the patient. To tie reimbursement to the patient's diagnosis and not to the condition of that patient on the scene is dangerous to both the individual patient came and the long-term financial health of our local EMS system.

A subcommittee of the negotiated rulemaking body developed a comprehensive list of medical conditions codes. This list represents a monumental effort to provide clarity to the issue of patient condition and should be utilized as recommended. Its implementation would greatly reduce the number of delayed and denied claims and ease the administrative burden upon local fire departments.

Finally, we are concerned about the poor coordination of Medicare policy through the carriers. It is clear from previous experience that discrepancies exist between policy development by CMS and the implementation and the administration by the carriers. Recently, we have become concerned that the implementation of the new fee schedule will be plagued by poor coordination, as it has become clear that many of the carriers have fundamental misunderstandings of basic definitions and level of service designated by CMS. Given the significant impact the new fee schedule will have on local government finances across the country, it is imperative that CMS implement the fee schedule with as little administrative confusion as possible.

America's fire departments are the backbone of the Nation's emergency medical response system, providing over 60 percent of the Nation's emergency ambulance transports. It is essential for the financial stability of our local governments that claims filed for Medicare patients be processed and paid in a prompt, efficient, and fair manner and that the amount paid reflect the actual cost of providing the service.

Mr. Chairman, the solutions that we have outlined above will significantly aid America's fire service as we adapt to the reality of the new ambulance fee schedule. We encourage Congress to direct CMS to take these steps to ensure the financial stability of the Nation's local EMS system so that we may maintain the highest level of emergency health care for our patients.

Thank you for providing me with the opportunity to testify before you today. I will be happy to answer any questions.

Senator DAYTON. Thank you, Chief Sinclair, and thank you and all of your members for the outstanding dedicated service you provide to our country. Thank you.

Chief SINCLAIR. Thank you.

Senator DAYTON. Ms. Moore.

TESTIMONY OF LORI MOORE,[1] MPH, EMT–P, ASSISTANT TO THE GENERAL PRESIDENT, INTERNATIONAL ASSOCIATION OF FIREFIGHTERS (IAFF)

Ms. MOORE. Thank you, Senator. My name is Lori Moore and I am here today to represent the 250,000 professional firefighters throughout the United States and their provision as the leader in emergency medical services in this country, providing EMS to more than 80 percent of this population.

I also represent the General President, Harold Schaitberger, and on his behalf, we will present our comments and our position on some of the things that have been said this morning as well as our written testimony that has been submitted. So if I may, I would just like to speak openly to that rather than following the written testimony.

I am, in fact, a paramedic and have been since 1984, operating in a large metropolitan system in Memphis, Tennessee, and am now a specialist in EMS system design, evaluation, and performance measurement, so I am familiar with most systems throughout this country and, in fact, have participated in designing the operations of many of those systems. We certainly appreciate the opportunity to speak on this fee schedule as well as some of the other issues that have been presented this morning.

Just to reiterate some of the information that Mr. Scully presented earlier so that everyone in the room understands what took place in the process of negotiated rulemaking, there is today and has been historically some discrepancy throughout the United States on payment for Medicare services provided through ambulance services. Again, as the gentlewoman to my right said, there are discrepancies city to city for the exact same service. I will give you an exact dollar amount, where in parts of California for an advanced life support transport pays as much as $541. The exact same service here in Washington, DC, $113. There is a discrepancy for you. That is what the fee schedule was designed to eliminate.

That is why in the 1997 Balanced Budget Act, we were directed to come together as industry leaders to negotiate a fee schedule, and that is, indeed, what occurred. The organizations, leadership from all of the organizations sat at the table. I was one of those that sat at the table, and none of the others, I would add, that have testified this morning were actually in those negotiations or signed on the dotted line. We all signed the agreement that we could live with what was negotiated at that table and that is what we expect to be implemented by HCFA, or now CMS.

That fee schedule was something that we all talked through. We looked at all the data that was available at the time and we all agreed that we could live with it. That includes all industry providers. We all compromised, including the International Association

[1] The prepared statement of Ms. Moore appears in the Appendix on page 83.

of Firefighters, as we were there seeking certainly payment for treatment separate from transport, because under Medicare law today, you have to transport the patient before you can be paid. Much of the emergency medical services that are delivered in this country are delivered separate and prior to the arrival of an ambulance on the scene. So no longer is emergency medicine linked to that patient transport, and yet we compromised our position on that for the betterment of the good and eliminating those discrepancies in payment throughout this country today.

There were also other considerations that took place. We did consider the rural providers. There was an adjustment made in there and everyone stipulated it was an adjustment that we could live with through the mileage adjustment that was made for the rural providers. We considered labor costs. We considered call volume. We considered historical charges and the way that was done.

So the process that took place throughout the negotiated rulemaking and the integrity of that process must be maintained and Congress should encourage CMS to implement that fee schedule as it has been negotiated.

We will, however, and stipulate to the fact that there are denials of claims that should not be taking place. We will, however, also say that through the implementation of the negotiated rulemaking fee schedule as it was negotiated, and specific instruction to both the carriers and the fiscal intermediaries that this can be eliminated, that is what is going to have to take place. As the fee schedule is implemented, we have to give the instruction to these carriers, to the fiscal intermediaries on how they are to process these claims. That can be also handled through the process as has been laid out to date.

One other thing I would like to remind everyone in this room is that Medicare was never meant to be a funding source for emergency medical services systems in this country. That is the responsibility of local governments and local governments should take on and carry forward that responsibility. Medicare is designed as an entitlement program to pay for the services that Medicare beneficiaries use, not to fund the base of those systems. Just so there is a point of clarification as to the intent of what Medicare is supposed to be providing.

With that, sir, I will sum up, and again encouraging that the fee schedule be implemented as it was designed and that Congress encourage CMS to do so. Thank you.

Senator DAYTON. Thank you very much.

I am a member of the Senate Agriculture Committee, which is marking up the reauthorization of the Federal law for the next 6 years and I have an amendment that I need to get there to introduce on behalf of Minnesota farmers, so I am going to need to bring this hearing to a conclusion. I would like to reserve the right to ask questions in writing to this panel and the others, as well.[1]

If you have any additional comments you would like to submit for the record, the record will remain open until November 21.

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[1] The question and response from Mr. Scully submitted by Senator Thompson appears in the Appendix on page 123.

There are other letters including one from the Oregon Ambulance Association [1] and also a prepared statement from Steven Murphy, the CEO of National Products and Services for American Medical Response, and without objection, those will be inserted in the record, as well as any other items that anyone wishes to submit before November 21.[2]

With that, I want to thank you very much for your presence here today and I will conclude the hearing. Thank you.

[Whereupon, at 10:51 a.m., the Committee was adjourned.]

[1] The letter from the Oregon State Ambulance Association appears in the Appendix on page 105.

[2] The prepared statement American Medical Response submitted for the record appears in the Appendix on page 113.

APPENDIX

PREPARED STATEMENT OF SENATOR TORRICELLI

Mr. TORRICELLI. Healthcare in New Jersey has a long history of innovation and advancement. From the large number of pharmaceutical companies that create new medicines, to the hospitals and facilities where innovative therapies are developed, New Jersey remains one of the most progressive healthcare States in the country. Our State was one of the first to introduce and pass a comprehensive patient's bill of rights, and one of the first to recognize the importance of expanding access to healthcare to children and low income families.

One of New Jersey's greatest innovations, and one which truly demonstrates the community based approach which has been so successful, is the development of our Emergency Medical Services (EMS) system. The current EMS system in New Jersey, which has been in place for roughly 25 years, was designed as a modern remedy to the age old problem of guaranteeing access to emergency transport, while at the same time preserving local involvement in the delivery of services and preventing skyrocketing costs.

The New Jersey EMS system accomplished all three goals by establishing a two-tiered approach to emergency transport. This two-tiered system includes volunteer and for-profit Emergency Medical Technicians (EMTs) who provide basic life support (BLS), and hospital-based paramedics, who provide advanced life support (ALS). Basic and advanced life support are differentiated by the status of the victim, with the most serious injuries, such as heart attacks, treated by ALS paramedics.

The two-tiered system has been an unqualified success in New Jersey, providing universal access for all residents to affordable emergency services, while simultaneously ensuring that those persons in need of the most advanced care receive it from the proper authorities. The system allows almost 500 local volunteer emergency medical technician (EMT) squads to blanket the entire State with quick and effective initial responses to emergencies. In the case of more serious emergencies, paramedics are strategically stationed at various hospitals throughout the State to provide secondary assistance. In either case, the EMTs will generally transport patients to the hospital with the paramedics along, if necessary, to provide additional care.

There are currently an estimated 20,000 EMTs providing ambulance transportation for virtually all BLS and ALS emergencies, close to 400,000 calls each year. It is estimated that over 80 percent of these calls are handled by volunteers who are not reimbursed by Medicare. In contrast, the hospital-based paramedics, also known as mobile intensive care units (MICUs), are reimbursed by Medicare when they respond to ALS emergencies, just as all other paramedics.

Unfortunately, the great success of this system would be jeopardized if the Centers for Medicare and Medicaid Services (CMS) finalizes plans to implement new rules on EMS services, required when Congress enacted the Balanced Budget Act (BBA). While I applaud CMS' intentions in enacting a new fee schedule, which is designed to control costs by enforcing one, standardized, system throughout the country, I am dismayed by the impact this will have on New Jersey, an impact that runs counter to the spirit of the BBA and the intent of the fee schedule itself.

The proposed Medicare Ambulance Fee Schedule would, in essence, require paramedics to be the only responders to provide transport for victims, regardless of medical condition, in order to be reimbursed by Medicare. This, in turn, would eliminate the two-tier structure by solely recognizing MICUs, and thus also eliminate the need for volunteer EMS units, which currently provide the bulk of the transport. Under the new rules, there would be no incentive for EMS units to respond to calls if they know their mission has been given to MICUs.

Our system, when compared to the system CMS is set to approve, would save an estimated $39 million annually, due to the preponderance of BLS calls and the large

number of EMS volunteers who respond to these calls. But beyond the cost savings, the limitation of EMS units would jeopardize the prompt service that New Jersey residents have come to rely on.

This hearing is not the first time the Senate has considered the impact a proposed fee schedule would have on Emergency Medical Services. In a resolution I sponsored that was passed last year during consideration of the FY 2001 Labor/Education/HHS Appropriations bill (S. Amendment 3612 to H.R. 4577), the Senate unanimously agreed that any changes to Medicare's reimbursement for EMS must take into account unique systems such as New Jersey's, and that HCFA (now CMS) must do its best to preserve this highly beneficial and cost effective system. While a Senate Resolution, as we all know, is non-binding, it certainly does signal the intent of the Senate to closely monitor subsequent developments. CMS has always been a strong supporter of measures that improve the delivery of healthcare services, while lowering the cost to taxpayers. In passing this amendment last year, the Senate reaffirmed its belief that once CMS had been made fully aware of the importance of this issue, the agency would act responsibly. To date, CMS has not fully acknowledged that any new fee schedule would hurt the two-tiered system in New Jersey, nor has CMS committed to preserving the system.

While undoubtedly my interest in the Medicare Ambulance Fee Schedule arises primarily from the impact it would have on New Jersey, I am concerned about the national scope of the matter as well. Dozens of States, not just New Jersey, stand to be negatively affected by the new fee schedule as it now stands. In recognition of this, I was pleased to recently become a cosponsor of the Medicare Ambulance Payment Reform Act, Senator Dayton's bill to ensure that the new fee schedule is based on the national average of ambulance service, and not harmful to emergency responders. This bill represents a strong effort to address the clear problem that the new fee schedule presents, namely, that reimbursements will not be high enough to allow responders to continue their work.

It is my hope that this hearing will finally provide CMS with the impetus to implement a fair fee schedule, one that takes into account the unique systems in place throughout the country.

TESTIMONY OF
THOMAS A. SCULLY
ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
MEDICARE PAYMENTS FOR AMBULANCE SERVICES
BEFORE THE
SENATE GOVERNMENT AFFAIRS COMMITTEE

November 15, 2001

Chairman Lieberman, Senator Thompson, distinguished Committee members, thank you for inviting me to discuss Medicare payments for ambulance services. I have always been sensitive to the vital role that emergency providers play in caring for Medicare beneficiaries, and the tragic events of the last two months have ensured that every American is aware of how important these men and women are to our society. Now, more than ever, I am highly aware of the importance of ensuring these brave providers receive appropriate payment for the care they give. Although we are still in the last stages of finalizing the ambulance fee schedule, I am pleased to talk with you about the value of using a fee schedule to pay for ambulance services, as well as the process we are using to develop the final rule.

Currently, Medicare pays for ambulance services based on the amount providers historically charged for their services. This payment system is outdated, and has led to large discrepancies in payments in different geographic areas, which are unrelated to providers' actual current costs. Years ago, we began moving all of the other major Part B services toward payment based on fee schedules, which more accurately reflect the resources used in providing services. Fee schedules also are able to reflect regional cost differences, limit inappropriate price increases, and adjust prices appropriately for inflation, along with other benefits. In the Balanced Budget Act of 1997 (BBA), Congress wisely mandated that Medicare also pay for

ambulance services based on a national fee schedule. Since then, we have been working to develop an ambulance fee schedule that is fair and that most effectively advances our goal of ensuring that Medicare beneficiaries receive the high quality care they deserve while safeguarding taxpayer dollars by paying appropriately for these services.

Congress also mandated that we use a collaborative approach to develop the fee schedule rule, working with the broad group of interests that will be impacted by it. We completed this process of "negotiated rulemaking," and published a proposed rule in the *Federal Register*, seeking even more public input. We received hundreds of suggestions and comments in response to the proposal, we have considered them carefully, and now we are in the last stages of finalizing the rule.

Mr. Chairman, I appreciate that you and the rest of the Committee are very interested in ensuring that Medicare beneficiaries receive high quality health care, and that Medicare providers are paid appropriately for this care. We share your dedication to these goals. The ambulance fee schedule, once finalized, will be a tremendous improvement for Medicare.

BACKGROUND

The Centers for Medicare and Medicaid Services (CMS) pay for the health care of nearly 40 million Medicare beneficiaries. We strive to be prudent purchasers of care, paying appropriately for health services so physicians and providers can give high quality care to our beneficiaries. At the same time, we have a duty to the taxpayers to safeguard the Medicare trust fund. Striking this balance is an inexact science, and we work hard to get it right.

By law, Medicare covers medically necessary ambulance services, but only when no other transportation is appropriate for the beneficiary's medical condition and when the provider meets basic vehicle and staffing requirements. The specific methodologies that we use to pay for Medicare services are established for us in law. For the most part, we pay physicians and providers for Medicare Part B services, which are mostly outpatient services, based on fee schedules. These services are assigned a specific, predetermined base payment rate that we adjust to account for differences in wages and other local costs. We also update the fee schedules annually to account for inflation, technological improvements, and other events that might raise or lower the cost of providing Medicare services.

We have not always paid for Part B services this way. In fact, we still pay for ambulance services the way we used to pay for all Part B services. If the ambulance service is given by a hospital-based provider, we pay the individual providers' "reasonable costs" for the services, subject to an inflation cap imposed by BBA. If the service is given by an entity that is independent of a hospital or other institutional provider, we call the entity a "supplier" and we pay them based on "reasonable charges." Like reasonable costs, reasonable charges are subject to an inflation cap. As a reasonable charge, we pay the lowest of the customary, prevailing, actual, or inflation-indexed charge, based on historic patterns at the local level. These historic patterns are now out of date and have resulted in unjustifiably wide variation in payment rates for the same service, depending on where the service is provided. Additionally, the old payment methodology is administratively burdensome and requires substantial record keeping.

AMBULANCE FEE SCHEDULE

Recognizing the limitations of cost- and charge-based payment systems, Congress has taken steps to improve the way Medicare pays for its beneficiaries' health care. For years, Medicare has been moving towards prospective payment systems and fee schedules as more appropriate ways to pay for health care. For ambulance services, Congress took this step in 1997. In the BBA, Congress wisely mandated that we replace the existing ambulance payment methodologies with a national fee schedule. The new fee schedule will standardize payment rates for providers and suppliers, and will set national base rates for services.

Congress also required us to develop the rule through negotiated rulemaking, which requires a committee of representatives of all of the interests that may be significantly affected by the rule, including the agency, to develop the rule. The idea behind negotiated rulemaking is to reach consensus on the content of the proposed rule, which is then published for further public comment. This tends to involve the most interested parties earlier in the process, ensuring that the rule is acceptable to them before it is ever formally proposed. The parties involved in the ambulance fee schedule negotiated rulemaking process represented a wide range of industry interests, including urban, rural, volunteer, independent, hospital-based, ground, and air ambulance service providers, as well as emergency physicians. In addition to CMS, they included the American Ambulance Association; American Hospital Association; Association of Air Medical Services; International Association of Fire Fighters; International Association of Fire Chiefs; National Volunteer Fire Council; National Association of Counties; National Association of State Emergency Medical Services Directors; and National Association of EMS

Physicians. The negotiations were coordinated by neutral facilitators from the Federal Mediation and Conciliation Service.

Although a rulemaking committee typically has the flexibility to develop the specifics of the rule, Congress sets the framework within which the committee must operate. The BBA laid out a number of requirements for the ambulance fee schedule, including:

- Ensure the aggregate payment to ambulance providers and suppliers during the fee schedule's first year does not exceed the aggregate amount that would have been paid that year under the old methodology;
- Establish ways to control increases in expenditures for ambulance services;
- Establish definitions for ambulance services that link payments to the type of services provided;
- Consider appropriate regional and operational differences that impact the cost of caring for Medicare beneficiaries;
- Consider adjustments to payment rates for inflation and other relevant factors;
- Phase-in the fee schedule in an efficient and fair manner; and,
- Require ambulance suppliers and providers to accept assignment, which means accepting Medicare's allowed payment amount as payment in full. This protects Medicare beneficiaries from being billed for any part of the ambulance service other than unmet Part B deductible or coinsurance amounts.

The committee began negotiating in February 1999, and for an entire year the members considered a wide variety of complex issues. In February 2000, once the negotiations were

complete, all of the committee members signed a consensus agreement. In that agreement, the committee provided for:

- Seven levels of service intensity and complexity to replace the two current levels of "basic" and "advanced" life support;
- A base payment rate, plus a separate mileage payment adjusted to account for the costs associated with each level of ambulance service;
- Higher payment for services that qualify as an "emergency response," where a lower-level service costs the ambulance supplier more because the supplier began as quickly as possible to take all of the steps necessary to respond to the call;
- Payment adjustments to recognize geographic "cost of living" differences, and the higher costs of delivering services in less densely populated rural areas;
- Incorporation of the annual updates mandated by the BBA to account for inflation; and,
- A four-year phase-in of the fee schedule, with payment in the first three years based on a blend of the old and new methodologies, and 100 percent payment under the fee schedule in the fourth year.

The input of the affected parties during the negotiated rulemaking was invaluable; and as we developed the proposed rule, published in the *Federal Register* in September 2000, we tried to follow the consensus agreement reached in the negotiations as closely as possible. In addition to the parameters set by the negotiated agreement, the proposed rule addressed a number of other issues, including:

- Revised requirements for physician certification of non-emergency services, making it easier for ambulance suppliers to document that the service they provided was eligible for Medicare coverage;
- Inclusion of certain services, which currently may be paid separately, in the fee schedule's base rate. This change eliminates the need for ambulance suppliers to bill separately for items such as oxygen, drugs, extra attendants, and EKG testing;
- Payment based on the patient's medical needs regardless of state or local ordinances creating all-advanced life support systems. This policy adheres to the Medicare statutory requirement to link payments to the types of services provided; and,
- Implementation of mandatory assignment when the fee schedule phase-in begins, as required by BBA.

The proposed rule included a 60-day comment period for the public to provide us with additional input to improve the rule. We received literally hundreds of comments regarding practically every aspect of the proposal, and we considered them closely. There are several issues that have proven to be particularly challenging. For instance, we know rural ambulance providers face unique challenges in delivering care. Through the negotiated rulemaking process and our further development of the rule, we have worked hard to address these and other concerns. We are now in the last phases of completing the rule, and we expect to publish it as soon as possible.

CONCLUSION

Emergency providers have played a selfless, vital role in America over the last two months, and for many years, and the entire country is aware of how important these providers are to our health care system. And we know that Medicare beneficiaries, in particular, depend on ambulance providers for high quality care practically every day. We are striving to ensure that these providers are paid appropriately for this care. The process of negotiated rulemaking allowed interested parties impacted by the ambulance fee schedule to play an integral part in developing the proposed rule. As we have worked to finalize the rule, we have stood by our commitment to adhere to the rulemaking committee's consensus agreement as closely as possible. Once the rule is finalized, and the fee schedule is implemented, Medicare's ambulance payment system will be vastly improved and will pay more appropriately for services than it does today. I appreciate your dedication to improving the way Medicare pays for ambulance services, and the opportunity to discuss this important issue with you today. I am happy to answer your questions.

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Prepared statement of Mark D. Linquist, M.D., Medical Director, Emergency Department, St. Mary's Regional Health Center

I wish to thank Chairman Lieberman and Ranking Member Thompson for inviting me to appear before this committee to discuss the proliferation of Medicare denials of ambulance claims and the inconsistent application of standards with regard to claim adjudication. I also wish to thank Senator Dayton for his hard work on the issues we are discussing today. I am honored to be present for this hearing.

I am an emergency physician practicing in Detroit Lakes, Minnesota. I am the Medical Director of four Advanced Life Support air and ground ambulance services and eight police, fire and rescue departments in Minnesota. I am also the co-owner of an air ambulance service, an ambulance billing and consulting company, and until recently, two ground ALS ambulance services.

On July 17th, 2000, my 69 year-old father suddenly collapsed while painting a gazebo in the back yard of his home in Moorhead, Minnesota. My mother was trapped inside the gazebo for a short time, as my father was lying unconscious against the door, bleeding from a head wound. She was eventually able to push the door open, moving him away enough to go to a phone and call 911.

Fargo-Moorhead Ambulance Service paramedics arrived quickly. My father began to regain consciousness. He had marked post-concussion confusion and agitation. Whether he also had neck or other injuries was unknown at that time. He was brought by ambulance to the Emergency Department at a Fargo hospital, where an evaluation showed the presence of a large, complex brain aneurysm. My father's sudden collapse had been caused by a small leakage of blood from the aneurysm, an event usually followed within a month by a catastrophic aneurysm rupture and massive brain bleeding.

Because of the size, location and complexity of the aneurysm, he was referred to a neurosurgeon at the University of Minnesota who specializes in aneurysm repair, and he underwent surgery on July 28th. The long, complex surgery resulted in a serious

secondary brain injury. He subsequently developed serious infections and respiratory failure, and he died on August 13th, 2000.

Medicare initially denied payment of the $500 911 ambulance call to his home where he had collapsed. The explanation from WPS, the HCFA contracted carrier, stated that the ambulance transfer from his home to the hospital was not medically necessary. Apparently, according to WPS, my 67 year-old mother should have been able to load his 190 pound body into a car and drive him to the hospital.

Upon being informed that the claim had been denied, my mother promptly paid the ambulance bill. It was only when I asked her several weeks later whether my father's medical bills were being covered that she told me the claim had been denied by Medicare. Like most non-medical laypersons, she was unaware that 20% or more of all Medicare ambulance claims are denied by HCFA contracted carriers. I urged her to obtain a letter explaining medical necessity from the attending physician and appeal the denial. The bill was resubmitted to Medicare, along with a letter from my father's attending neurologist explaining why the ambulance transport had been necessary. The explanatory letter was returned to the neurologist by a WPS customer service employee, who stated he did not understand the purpose of the letter. The bill was resubmitted a third time and was finally partially paid by Medicare after the third submission.

Needless to say, my mother was perplexed. She did not understand why the ambulance claims were denied, as she felt strongly that skilled emergency medical care was required when my father collapsed. I have been unable to give her a logical explanation, and I am frankly disgusted by the disregard shown by WPS for the competent medical judgment of my father's physicians.

As an owner of ambulance services and an ambulance billing company, I am very aware of these frequent claim denials, including cases where payment has been denied

for patients in complete cardiac arrest, the explanation being given that an ambulance transport was not necessary, even though the patient's heart had stopped beating.

This summer, the mother of one of my employees was brought by ambulance to a hospital in Fargo after developing pneumonia while recovering from a broken hip. The one-year mortality rate for patients recovering from a fractured hip is as high as 50% because of such complications. The woman was short of breath, had low blood oxygen levels and a build up of fluid in her chest, and she died 16 hours after being brought to the hospital. WPS stated the ambulance transfer was not medically necessary and denied payment of the claim. The patient's daughter, who is a flight nurse, resubmitted the claim with a harsh letter, and it was ultimately partially paid.

The Prudent Layperson Standard contained in ***Senate Bill 1350, The Medicare Ambulance Payment Reform Act of 2001*** states that if a prudent, non-medically trained layperson has reason to believe that a medical emergency exists when calling for an ambulance, Medicare would be required to pay the claim. Currently, an ambulance claim filed by a patient who suffered chest pain can be denied if he or she is eventually found to have a non-cardiac source of pain. Of course, at the time of the initial symptoms, it is impossible for the patient, paramedics or even emergency physicians to know that the source of pain is not an emergency condition.

I ask you to carefully consider implementing the Prudent Layperson Standard as part of ***Senate Bill 1350,The Medicare Ambulance Payment Reform Act of 2001.*** The standard would eliminate much of the inconsistency currently found in the payment or denial of Medicare claims. Thank you for the opportunity to address this committee.

US Senate Governmental Affairs Committee
Hearing on Ambulance Service & Medicare Program
Thursday, November 15, 2001
Remarks by James N. Pruden, MD, FACEP
NJ EMS Coalition

New Jersey EMS leaders have found themselves confronted with a proposed Medicare Ambulance Fee Schedule that threatens to dismantle the states EMS system. How did this happen and what does it mean?

In attempting to formulate a one size fits all fee schedule, the Negotiating Rulemaking Committee (NRC), established by HCFA [CMS] to formulate the regulations, completely ignored New Jerseys unique EMS system. For NJ EMS, the proposed fee schedule is a blueprint for disaster.

The Balanced Budget Act of 1997 mandates: The Secretary will consider appropriate regional and operational differences. Because New Jerseys operational differences were never allowed on the NRC table the resulting fee schedule did not take into consideration the states enormous volunteer BLS contingent. In fact there was no representative from the volunteer segment of the prehospital community on the NRC. In addition, the committee did not examine how the fee schedule would impact each state individually. If these regulations are implemented, New Jerseys EMS system, which provides the highest standard of patient care in the country, will cease to exist.

In order to understand the implications of the proposed regulations, it is first necessary to understand how NJs EMS system works.

New Jersey has a two-tiered EMS system which provides Advanced Life Support (ALS= paramedic services) as well as Basic Life Support (BLS= emergency medical technicians=EMTs). Customarily, ALS does not transport patients. BLS does.

Paramedics (ALS), are the highest level of prehospital medical technicians and are dispatched only to life-threatening medical emergencies, such as difficulty breathing, chest pain, and severe allergic reactions. Presently, every citizen in NJ has access to immediate Mobile Intensive Care Unit, or MICU treatment whenever and wherever the need arises.

By law, MICUs are typically part of a hospital and bound by a state certificate of need (CN). Also, MICUs are prohibited by law from transporting patients, but some do transport as a last resort, as for example, when no BLS ambulance is available. As you can imagine, paramedic service is not cheap: If treated, a hospital charges the patient an average of $525.

EMTs (BLS) provide emergency medical treatment and ambulance transport. EMTs are not as highly trained as paramedics, but can support a patients life with defibrillation, CPR, and oxygen and other modalities. EMTs are dispatched for all calls and are responsible for transporting the patient to the hospital in their ambulances. If the patient has a life threatening medical emergency, the paramedics are dispatched simultaneously with the EMTs. However, since the vast majority of 9-1-1 dispatches are not life-threatening medical emergencies, most ambulance calls in New Jersey are handled solely by EMTs.

BLS is provided by both volunteer and proprietary squads. Eighty percent of New Jersey BLS squads are volunteer and do not charge the patient or his insurance for their service. (There are 330 volunteer squads representing approximately 20,000 volunteer EMTs.) The volunteers transport approximately 400,000 patients annually - 85% of the total number of patients transported to hospitals -- providing approximately 48 million dollars of transport service at no cost annually.

Proprietary BLS, i.e., fee for service, operates primarily in big cities, for example, Trenton, Camden and Newark. These commercial BLS providers bill patients and insurance carriers for their service.

When ALS treats the patient and he is transported by proprietary BLS, only one bill is generated to Medicare/Medicaid. Under a billing agreement, the MICU splits the fee then pays the BLS provider its transport portion.

What will the proposed Medicare Ambulance Fee Schedule do to NJ EMS?

At a conversion rate of $152.52, NJ MICUs stand to lose, at a minimum, an estimated $150 per Medicare patient. (Those patients account for about 50% of MICU revenues annually.) If the MICUs treat and transport a patient using a proprietary ambulance, the reimbursement would be split between the two providers and ALS payment would decrease another $200. At this rate, MICUs, and the hospitals sponsoring them, would stand to lose about $19.5 million a year statewide.

How would hospitals recoup their losses? Two ways.

By curtailing ALS services, i.e., delete coverage areas that yield fewer patients. NJs unique 100% BLS and ALS coverage would cease to exist. A patient suffering a heart attack in the less populated areas of New Jersey would not get MICU treatment. Citizens would suffer increased morbidity and mortality.

New Jersey ALS would be forced to transport patients along with fee-for-service and volunteer squads. Once ALS begins transporting patients, they are in direct competition for transport dollars with proprietary BLS. Turf wars would be inevitable. Worse yet, volunteer squads would cease to operate as their services would be redundant. They would not feel the need to offer their services with ALS treating and transporting. Within a decade, volunteer first aid squads would cease to operate. Medicare would then be billed for services that volunteers in NJ have provided its taxpayers free for 74 years. This would cost Medicare an estimated $39 million annually!

In addition, that savings does not reflect the millions of dollars volunteer first aid squad save the citizens of NJ on disasters. Of the approximately 450 NJ ambulances that responded to the World Trade Center incident on Tuesday, September 11th, 90% were volunteer. Hundreds more responded over the next two weeks. Disasters cost billions; volunteers save millions.

There is an additional saving that the present ALS system provides Medicare. Nationwide, 30% of ambulance transports are accompanied by ALS units. Because NJ ALS units are independent of the BLS squads, only 13% of patients transported by ambulance are accompanied by ALS units. By having medics respond independently, we cut the number of calls requiring paramedic intervention in half, compared to the national average.

What are CMS options?

Any change in the way our system operates will destroy the volunteers and cost the federal government more money in NJ. We urge CMS to:

allow our non-transport MICUs to continue billing under Medicare Part A with reconciliation on the year-end cost report at current rates. We acknowledge that only one bill is permissible under Medicare regulation. We ask that the current configuration be allowed to continue. That is ALS contracts with the BLS provider and one bill is submitted.

keep Advanced Life Support (ALS) reimbursements at their present rates.

leave the volunteers to continue transport and treatment of patients in our communities thereby saving the citizens of NJ and Medicare millions of dollars.

The NJ EMS Coalition submits that based upon the specific language and intent of the 97 Balanced Budget Act, CMS (HCFA) has the legal authority to grant waivers or carve-outs to states. It is imperative that the federal government recognize that our present EMS system saves federal tax dollars. The proposed Medicare Ambulance Fee Schedule threatens to kill the volunteer system entirely by forcing ALS providers into the ambulance transport business. Paradoxically, this will cost the federal Medicare program millions of dollars more.

US Senate Governmental Affairs Committee Testimony
November 15, 2001

Gary L. Wingrove, EMT-P
Minnesota Ambulance Association

Mr. Chair and Members of the Committee:

My name is Gary Wingrove. I am a paramedic and manager at Gold Cross Ambulance. We are a unit of Mayo Medical Transport, a non-profit division of the Mayo Foundation for Medical Education and Research based in Rochester, Minnesota. I am here today representing the Minnesota Ambulance Association (MAA). MAA president Buck McAlpin is also present.

There are two major problems facing the ambulance industry in Minnesota and throughout the nation. These include a severe increase in the number of denied Medicare emergency ambulance claims and the impact of the proposed fee schedule.

Denied Medicare Ambulance Claims:

I would like to tell you about some Minnesotans who have used ambulance service.

- A gentleman was traveling the wrong direction down the freeway. After some time, the Minnesota State Patrol was able to get the vehicle stopped. The driver of the car was confused and did not know where he was. The officer summoned an ambulance to transport him to the hospital. Among other treatment, the paramedics started an IV.
- A woman had an implanted defibrillator that failed to function. She was in cardiac arrest. The paramedics were summoned and successfully resuscitated her using an external manual defibrillator.
- A gentleman went to the grocery store. He became unconscious while still driving his car in the parking lot. His car slammed into a light pole and the tires were burning black smoke as his foot was still against the accelerator. The police and paramedics were summoned. He was conscious when the paramedics arrived and he was treated with high concentrations of oxygen, and an IV and was transported to the hospital.
- A woman was moving a mattress in her apartment. She lost her balance. The mattress fell on top of her and she couldn't breathe. She screamed for help and her neighbor called 9-1-1. The paramedics arrived and removed the mattress. She had excruciating back pain and couldn't move.

While two of these people live in urban areas and two in rural areas, they all have a few things in common. They are all over 65. They all have Medicare as their primary health care insurance. They were all transported to hospitals for physician evaluation, diagnosis and treatment. Medicare paid all of their hospital, physician, lab and diagnostic bills. Yet, all of their ambulance claims were denied. The reason given by the contractors was that the ambulance was "not medically necessary." We disagree, and like the beneficiaries, we are outraged that this occurred.

In July 2000, the General Accounting Office (GAO) notified CMS and some members of Congress that there is a problem with Medicare contractors denying emergency ambulance claims.[1] The GAO described variation in payment policy by contractors by saying "these discrepancies can translate into unequal coverage for beneficiaries."

Denied emergency ambulance claims place ambulance services and beneficiaries in a tough position. When Medicare contractors determine an ambulance is unnecessary, the beneficiary is liable for the entire claim. Many beneficiaries do not understand why Medicare thought the ambulance was unnecessary. Next time they think twice before calling 9-1-1. On the urging of ambulance services, for those that do decide appeal their denied claim, we find that 90% of the claims are paid on the first appeal attempt[2]. One of our members reports that they frequently have to fax pages from the carrier's ambulance billing manual back to them because they give wrong information over the telephone both to the provider and to beneficiaries.

Some Minnesota ambulance companies who bill through Medicare's carrier are experiencing 70% claim denial rates on the first submission. Often times, on identical ambulance trips with two different beneficiaries who have identically coded claims, one claim is paid and the other isn't. We have even seen cases where a beneficiary has been to the hospital and discharged and had to return for the same medical problem, and on identically coded claims (except for the date) for the same beneficiary, one is paid and the other is denied.

In January of this year, the Medicare contractor processing hospital-based ambulance claims in our state put those ambulance services on "focused review." This means they suspended 100% of the claims and required the provider to submit both the ambulance run form and hospital records before they would process the claims. This is not an easy task to complete. Hospitals do not simply photocopy private medical records because an ambulance service asks them to. The ambulance service must locate the beneficiary and get a release for their medical records and then make the request of the hospital the patient was treated at to obtain the records. This was confusing to our members, because the contractor that processes these ambulance claims also processes all the hospital claims in our state. They already have what records they should need to pay the ambulance claim, because they have the records to process the hospital claim. By the middle of 2001, one of our hospital-based providers had over 1,500 unpaid Medicare claims totaling over $6 million. This Medicare contractor is also over-riding the decisions of physicians who determine that air ambulances are necessary and instead are sometimes paying air claims at ground rates.

Last year the GAO commented that "... HCFA officials agree, that the national medical coverage criteria for ambulance services are vague. Generally, Medicare coverage policies are set by individual carriers rather than nationally by HCFA. Consequently, similar claims may be treated differently across carriers." [3]

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[1] United States General Accounting Office, *Rural Ambulances: Medicare Fee Schedule Payments Could Be Better Targeted*, GAO/HEHS-00-115 (Washington, DC, July 2000).

[2] There are three levels of appeal. The first appeal is a second review of the claim by an employee of the contractor who did not participate in the initial determination. If that employee upholds the denial, the decision can be appealed to a Hearing Officer employed by the contractor. If the claim denial is upheld, it can be appealed to an Administrative Law Judge.

[3] Ibid, page 20.

Mr. Chair and Members of the Committee, we submit that the only person who should be allowed to determine whether a medical emergency exists is the person who decides whether or not to dial 9-1-1. It definitely should not be a non-medical clerk in a contractor's office.

There are two things Congress can do to fix this problem. First, Congress should establish a Prudent Layperson standard for the payment of emergency ambulance claims. Secondly, beneficiaries, providers and the contractors should have the tools necessary in advance to know if any claim is going to be paid by Medicare, whether emergent or not. This can be done if Congress directs CMS to adopt the condition coding system they participated in developing as part of the Ambulance Fee Schedule Negotiated Rulemaking process.

Paramedics do not diagnose, yet the only coding system we are allowed to use today was developed for physician use and is diagnosis-based. By adopting this new condition coding system, beneficiaries, providers and contractors would all know in advance whether an ambulance transport would meet the medical necessity test. If the beneficiary's condition matches a code specified in this set at the time of transport, the test of medical necessity is met. This condition coding system also links conditions to levels of ambulance service. For those cases where a beneficiary legitimately needs an ambulance but there isn't a condition code that matches their condition, then the contractor can process those claims manually to determine medical necessity. For those cases where the beneficiary didn't need an ambulance at all but wanted to use one for their convenience, the Medicare contractor will appropriately deny those claims in the future because the provider will have coded them for denial.

The Medicare Ambulance Fee Schedule

Ambulance service in the United States is a complex public trust. The application of EMS is provided to communities throughout the U.S as a health care service through diverse models including for-profit and non-profit, volunteer and paid, government services (police, fire and third service), hospitals, private entities, healthcare organizations, entrepreneurs and publicly traded companies.

EMS is a system containing a variety of components that include 9-1-1 telephone access, first responders, trained ambulance personnel and hospitals. Today's system was largely developed with the passage of the federal EMS Support Act of 1973. In this provision Congress appropriated funding for the development of EMS systems. With the exception of providing for federal agency programs, there has been little funding for EMS systems provided by Congress since that initial Act in 1973. Consequently, EMS systems vary widely in the United States in terms of their organization, operation, quality and access.

The federal Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) has described the current Medicare ambulance payment methods as "not based on reliable cost data. Instead they simply reflect historical charges."[4] The Medicare program has reimbursed ambulance service in a fee-for-service model since 1965. While the Medicare program went

[4] *Medicare Payments for Ambulance Services – Comparisons to Non-Medicare Payers*, OEI-09-95-00411, January 1999.

through structural reimbursement changes over time, ambulance service charges were capped in 1985 and reimbursement switched to the inflation-index model using a reasonable charge methodology. These payments were based on historical charges that were averaged geographically. Since then, reimbursement rates have consistently been limited to levels that fall below the cost-of-living index.

Some states used to cap, or even prohibit, volunteer ambulance services from seeking reimbursement for their costs. Many volunteer ambulance services that were highly subsidized followed the practice of charging "token" amounts of $25. These $25 "bills" were averaged with the bills of full-cost full-time providers to come up with average payments that would apply to a specific geography. This explains why many states with large rural geography ended up with lower reimbursement levels. The "token bills" of volunteer providers and subsidized bills of heavily tax-supported providers significantly dropped the average charge of all providers.

The OIG, when recommending that HCFA "develop a cost model that can be used as a basis for refining the fee schedule as needed to respond to emerging conditions," has concluded that such "historical charge data contain distortions and variations that undermine their usefulness as a basis for the new payment system."[5] The OIG continues, "we were unable to locate any sources of cost data that we could use to determine the reasonableness of Medicare rates… this type of information is not widely available."

Since 1965 most health care providers have transitioned through one or more reimbursement methods. Physicians and physical therapists, among others, have moved to a fee schedule structure. Hospitals are reimbursed in a variety of methods today, depending on the service provided. **In each of these cases, however, the formula for restructuring reimbursement has always started from a full-cost model**. This is not true for ambulance service. The BBA required CMS to develop a fee schedule for ambulance service providers that is **revenue-neutral** using a negotiated rule-making (NRM) proceeding. Those proceedings occurred between February 1999 and February 2000. The proposed rule evolving from these sessions will begin implementation in April 2002.

We do not know the actual number of ambulance services in the US that are either tax subsidized or reliant on the contributions of volunteer labor. But to illustrate this problem of not starting with a full-cost model, we could estimate that one-third of the ambulance providers are full-cost, one third of the providers are tax subsidized and one-third of the providers are volunteer. In this scenario, one-third of the providers are billing the full-cost of ambulance service (the full-cost providers), one-third are billing perhaps 50% of the cost (the tax subsidized providers) and one-third of the providers are billing perhaps 20% of the cost (the volunteers). In this example, Medicare is only being billed little more than 50% of the actual cost of providing service.

The average ambulance service in Minnesota has a payor-mix that is 50% Medicare. We are predicting a 50% decrease in reimbursement in our state as a result of the combination of mandatory Medicare assignment and the implementation of the proposed ambulance fee schedule. This means that the average Minnesota ambulance service will lose 25% of its total revenue (50% of the payment on 50% of the transports). The ambulance industry in Minnesota

[5] *Medicare Ambulance Payments: A Framework for Change*, OEI-12-99-00280, April 1999.

bills approximately $140 million per year, and we are predicting a decline in revenue of $37 million due to the adoption of the fee schedule and mandatory Medicare assignment.

While the anticipated payment rates are inadequate for urban providers, the situation is much worse for rural providers. Many rural government-operated ambulance services predict financial insolvency. Some ambulance services are anticipating reduction in service provided to Medicare beneficiaries from paramedic-level ALS to EMT-level BLS. A letter from the Minnesota Emergency Medical Services Regulatory Board (EMSRB) warns local and state elected officials expressing concern due to the impact of the BBA. The letter says, "As the state board responsible for regulating licensed ambulance services, we are concerned that a significant reduction in reimbursement and mandatory assignment of payment may impact the quality of pre-hospital emergency care provided the citizens and the visitors within Minnesota communities." The letter continues, "we strongly recommend that public and private policy makers vigorously plan for this coming fiscal impact on ambulance operations ..." It also warned that these changes may result "in significant financial shortfalls for ambulance services, because many already operate on a very small margin or even at a loss. It is possible that some ambulance services will fail."[6] (Emphasis added). The EMSRB issued a second similar letter to local and state elected officials and included our members of Congress this year when the implementation of the fee schedule was delayed.

Even though the fee schedule has not yet been implemented, some ambulance services around the country are already in dire financial straits. According to the January 2001 edition of the EMS Insider (a publication related to the Journal of Emergency Medical Services) the following have events already occurred. The article says, "Stories gleaned from local U.S. papers offer evidence that many EMS providers—private, hospital-based, public and volunteer—have recently had to cut their services or even close their doors. *The causes:* Shrinking revenues, rising costs, disappearing volunteers, closing hospitals and combinations of those."

- Prestonburg, Ky., disbanded its five-year-old municipal ambulance service in November 2000 because it had lost money every year.
- Webster County, Ky. reported its ambulance service has lost $9,529 a month and expects matters to worsen as coal companies, which have helped subsidize the ambulance service, close down.
- Citing financial problems, Southern Hill County Ambulance Service, Hubbard, Texas, went out of business last summer, forcing several small cities to rely on services more than 25 miles away.
- East Texas Medical Center, which provides EMS to dozens of rural communities in west Texas, notified residents of Honey Grove, Texas, that it would cease providing 24-hour coverage to the town. Beginning Dec. 1, 2000, ETMC will station a unit in Honey Grove only from 7 a.m. to 4 p.m. on Tuesday through Saturday; at other times it will send an ambulance from a town 20 miles away. The town has no first-responder service.
- Huron Hospital of East Cleveland, Ohio, announced on Oct. 13 that it was losing $250,000 to $400,000 annually by providing ambulance service and asked the city to take

[6] A letter from the Minnesota Emergency Medical Services Regulatory Board to State Senators, State Representatives, County Board Chairs and City Mayors, July 14, 1999.

over EMS by April 1. East Cleveland, which has been in a state-declared fiscal emergency since 1983, said it would explore its options.

- Redlands, Calif., Mayor Pat Gilbreath said the city would likely cut paramedic service after voters failed to approve an increase in the annual per-household assessment.

Though greater Minnesota makes up 47% of the state's population, it has 97% of the geography[7] and includes 57% (367,261)[8] of Minnesota's Medicare beneficiaries. Greater Minnesotans are older and poorer than the state as a whole, with both rural families and the rural health care system disproportionately dependent on the Medicare program. Many counties in greater Minnesota have a higher proportion of elderly than the state average. Some counties have twice as high a percentage of elderly residents (25%) as the state average of 12.5%. Of the 84,450 Minnesotans age 85 or older, 58.4% are in greater Minnesota.

Medicare beneficiaries make up approximately 32% of the health care business in urban Minnesota, and Medicaid is about 3%. In greater Minnesota Medicare is about 45% and Medicaid is about 10%. In rural Minnesota, Medicare is 70-80% and Medicaid is about 10-15%. Ambulance services must be available to meet the public's need for service 24 hours a day. In an urban core environment like downtown Minneapolis a single ambulance can reasonably be expected to perform 12-15 transports in 24 hours. In greater Minnesota locales it takes 3 full-time ambulances to complete 15 transports in 24 hours because of the way the calls come in, large distances traveled for each call and because of the need for complete long-distance hospital transfers. In rural Minnesota, one ambulance must be on duty 24 hours a day, but only 15 transports may occur in a week. While the cost per hour is almost identical in greater Minnesota as urban Minnesota, the revenue per day must either cover 3 units instead of one, or the ambulance service must make one day of urban reimbursement last an entire week. The problem of under-funding Medicare ambulance reimbursement is disproportionately rural.

We are not suggesting that Congress abandon the fee schedule. The disparity of payments between states[9] for ambulance service is just as wide as the disparity in AAPCC rates. The payments should be nationalized. Congress must recognize, however, this fundamental flaw in the historical way ambulance service has been reimbursed. Payments for rural ambulance services must be higher than urban payments. We suggest that Congress set the urban ambulance payment rates at a level consistent with the national average cost of providing service and require CMS to adopt rural payment adjustments next year in a manner yet to be determined by the General Accounting Office.[10] The proposed 4-year implementation plan works well for Minnesota, since we are a state that will see substantial revenue declines.

Thank you for the opportunity to address the Committee.

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[7] Population and geography figures are based on 1998 estimates by the Minnesota State Demographer's Office.
[8] Source: Minnesota Department of Human Services.
[9] We estimate that ambulance service Medicare payment rates under the fee schedule will improve over IIC payments in 12 states and territories, will average relatively the same in 8 states, and diminish for the majority of providers in 32 the remaining states and territories. Today some states have multiple payment rates.
[10] The Benefits Improvement and Protection Act of 2000 requires the GAO to report to Congress on rural ambulance service costs in June 2002.

Testimony of Mark Meijer
American Ambulance Association

Chairman Lieberman, Ranking Member Thompson, Senator Dayton and members of the Senate Committee on Governmental Affairs, on behalf of the American Ambulance Association (AAA), thank you for this opportunity to testify before you today. My name is Mark Meijer, and I am the Immediate-Past President of the American Ambulance Association and owner and C.E.O. of Life EMS Ambulance Service of Grand Rapids, Michigan. Life EMS provides emergency and non-emergency Basic and Advanced Life Support services to the communities of Grand Rapids, Kalamazoo, Lansing as well as many rural portions of Michigan including Ionia, Newaygo and Lake Counties.

The American Ambulance Association represents for-profit, not-for-profit and public ambulance services that provide emergency and non-emergency medical transportation services to over 95% of the U.S. urban population. As a result, many of our members provide the critical 9-1-1 and emergency ambulance services that comprise the backbone of our nation's health care safety net. The AAA was formed in 1979 to respond to the need for improvements in ambulance and emergency medical services. Today, the Association serves as a primary voice and clearinghouse for ambulance providers nationwide.

As former president of the AAA and a current member of its Board of Directors, I hear from ambulance service providers across the country regarding problems with Medicare claims administration as well as the impact that the proposed Medicare ambulance fee schedule will have on their organization. As an ambulance service provider myself, I also have firsthand knowledge of these issues. It is with these experiences in mind that I sit before you today.

Medicare Ambulance Fee Schedule

Under the Balanced Budget Act of 1997, Congress mandated that ambulance services be placed on a fee schedule for Medicare reimbursement. To develop the fee schedule, Congress required that a Negotiated Rulemaking Committee be convened to establish certain policies of the fee schedule.

The AAA was a member of the Negotiated Rule Making Committee and is, for the most part, pleased with the process and outcome of the issues the Committee was allowed to debate and negotiate during the proceedings. It is important to understand that the issues that most of us bring to you today with regard to the problems that will undoubtedly result from the implementation of the fee schedule were NOT a part of these negotiations. From the start of the negotiations, the representatives on the Negotiated Rule Making Committee who represented the Health Care Financing Administration (HCFA) insisted that issues of critical importance were deemed "off the table" and would not be discussed as a part of the process. Again, let me stress that the AAA has not

disputed the outcome of the negotiations. However, we believe that the Centers for Medicare and Medicaid (CMS) intends to implement the fee schedule without regard to certain decisions made by the Negotiated Rule Making Committee and without a reasonable solution to issues that they received numerous comments about in response to their Proposed Rule published last year.

We have met with CMS personnel on numerous occasions and have included the following issues in each of our meetings, comments and correspondence. While we have been very pleased that the new staff at CMS has been very supportive and have helped us with several of the issues we have brought to their attention, we believe there are still several issues that must be resolved to ensure that providers and beneficiaries will not be negatively impacted.

Need for Use of Current Data to Calculate Fees

Originally, the fee schedule was to be implemented in January of the year 2000. Data used to calculate both the baseline budget or "pot of money" which is then used to derive the base fees for the new fee schedule was to be based upon the most current calendar year's data available at the time – 1998. Due to the problems associated with Y2K issues and other issues which have arisen since then, the fee schedule is now scheduled for implementation sometime in 2002. Many changes have occurred in our industry and with Medicare claims processing systems since we initially began discussing the fee schedule. As a result, we believe that current data is far more reflective of the industry today and is more accurate of dollars spent for the volume of services performed. We have made a good case that CMS should use the most current data available now for the 2002 implementation which would be the calendar year 2000. Because of staffing issues and the additional time and effort it would take to perform the recalculation using the current data, CMS has refused to use the more current and accurate data to derive the fee schedule reimbursement levels. We believe this will cause the base fee to be far less than it should be. Because many ambulance providers will already suffer large declines in reimbursement with the new fees, this refusal to ensure that every dollar of current monies spent on ambulance services is included in the pot of money will surely worsen the negative impact on these providers.

Implementation of Condition Codes

A working group of the Negotiated Rulemaking Committee developed a list of condition codes and the Committee voted unanimously for these codes to be used to more accurately communicate the medical need for ambulance by describing the condition of our patient at the time of transport. Currently, we are forced to use a standardized list of diagnostic codes that are used in the hospital and facility settings after the patient has undergone diagnostic review and appropriate testing to arrive at the true nature of the problem. We do not diagnose patients – we treat the condition of our patients as we see it BEFORE

the patient is tested at the hospital. We have been asked to fit a round peg into a square hole for decades and believe strongly that we have unanimously agreed upon a system that will allow us to communicate exactly what we do in the setting we work within. Regardless of this unanimous agreement, it is our understanding that CMS intends to move forward with the fee schedule implementation without using the new set of condition codes. The definitions of service that were developed by the NRM committee are linked directly to this list of conditions and we continue to stress that the fee schedule cannot and should not be implemented without the condition codes. The condition codes MUST be implemented simultaneously with the rest of the fee schedule.

Below Cost Reimbursement

The ambulance industry has been under enormous financial stress for many years. Ambulance service providers have historically been reimbursed for their services at levels far below their true operating costs. A recent Project Hope study reports the average cost of providing the most basic level of ambulance service at $236.58. Under the Proposed Rule, CMS has stated that the reimbursement level for this same service will be $161.09. Thus, once the fee schedule is implemented, ambulance providers will be required to provide services to Medicare beneficiaries while losing an average of $75.00 for every transport.

With Medicare patients comprising 50% of total transports for our industry on average, we cannot shoulder this burden of below cost reimbursement and still remain in operation. Ambulance providers which deliver services to Medicare beneficiaries are also, in most cases, providing 9-1-1 emergency medical services in their local communities. These dramatic Medicare reimbursement cuts will seriously degrade our entire nation's emergency response system.

We urge you to do whatever is necessary to ensure that this does not happen. Ambulance providers should be able to cover their cost of providing service to Medicare beneficiaries and the fees should be increased accordingly to ensure that beneficiary access does not suffer as a result of the negative impact of the fee schedule.

Denials of Ambulance Claims

With Medicare reimbursement accounting for 50% of an ambulance service provider's revenue on average, the denial of a significant number of claims by a Medicare carrier can cause severe financial hardship for an ambulance service provider and their ability to not only serve Medicare patients, but their entire community.

Claim denial problems that ambulance service providers face are totally carrier dependent. Ambulance providers who have the same carrier often find that

similar claims are being denied, while providers who submit claims to different carriers have no problems with reimbursement for the same type of claim. This is because Medicare carriers do not implement Medicare policy on a consistent basis. This results in a nightmare for ambulance service providers who are trying to determine why there claims are being denied.

Providers often learn that there is a perceived problem with their claims submissions totally by accident. There is no standard requirement that carriers contact a provider if a problem or issue is discovered with their claims. Carriers usually begin to mass deny claims or simply place a provider on a prepayment review process which requires providers to provide large quantities of additional documentation to become eligible for payment. In the case of an ambulance provider, this documentation requested is often not even within our possession. Carriers often require hospital discharge reports or medical charts from skilled nursing facilities and expect ambulance providers to somehow obtain this information – even though they do not have direct access or sometimes the permission to obtain these files. If these documents cannot be retrieved which is often the case, the claims are simply denied by the carrier. This causes a huge financial burden for beneficiaries since they then become responsible for the ambulance bill which SHOULD have been paid by Medicare.

We believe that the condition code system would substantially reduce the problems resulting from our inability to effectively communicate the true nature of our patient encounters. Once we are given an effective means of describing the patient condition that requires an ambulance transport at the time we render our service, we believe that claims denials, appeals and hearings will be unnecessary and claims will be paid or denied correctly from point of the initial submission.

Since our members communicate problems with claims denials and carrier issues on a continuous basis and request our assistance and advice to resolve these issues, the AAA has a good idea of these problems and their status as a part of our everyday activity. We have put together a summary for you and I will be submitting this as a part of my written statement. This summary will show you the problems ambulance providers regularly face with carriers across the country and the complicated process it currently takes to resolve these issues. Unfortunately, all too often, the cash flow shortages that are caused by these unnecessary denials and claims processing delays result in operational reductions, negative quality impacts and in some cases, providers are forced to close their doors to their service altogether.

Solutions To Reduce Number of Ambulance Claim Denials

In addition to the necessity of implementing the condition codes simultaneously with the fee schedule, which will go a long way toward solving many of these claims denial problems, we have also put together a list of more technical

recommendations which would help reduce the amount of problems for providers, carriers and beneficiaries and result in a far more efficient and effective claims processing system. I am submitting this list of recommendations as part of our written statement.

Conclusion

Once again, thank you for allowing me to testify before you today on behalf of the American Ambulance Association. I would be happy to respond to any questions, either today in person or later in writing, that the members of the Committee may have on these issues.

Examples of Carrier Issues and Problems

The American Ambulance Association submits the following summary of examples of carrier issues and problems that have caused many suppliers to decrease the level of the services they are able to offer to beneficiaries, or in some situations, close their doors to their businesses altogether. Carrier problems can take inordinate lengths of time to resolve. As Medicare reimbursement averages over 50% of an ambulance provider's cash flow, lengthy problems with claims denials and inappropriate reimbursement of submitted claims can be devastating.

Railroad Retiree's Medicare Claims Administration (Claims Administrated by Palmetto Government Benefits Administrators)

Although the volume of an ambulance provider's claims submitted to the Railroad Retiree Claims Administration may be small, they are by far the most difficult and cumbersome claims to obtain appropriate reimbursement. Although the industry has attempted to work with Palmetto GBA who administers these claims under contract by CMS, we have had no success in resolving the problems. Current unresolved problems with these claims include, but are not limited to, the following issues:

- Inappropriate denial rates are extremely high. Claims, which clearly satisfy coverage requirements for payment, are routinely denied as not medically necessary services. Examples include:
  - Emergency claims that should clearly be paid are denied.
  - Non-emergent transports for bed confined patients are denied.

- Claims are routinely denied for "lack of information" when all information required by CMS regulations are initially submitted by the provider.
  - Physician Certifications are submitted but ignored during claims administration.

- Utilizing electronic claims submission is impossible since the claim will simply be denied.
  - The carrier ignores information in the narrative comment field within the electronic record, which is critical to communicating that the transport was medically necessary, and satisfies payment terms.
  - The carrier requests a hard copy of the Patient Care Record completed by the crew as well as a hard copy of the Physician Certification statement (for non-emergent transports) before they process any claim. Carriers who process all other Medicare claims do not routinely require these paper documents for electronically submitted claims.

- CMS payment policies are not followed when administering claims.
  - Advanced Life Support claims are paid using completely different criteria than stated in CMS claims processing polices.

- Because Palmetto GBA adjudicates claims nationally for all Railroad Retiree beneficiaries, they are not aware of services that are offered locally by area facilities. The carrier routinely denies claims appropriately submitted by suppliers, due to the lack of this local knowledge. For example, a transport from one hospital to another to obtain a higher level of care not present at the initial facility, normally a covered service, is routinely denied by Palmetto GBA since they are unaware of the different services that are offered at individual hospitals at the local level. These claims must ALWAYS be resubmitted and are normally overturned and paid once the carrier does the required research into the capabilities of the local facilities involved with the transport.

Minnesota (Claims administered by Wisconsin Physician Services – WPS and Noridian)

Minnesota ambulance operators continue to experience huge difficulties with appropriate claims processing and reimbursement from WPS (the company that administers claims for non-hospital based ambulance suppliers) and Noridian of North Dakota (the company that administers claims for hospital-based ambulance providers).

WPS Problems include the following:

- There has been a significant increase in denied claims since January 2001. Some companies report medical necessity denials of 70% or higher.
- Inconsistent claims processing – identically coded claims are submitted and some are paid and some are denied.
- Appeals have become incredibly cumbersome. Suppliers have to appeal everything; even when WPS has admitted the problem is their error.
- Suppliers are incorrectly told that they may not bill the beneficiary if the claim is being appealed which does not follow CMS guidelines.
- Telephone claims reviews are not granted by WPS, which is a normal step before an appeal process, which is routinely granted by other carriers in the claims adjudication process.
- In July 2001, when a huge problem already existed with claims processing delays, the Minnesota provider services department was closed and WPS referred all calls to their Illinois call center. It now takes over 2 days to get a returned telephone call to answer provider related issues.
- Covered charges for supplies and drugs are routinely denied which should be paid.
- Physician Certification Statements are being required for transports that are not within the scope of this requirement outlined in the CMS regulations.
- Transports for dialysis patients are routinely denied even though they meet CMS coverage guidelines.

Noridian Problems include the following:

- The provider call center is unable to provide timely, adequate and consistent information.

- The beneficiary call center routinely informs beneficiaries that the provider has not yet submitted their claim, even though the claim has already been processed and denied by Noridian.

- All ambulance services were placed on "focused review" in January 2001. As a result, providers are required to submit not only ambulance records for claims review, but entire hospital records for the patient as well. It is believed that Noridian is basing their payment on the ultimate diagnosis made for the patient after their hospital testing and treatment has occurred rather than the condition of the patient at the time of the ambulance transport. One provider reports that at one time during this year, over 1,500 claims were outstanding with Noridian while this unnecessary review was conducted.

- Noridian frequently reports that they are not receiving claims, medical records and appeals that providers are submitting. As a result, providers have been forced to send claims manually through a method that requires a signature for proof of delivery, which adds substantial cost and delays to the claims process.

- Because secondary payers routinely require a denial from Medicare to process a claim for payment, providers will submit a claim to the carrier using a code that instructs the carrier to automatically deny payment so that the claim can be submitted to the patient's secondary insurer. Noridian routinely pays these claims coded for denial which causes huge confusion and additional processing requirements by providers who must then reimburse Noridian and ask that the claim be reprocessed correctly before payment can be sought by the alternative insurer.

- In May 2001, one Minnesota ambulance provider notified Noridian that their computer was incorrectly calculating patient co-pay amounts. As a result, Noridian is now withholding payment on *ALL* claims until the problem is fixed. Providers have also been notified that when the computer glitch has been rectified, Noridian will hold providers accountable for any incorrectly processed claims.

- Noridian routinely ignores information submitted in narrative fields on electronic claims, which results in large quantities of denials for lack of medical necessity, even though the information has been properly submitted on the claim.

Mississippi (Claims formerly administered by United Healthcare)

In 1998, the former claims carrier, United Healthcare, began denying claims in huge percentages. Cash flow problems within the provider community were enormous. Senator Trent Lott (R-MS) and other elected officials had to become deeply involved to resolve the problems and these individuals need to be credited for saving the entire local ambulance supplier community from extinction. The problem began when the carrier reviewed some Focused Medical Review Data and determined that Mississippi suppliers were receiving twice the national average for Advanced Life Support emergency ambulance transports. There was a very easy explanation to this anomaly, but the carrier did not ask for any explanation from the provider community and simply began incorrectly denying claims in large percentages. The majority of these claims were then appealed and overturned for payment, causing huge processing delays, cash flow shortages and significant and unnecessary processing costs for the industry and the carrier. The largest provider in the state reported denials that were overturned on appeal at 75% in 1999, 72% in 2000 and 79% in 2001. This carrier no longer services the Mississippi ambulance community.

Upstate New York – (Claims administered by Blue Cross Blue Shield of Western New York)

This carrier placed most of the larger ambulance suppliers in the area on pre-payment review for all claims submitted involving a patient transported after a hospital discharge. The carrier demanded hospital discharge summaries as a part of the submitted record, which were not in the possession of the ambulance supplier and were very difficult, and in some cases, impossible to obtain. Claims were then routinely denied as "not medically necessary", even when this document was obtained. The cash flow problems that ensued were severe and denial rates soared to 84% by the fall of 2000. Senator Charles Schumer (D-NY) intervened on behalf of the industry and with the help of high-level CMS and HHS personnel, the carrier finally terminated the pre-payment review action in the late spring of 2001. In a June 20, 2001 letter from HHS Secretary Thompson to Senator Schumer, the Secretary indicated that the denial rate for hospital discharge transports had been reduced from 84% to 23% in April of 2001. Secretary Thompson also verified that the carrier had been using incorrect payment review criteria to satisfy coverage requirements, which had also been rectified prior to his correspondence. Unfortunately, since this problem had taken over a year to resolve many ambulance suppliers were forced to institute service reductions to compensate for the huge cash flow shortages that resulted from the carrier's refusal to rectify its claims processing issues on their own.

Wisconsin (Claims administered by Wisconsin Physician Services – WPS)

The state's four largest ambulance companies were placed on pre-payment review for all non-emergent ambulance claims submitted for payment. Some pre-payment reviews included emergency transports as well.

In addition, the following problems occurred:

- The carrier denied large quantities of claims that should have been paid.
- The carrier claimed that while they knew how to place a supplier on pre-payment review, they were unclear how to remove them from this process.
- Claims overturned on appeal were not included in the calculations of the denial percentage, which was what the carrier determined was the cause to keep them in the pre-payment review process.
- The carrier did not have a methodology, which allowed suppliers to ask for a claim to be automatically denied until March 2001. Claims submitted "for denial only", which is a requirement by secondary payers before suppliers can obtain reimbursement, were inappropriately included in the calculation of the supplier's denial ratio, which was the reason they had been placed into the pre-payment review process in the first place.

Southern California (Claims administered by National Heritage Insurance Company - NHIC)

NHIC took over processing ambulance claims for Southern California in December 2000. There have been continuous system problems that have caused huge problems with inappropriate claims denials since this occurred. Major cash flow problems still exist for many of the suppliers in this service area. Some examples include:

- Provider payment screens were initially loaded into the NHIC system incorrectly causing suppliers to be grossly underpaid for services rendered for many months. (This problem was only rectified when the central CMS office intervened.)
- When new procedure codes were implemented on January 1, 2001, additional claims processing problems began:
  - Suppliers were denied all mileage payments on claims.
  - Claims were denied for lack of medical necessity, which clearly should have been paid.
  - All hospital discharges to a second hospital for a higher level of care were routinely denied, even though coverage requirements were met.
  - Claims containing zip codes listed as valid by the US Postal Services are still denied because the carrier does not recognize the zip code submitted.

Kentucky/Indiana (Claims administered by AdminaStar)

Beginning in August 2000, AdminaStar began arbitrarily denying ambulance claims. The volume of these denials was so high; that claims resubmitted for review by suppliers became substantially backlogged. The Carrier estimated it would take more than a year to process reviews and almost two years for suppliers to obtain a hearing on improperly denied claims.

Examples of these inappropriately denied claims include the following:

- Valid emergency claims routinely denied as not medically necessary services.
- Non-Emergent claims were routinely denied since the carrier stated that all patients had to be bed confined AND have another reason for transport to satisfy coverage requirements. These are not the same coverage requirements outlined within CMS regulations.
- The carrier incorrectly determined coverage by the patient's ultimate diagnosis once treated by the receiving facility, NOT by the condition of the patient at the time of the ambulance transport.
- Even when claims were resubmitted and paid, most were downgraded to a lower payment level based upon the level of treatment given rather than the service level required by the condition of the patient.

Although the issues were resolved in February of 2000 after the central office of CMS and elected representatives intervened; cash flow problems within the provider community were severe. In fact, three suppliers who were sole operators in rural communities had to close their doors.

Maryland (Claims administered by Trailblazer)

Suppliers submitting high volume of ambulance claims were placed on pre-payment review for all claims in 1999. The carrier justified this action through their review of data, which apparently indicated that they were paying more per 1,000 beneficiaries for ambulance services than other states. For a provider to be taken off of pre-payment review status, they had to get their denial percentage below a certain percentage known only internally at the carrier, which they refused to share with the provider community. Long delays for claims payment and review ensued which caused severe cash flow problems for suppliers. Meetings with high-level carrier personnel were finally granted and some important discoveries were uncovered. Unfortunately, by then, many suppliers either closed their doors completely or curtailed services offered to local beneficiaries. As a result of this action by the carrier, the number of certified suppliers and licensed vehicles has decreased by 50% in the past 18 months. This has caused a significant delay (i.e., hours) for non-emergency responses in the entire service area.

Pennsylvania (Claims administered by XACT/HGS Administrators)

In 1999, the carrier denied all claims for transports originating in a Skilled Nursing Facility based upon wording included in HCFA Transmittal AB-99-53 dealing with the newly instituted SNF/PPS payment policies. They refused to pay any of these claims until they received written clarification from HCFA stating that the claims could be paid. Once this was received, the carrier began paying the claims but the long delays set in motion major cash flow problems for suppliers.

Shortly thereafter, HGS began pre-payment reviews and other procedures that caused further cash flow shortages for the industry.

- Additional information was routinely requested from healthcare facilities before ambulance claims would be paid or processed. Since this request was made to a source outside the scope of the ambulance supplier, claims payment became dependent upon a supplier who had very little reason to comply with the information request. As a result, most claims were denied when the requested information was not received.
- Supporting documents, which were successfully obtained by ambulance suppliers and submitted with their claims were routinely lost.
- Because of these additional documentation requirements, claims were not processed for at least 90 days, which caused huge cash flow shortages for the local ambulance community. Further, because the documents required were usually not in the possession of the ambulance operator, most claims were ultimately denied even after this lengthy delay.

As a result of these issues, many ambulance suppliers in the area were forced to institute service reductions to accommodate for the cash flow shortages which occurred.

South Carolina (Claims administered Palmetto Government Benefit Administrators)

In February 2000, Palmetto GBA arbitrarily began denying over 75% of all Medicare ambulance claims. The carrier stated that the denials were a direct result of the content of the ambulance regulation that was effective on February 24, 1999. The regulation stated that non-emergency ambulance transports are only covered if the patient is bed confined, but this error was clarified by HCFA in a Q&A dated March 12, 1999 which was well in advance of the instituted policies incorrectly implemented in early 2000. The clarification stated that other non-emergencies are covered even if the patient is not bed confined as long as other reasons for transport, which established the medical necessity for the service were provided. Palmetto incorrectly interpreted this clarification to mean that patients had to be bed confined *in addition to* an alternative reason for ambulance transportation in order for payment to occur. The carrier also alleged that HCFA advised them that they had been paying too many claims and they should increase their denial ratio. It took over 5 months and enormous pressure from local elected officials working on behalf of the ambulance community to force the carrier to abandon these incorrect payment polices. Unfortunately, by the time this issue was resolved, many suppliers suffered cutbacks in service in order to keep their doors open while they experienced the resulting severe cash flow shortages. Other problems with reimbursement for covered non-emergent transports remain unresolved and some covered claims continue to be incorrectly denied by this carrier.

Recommendations to Resolve Claims Processing Problems

- Railroad claims for ambulance should be processed by the local Medicare carrier. It will save the industry and Medicare substantial administrative expenses currently resulting from the huge number of appeals and manual claims processing costs, which are required by the current carrier.

- Require that Medicare carriers have a special unit to process ambulance claims.

- Appoint an ambulance representative to the Carrier Advisory Committee and include them whenever an ambulance issue is on the agenda.

- Before putting the ambulance industry on pre-payment reviews based on Focused Medical Review data, require the Carrier to meet with industry representatives to see if there is a logical reason for the apparently aberrant data.

- Require education to occur and allow providers to rectify problems BEFORE placing them on pre-payment review.

- Allow advance payments, based on a set formula, e.g. 80% of the supplier's average payments, when there is a problem with a Carrier's system for processing claims that cause payment and processing delays.

- Open eligibility files so ambulance providers can determine if there is a payer that is primary to Medicare.

- Eliminate signature authorization requirement for suppliers. Require that Medicare obtain the signature at the time of enrollment. Allow electronic patient signatures.

- Providers should only have to submit documents that are within their custody and control. Pre-payment reviews, development letters and audits should not request documents from us that are not directly within our custody and control.

- Allow us to send the Physician Certification Statement and all other claims processing requirements electronically. Manual claims are far more costly for providers and carriers alike.

- Carriers should not include claims where the supplier requested a denial for determination of denial percentages used to place providers onto the pre-pay reviews process.

United States General Accounting Office

GAO

Testimony
Before the Committee on Governmental Affairs,
U.S. Senate

For Release on Delivery
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AMBULANCE SERVICES

Changes Needed to Improve Medicare Payment Policies and Coverage Decisions

Statement of Laura A. Dummit
Director, Health Care—Medicare Payment Issues

GAO-02-244T

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

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[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.

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.

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.

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

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

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.

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.

GAO CONTACT AND
STAFF 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.

(290156)

Oversight of the Centers for Medicare and Medicaid Services:
Medicare Payment Policies for Ambulance Services

Statement by

Deputy Chief John Sinclair
Central Pierce Fire and Rescue

presented to

Committee on Government Affairs

United States Senate

November 15, 2001

International Association of Fire Chiefs
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Testimony of
John Sinclair
Deputy Chief of Operations, Central Pierce Fire and Rescue

Good morning, Mr. Chairman and members of the committee. I am Chief John Sinclair, Deputy Chief of Operations for Central Pierce Fire and Rescue in Tacoma, Washington and Secretary of the EMS Section of the International Association of Fire Chiefs. I served as a member of the team that represented the IAFC on the negotiated rulemaking committee that drafted several components of the Medicare ambulance fee schedule.

I represent the fire chiefs and other senior managers of the more than 31,000 fire departments in the United States. While pre-hospital Emergency Medical Services systems are noted for the wide range of organizations that provide emergency medical care and ambulance transport, there is one unifying force in nearly all EMS systems nationwide—the critical role of local fire departments. In over eighty percent of America's communities, fire departments are the provider of EMS first response. In addition, the fire service is the single largest provider of ambulance transport comprising over one-third of CMS's ambulance transport providers.

Mr. Chairman, before turning to the business of this hearing, I would like to thank you, Senator Lieberman, Senator Thompson and the other members of this committee. Recent events have demonstrated the critical importance of local EMS systems in the event of a natural or man-made disaster. The issues this committee is hearing about today—timely and adequate reimbursement for ambulance transport services—are tremendously important to ensuring that local EMS systems have the necessary resources to serve their communities in times of great need.

In 1997 the Congress passed the Balanced Budget Act (BBA) that mandated a single fee schedule for ambulance reimbursement in the United States, eliminating the widely varying reimbursement rates across the country. The new fee structure, created through the negotiated rulemaking process, reflects the consensus of our industry on a wide variety of issues. There were, however, several issues that were designated as being "off the table" by CMS during the negotiations. We view two of these issues as being most critical to the successful implementation of the new fee schedule. First, the proposed lower reimbursement rates must be raised to reflect the actual costs of providing ambulance transport. Second, CMS should implement a system of condition codes to properly reflect the patient's symptoms when calling 9-1-1 and reduce the number of denied and delayed claims that are a result of current practices and add to the already substantial administrative burden of seeking reimbursement for Medicare patients.

The issue of determining the cost of ambulance transport is notoriously difficult. The broad array of organizations that provide ambulance transport, the different ways in which these organizations are funded, and the variety of service levels in different communities result in a situation where estimating costs across the industry is very difficult. However, we believe it is critical that Medicare reimbursement reflect, to the maximum extent possible, the actual cost of providing the service. The current proposed rates established by CMS are simply too low. Fire Department budgets, already under extreme pressure in the aftermath of the recent terrorist attacks and subsequent anthrax scare, will be further impacted by the proposed rates under the new fee schedule. Project Hope, a highly respected health care think tank, arrived at a reliable estimate for the cost of providing ambulance services throughout the U.S. Mr. Chairman, you recently introduced a bill—the Medicare Ambulance Payment Reform Act of 2001, S. 1350—that would require CMS to set the reimbursement rates based on the average costs of the service. We strongly encourage Congress to direct CMS to set reimbursement rates on this basis.

Of great concern to all ambulance providers is the extremely uneven and seemingly arbitrary manner in which claims are accepted for or denied payment by fiscal intermediaries and carriers. The General Accounting Office's report on rural ambulance payment under the proposed fee schedule notes that there are significant and somewhat inexplicable disparities in denial rates across carriers. The report states that difficulties with claims review and subsequent denial levels are "exacerbated by the lack of a national coding system that easily identifies the beneficiary's health condition and links it to the appropriate level of service."

At issue is how to determine whether a beneficiary meets the medical necessity criteria for ambulance transport. Often, the patient's condition at the time of pickup does not ultimately match the diagnosis determined in the hospital.

Let me provide the Committee with a short example. One of the most frequent calls received by local EMS providers is for a patient with severe chest pain. Given the possibility of a life-threatening cardiac event, EMS providers will aggressively treat this patient as they rapidly transport to the hospital. Upon arrival, the patient is ultimately diagnosed not with a heart attack, but with a case of severe indigestion. While it was impossible for the firefighters in the field—without the aid of the advanced diagnostic tools available in the hospital—to know of the patient's actual condition, CMS will refuse to reimburse this transport, deeming it "medically unnecessary." Mr. Chairman, this situation is simply unacceptable. Firefighters in the field need to make rapid decisions based on the best interest of the patient. To tie reimbursement to the patient's diagnosis and not to the condition of the patient on scene is dangerous to both individual patient care and the long-term financial health of our local EMS systems.

A sub-committee of the Negotiated Rulemaking Team developed a comprehensive list of medical condition codes. This list, crafted by industry experts through a consensus process, represents a monumental effort to provide clarity to the issue of patient condition and should be utilized as recommended. Its implementation would greatly reduce the number of delayed and denied claims and ease the administrative burden upon local fire departments.

Finally, we are concerned about poor coordination of Medicare policy through the Medicare carriers. It is clear from previous experience that discrepancies exist between policy development by the CMS and implementation and administration by carriers. Recently we have become concerned that the implementation of the new fee schedule will be plagued by poor coordination as several discussions between fire service EMS leaders and the carriers have demonstrated that the carriers have fundamental misunderstandings of basic definitions and levels of service designated by CMS based on the work of the negotiated rulemaking team. Given the significant impact the new fee schedule will have on local government finances across the country, it is imperative that CMS implement the fee schedule with as little administrative confusion as possible.

America's fire departments are the backbone of the nation's emergency medical response system providing over sixty percent of the nation's emergency ambulance transports. It is essential for the financial stability of our local governments that claims filed for Medicare patients be processed and paid in a prompt, efficient, and fair manner and that the amount paid reflect the actual cost of providing the service. Mr. Chairman, the solutions we have outlined above—increasing the reimbursement rates, implementing the condition codes developed by the negotiated rulemaking body, and ensuring that CMS provides clear oversight to the Medicare carriers—will significantly aid America's fire service as we adapt to the reality of the new ambulance fee schedule. We encourage Congress to direct CMS to take these steps to ensure the financial stability of the nation's local EMS systems so that we can maintain the highest level of health care for our patients.

Thank you for providing me with the opportunity to testify before you today. I will be happy to answer any questions.

Prepared statement of Lori Moore, Assistant to the General President of the International Association of Fire Fighters (IAFF)

Mr. Chairman. My name is Lori Moore, and I am the Assistant to the General President of the International Association of Fire Fighters (IAFF). I previously served as the IAFF Director of Emergency Medical Services, and spent seven years as a paramedic for the City of Memphis Fire Department. I am pleased to appear before you today on behalf of General President Harold Schaitberger, and the 250,000 men and women who comprise the International Association of Fire Fighters. As the nation's primary providers of pre-hospital emergency medical services, we appreciate this opportunity to share our organization's perspective on Medicare Payment Policies for Ambulance Services.

The Need for an Ambulance Fee Schedule

Payment for ambulance services from health insurance carriers including Medicare is and has historically been linked to "medically necessary" patient transport. In order to obtain payment for emergency medical care services provided to a Medicare beneficiary, providers must bill in conjunction with ambulance transport. The levels of payment vary widely across the United States for the exact same service. For example, the prevailing rate of payment for advanced life support care provided in conjunction with emergency transport in parts of California is $541 while the exact same service billed the same way in the District of Columbia has a prevailing payment amount of $113. Using another billing method whereby all services, mileage, and supplies are bundled and billed together in Pennsylvania is $321 and the exact same service using the

same billing method in Delaware has a prevailing billing amount allowable of $175. This payment system was and remains unfair to providers throughout the country.[1]

In June 1997, the Health Care Financing Administration (now the Center for Medicare and Medicaid Services) proposed to revise the Medicare ambulance regulations (42 CFR 410.40) to base Medicare payment on the level of service required to treat a beneficiary's condition; clarify and revise policy on coverage of non-emergency services; and to set national vehicle, staffing, billing, and reporting requirements. The Health Care Financing Administration efforts to draft policy were derailed however by strenuous opposition from certain industry groups.

Because of this opposition, and in order to meet the requirements of the Balanced Budget Act of 1997, HCFA established a negotiated rulemaking process to determine the rules addressing Medicare payment for ambulance services. This brought emergency medical services (EMS) industry stakeholders together to negotiate regulations specifying how ambulance services are reimbursed under Medicare. The process of negotiated rulemaking was intended to allow affected parties to hammer out their respective issues and break regulatory gridlock. A neutral facilitator assisted the negotiations. The goal was to reach consensus on the language and issues involved in the final rule.

This negotiated rulemaking effort took place over a thirteen-month period and included input from all major industry representatives. The negotiating team considered the aspects of the Medicare provision as instructed in the Balanced Budget Act of 1997. The negotiating rulemaking process resulted in a number of successful outcomes. Definitions were established for the levels of prehospital emergency medical care. These

[1] Prevailing Medicare Rates by State/ Locality. Health Care Financing Administration, March 17, 1999.

definitions included both advanced and basic life support care levels categorized as emergent or non-emergent and critical care transport. The fee schedule also provided for payment for advanced life support (ALS) treatment separate from transport under certain circumstances using the paramedic intercept designation. Additionally, relative value units were determined for each level of patient care in association with ambulance transport.

IAFF Position During Negotiated Rule Making

During the negotiated rulemaking process it was the stand of the International Association of Fire Fighters (IAFF) to assure that the negotiating committee recognize and propose a solution to the discrepancy in payment amounts regionally and to assure equal distribution of Medicare funds allocated to ambulance services based on service provided regardless of type of provider or location. As a successful result of the work of the committee, a single payment amount was established for each level of care provided in conjunction with patient transport.

The payment amounts established considered various aspects of service provision including associated labor and operations costs, historical call volume, historical payment for like services, level of service provided, and community type. Additionally, air and ground ambulance transport categories were thoroughly discussed and provided for in the fee schedule. The committee reached consensus on the resultant fee schedule. The base amounts and relative value units were established for each service level and were intended to apply throughout the United States with an adjustment for labor and operations costs using the Geographic Practice Cost Index (GPCI). The GPCI is an index

regularly used by Medicare for adjustment of physician costs associated with geographic practice differences. Finally, the committee agreed that the fee schedule should be implemented over a four-year period so as to ease the adjustment of provider services and emergency response systems into the new payment scheme.

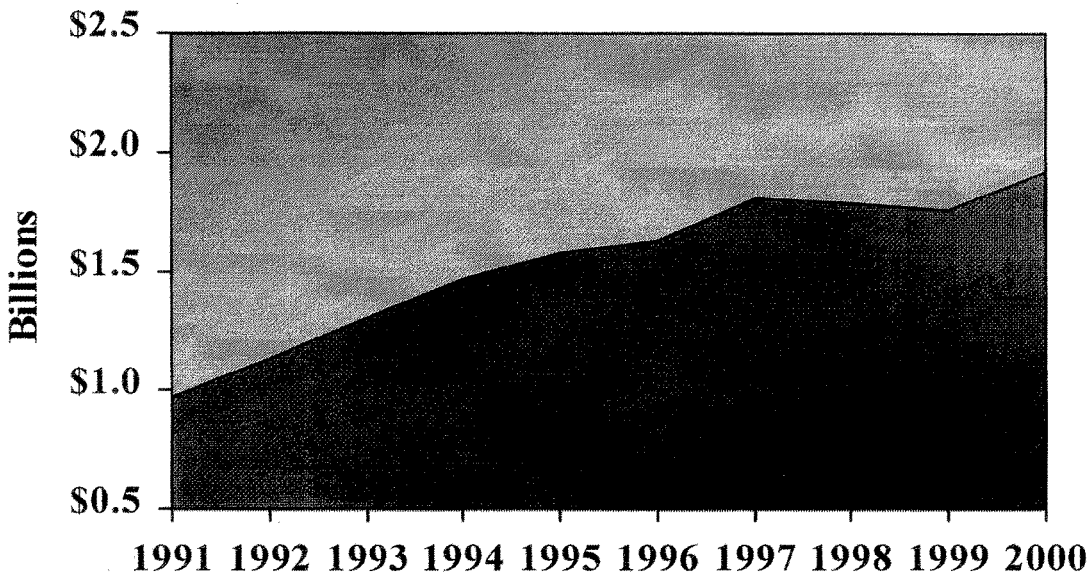
IAFF Position on Fee Schedule Implementation

It is the position of the IAFF that the fee schedule be implemented as it was intended and voted on by the negotiating committee. The base fees were established based on information provided by the Health Care Finance Administration and the expertise of industry representatives on the committee. The IAFF believes that it is the responsibility of local government to build and fund local emergency medical response systems and that Medicare is intended to pay for use of the system by a beneficiary *not* to be the base funding for the entire system. Therefore we do not agree that the base fee should be increased or otherwise adjusted except for normal inflationary adjustments.

The IAFF also believes that denial of claims and the inconsistent application of standards with regard to claims are indeed problematic. Medicare Carriers and Fiscal Intermediaries must be given sufficient direction and resources by which they may judge and pay ambulance service claims without delay. Though this is a substantial problem at this time, it will likely be resolved with universal implementation of the fee schedule as negotiated and voted by the agreement of industry representatives in February 2000.

Thank you very much for your attention and interest in this vital issue. I would be happy to answer any questions you may have.

Medicare Ambulance Payments
1991 - 2000



METROPOLITAN AMBULANCE SERVICES TRUST
6750 Eastwood Trafficway, Kansas City, Missouri 64129-1940
Telephone (816) 924-1700 • Administration Fax (816) 924-1011
Billing Fax (816) 924-1110 • Medical Records Fax (816) 924-1112
Web Site: **www.mastambulance.org**

TESTIMONY BY JOHN A. SHARP, EXECUTIVE DIRECTOR OF METROPOLITAN AMBULANCE SERVICES TRUST (MAST), A NOT-FOR-PROFIT PUBLIC TRUST, SUBMITTED TO THE SENATE GOVERNMENTAL AFFAIRS COMMITTEE HEARING NOVEMBER 15, 2001, ON S. 1350.

On behalf of the approximately 400 employees of the MAST system and the citizens we protect in the 17 municipalities in Missouri and Kansas we serve in the Kansas City metropolitan area, we respectfully request your committee to recommend S. 1350 for passage.

S. 1350 will require Medicare to pay the national average cost of providing ambulance service under the proposed Medicare fee schedule for ambulance services.

Such a requirement is essential to protect our nation's ambulance providers from being financially devastated by the effects of the fee schedule if it is implemented as originally proposed, just as other segments of health care were financially devastated by earlier Medicare reimbursement cutbacks mandated by the Balanced Budget Act of 1997.

The fees that have been proposed are significantly below the costs of even the most efficient ambulance providers in the nation such as MAST. These fees are based on outdated and unreliable data from 1998 that does not reflect today's cost of providing quality ambulance service.

If the fee schedule as originally proposed is implemented April 1, 2002, MAST will lose approximately $2 million in Medicare reimbursement in Missouri and Kansas next fiscal year compared to our present Medicare reimbursement rates. This loss will increase to approximately $2.9 million annually when the fee schedule is fully phased in.

Cuts of this magnitude will force ambulance providers throughout Missouri, Kansas and most of the nation to layoff employees and lengthen response times unless they can secure replacement funding from financially strapped state and local governments which appears extremely unlikely for most ambulance providers.

Financially crippling our nation's ambulance providers at this crucial time in our nation's history when we should be strengthening their capacity to respond to mass casualty incidents is just nuts!

Please promptly recommend S. 1350 for passage and protect this essential component of our public health and safety system from financial devastation.

John A. Sharp
MAST
6750 Eastwood Trafficway
Kansas City, Missouri
64129

Projected Financial Impact of Medicare Fee Schedule on MAST Operations

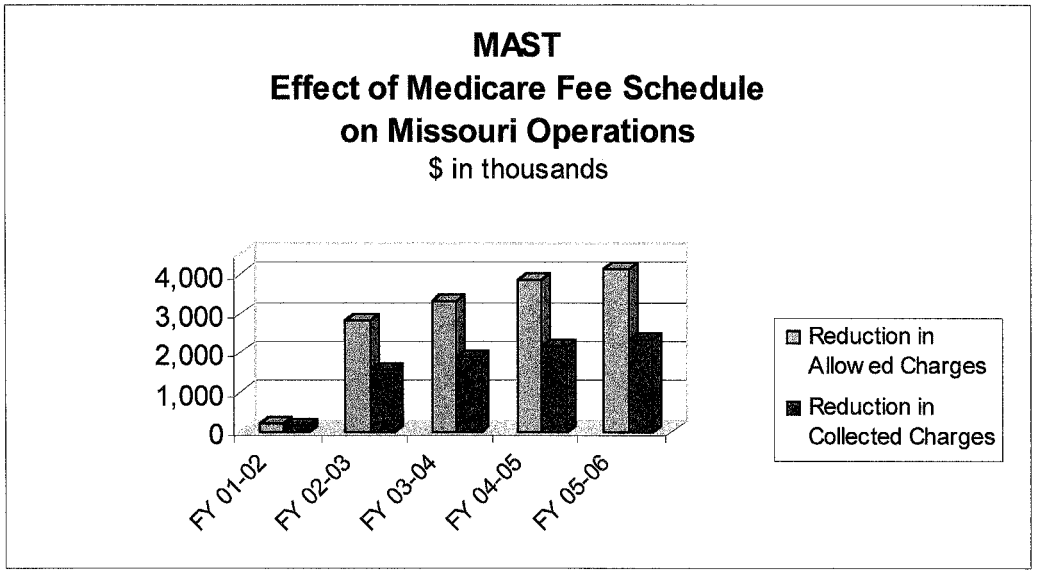
Projected Financial Impact of Proposed Medicare Fee Schedule

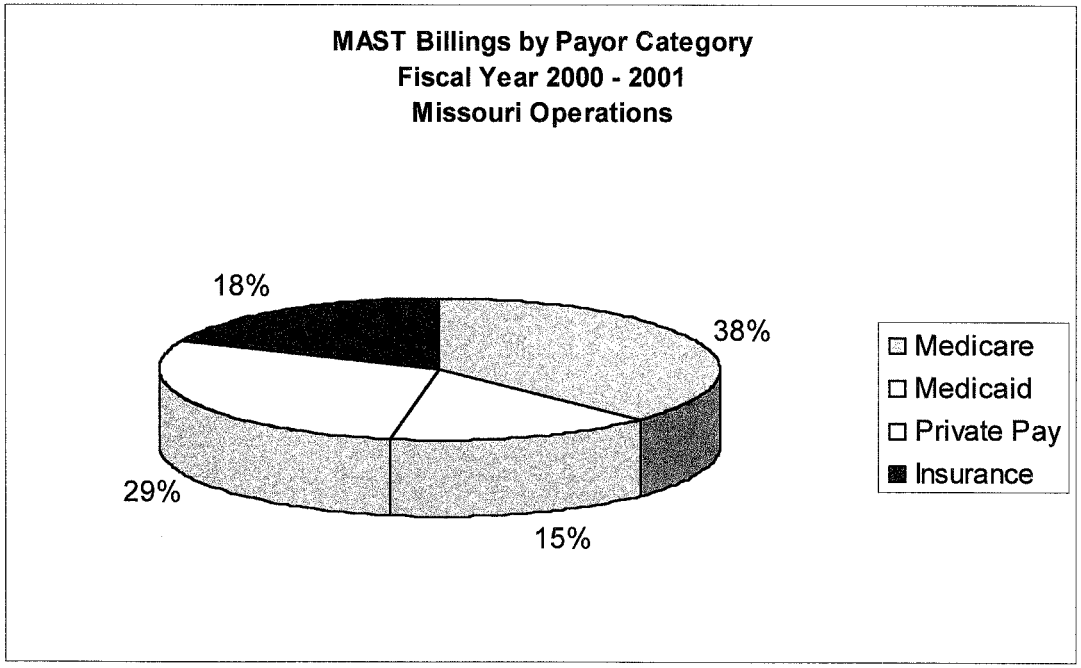
MISSOURI OPERATIONS

	Fiscal Year 01 - 02	Fiscal Year 02 - 03	Fiscal Year 03 - 04	Fiscal Year 04 - 05	Fiscal Year 05 - 06
Annual Reduction in Allowed Charges	$231,438	$2,820,095	$3,334,232	$3,834,103	$4,148,302
Cumulative Reduction in Allowed Charges	$231,438	$3,051,533	$6,385,765	$10,219,868	$14,368,170
Annual Reduction in Collected Charges	$130,022	$1,584,329	$1,873,172	$2,153,999	$2,330,516
Cumulative Reduction in Collected Charges	$130,022	$1,714,351	$3,587,523	$5,741,522	$8,072,038

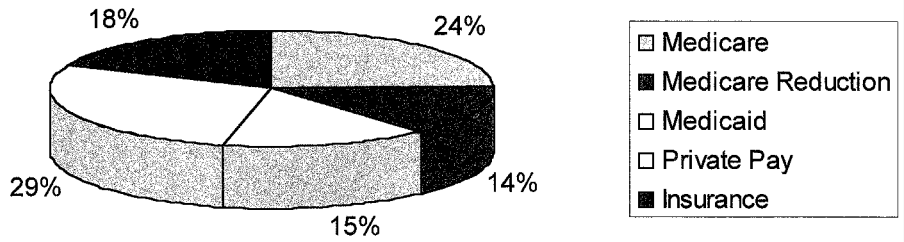
Assume implementation effective Apr 1, 2002, as originally published in the Federal Register.
Calculations are based on the allowed Medicare rates for 2001 compared to the fee schedule.


Serving Kansas City


MAST
Effect of Medicare Fee Schedule
on Missouri Operations
$ in thousands
4,000
3,000
2,000
1,000
0
FY 01-02
FY 02-03
FY 03-04
FY 04-05
FY 05-06
Reduction in Allowed Charges
Reduction in Collected Charges


MAST Billings by Payor Category
Fiscal Year 2000 - 2001
Missouri Operations
18%
38%
29%
15%
Medicare
Medicaid
Private Pay
Insurance

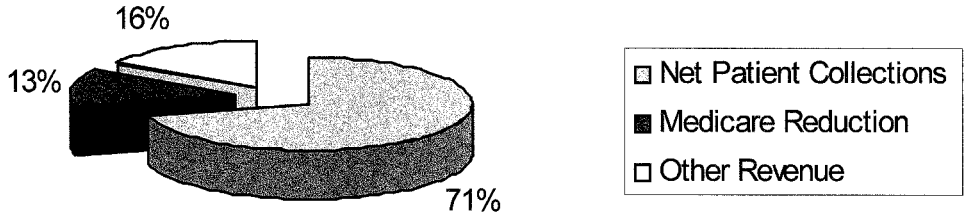
MAST Billings by Payor Category
with Reduction in Medicare Billings upon
Full Implementation of Fee Schedule
Missouri Operations



MAST Collections by Payor Category
Fiscal Year 2000 - 2001
Missouri Operations
Medicare
Medicaid
Private Pay
Insurance
54%
8%
11%
27%

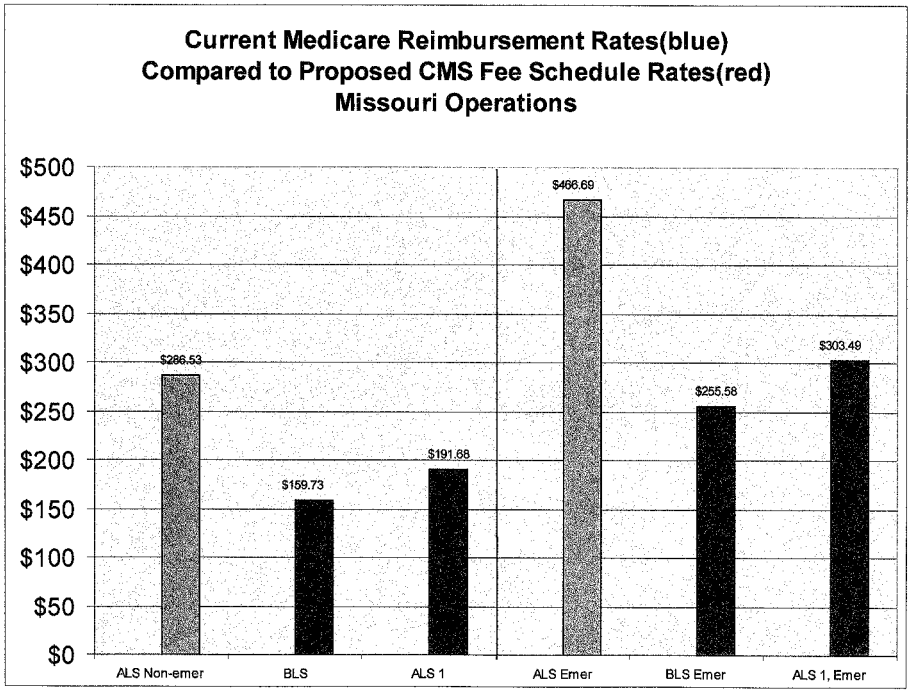
Serving Kansas City
MAST Collections by Payor Category
with Reduction in Medicare Collections upon
Full Implementation of Fee Schedule
Missouri Operations
Medicare
Medicare Reduction
Medicaid
Private Pay
Insurance
39%
15%
8%
11%
27%

MAST Total Revenue
with Reduction In Medicare Collections upon
Full Implementation of the Fee Schedule
Missouri Operations



Serving Kansas City
MAST Cost per Transport
(excluding bad debt expense) vs
Medicare Fee Schedule Rates
Missouri Operations
$400.00
$350.00
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$-
$334.56
$159.73
$191.68
$255.58
$303.49
MAST Cost
BLS
ALS
Emer BLS
Emer ALS


Serving Kansas City


Current Medicare Reimbursement Rates(blue)
Compared to Proposed CMS Fee Schedule Rates(red)
Missouri Operations
$500
$450
$400
$350
$300
$250
$200
$150
$100
$50
$0
$286.53
$159.73
$191.68
$466.69
$255.58
$303.49
ALS Non-emer
BLS
ALS 1
ALS Emer
BLS Emer
ALS 1, Emer

Statement on behalf of the Ambulance District Association of Missouri

The Ambulance District Association of Missouri represents tax-supported Emergency Medical Service and Transport entities in Missouri. Our member entities are predominately rural and must rely on third-party (insurance, Medicare, Medicaid) for the lion-share of revenue with which to operate. The proposed change in Medicare funding will shift the burden of financial support from the Federal to the local level. Since most of our member entities are rural, the tax base is not present to replace the lost revenue from Medicare cuts. These facts will reduce ambulance service on a day-to-day basis and therefore cripple the ability of EMS to respond to disaster or terrorist events.

Now is not the time to reduce the capability of our EMS systems in Missouri or the United States. EMS is an important part of Emergency Services just like Law Enforcement and Fire Services. We implore the federal government to remember that in many areas, especially rural areas, the local ambulance district is a major first responder to emergencies. In rural and urban areas, EMS plays a vital role in response to terrorist acts. The reduction of Medicare funding will mean that fewer EMS resources will be available for any emergency, large or small.

Ambulance districts are already strapped to find funding to pay paramedics so that advanced life support service is available to the public. We may be forced to reduce service to only BASIC life support services if funds are unavailable. This means that medications and therapies will be delayed during transport of seriously ill or injured patients. The delay or lack of advanced therapy that paramedics can provide BEFORE the patient reaches the hospital can result in longer recovery times and more expense care that Medicare will have to fund. This is a pound-wise but penny foolish philosophy.

In summary, reductions in Medicare funding can result in reduced care, longer response times, crippling disaster preparedness, and the real prospect that EMS service in some rural areas could cease to exist!

We urge the Federal Government to delay the implementation of reducing Medicare funding to ambulance services and indeed to understand the need to increase funding and maintain a healthy EMS system that is prepared to provide quality pre-hospital care and to handle any disaster or terrorist threat.

Respectfully Submitted

Randall Joe Davis
Member
Ambulance District Association of Missouri (ADAM)
62 Pearl Drive
Hillsboro, MO 63050-5031

Statement on behalf of the Missouri Emergency Medical Services Association

The Missouri Emergency Medical Services Association, (MEMSA) is the professional association that represents the interests of the 10,000 EMT's and paramedics that serve Missouri providing critical emergency health services.

MEMSA is very concerned about the recent attacks on the nation and on the ability of our ambulance services to respond to emergencies that might arise from the war. The proposed Medicare fee schedule will dramatically cut the funding for ambulance services throughout Missouri. These cuts will affect our ability to respond to attacks.

The proposed Medicare fee schedule will encourage ambulance services to cut services, limit the number of units, minimize the number of paramedic teams and in general weaken the financial health of the ambulance services throughout Missouri. This seems to MEMSA to be a very poor time for Medicare to cut funding to ambulance services when the nation is expecting more from us, not less.

The fee schedule was forced upon the ambulance services with limited study and flawed assumptions. Ambulance services cannot make decisions about what services to dispatch to a scene simply from phone interviews with individuals calling for help. This type of process is bad practice and STUPID yet Medicare will be making retrospective decisions regarding how to pay for our services. This process of retrospective decision-making will force ambulance services to limit the offering of paramedic level services and instead encourage them to offer only basic EMT services. This will lead to poor patient outcomes.

MEMSA believes that Medicare should not implement the proposed fee schedule when ambulance services are expected to be increasing our ability to deal with bio-terrorism or chemical attacks upon America.

During this time of crisis, now is not the time to slash funding for the emergency medical services systems in Missouri.

We urge Medicare to withhold the implementation of the proposed fee schedule until further study demonstrates that our ability to respond to attacks will not be compromised.

Sincere,

Jason White
Legislative Committee MEMSA
C/o 6750 Eastwood Trafficway
KCMO 64129

Statement on behalf of the Missouri Ambulance Association in Support of S. 1350, the "Medicare Ambulance Payment Reform Act of 2001."

The Missouri Ambulance Association would like to voice its strong support for Senate Bill 1350.

Senate Bill 1350 addresses certain inadequacies of the proposed Medicare Fee Schedule for ambulance services. The currently proposed Medicare Fee Schedule for ambulance services is significantly flawed and if left unchanged would significantly undermine the financial stability of our Nation's Emergency Medical Services System. Under the proposed fee schedule many ambulance services will be forced to cut staff thereby increasing response times in emergency situations, some ambulance services will be forced to reduce the level of service they provide from an advanced paramedic level to a basic EMT level and still others may cease to exist altogether.

The proposed Medicare fee schedule for ambulance services is based upon data related to ambulance service reimbursements made by HCFA in 1998 and does not take into account the significant changes that have occurred in the EMS industry since that time. Safety sharp and needless systems now mandated by OSHA to prevent needle stick exposures for EMS workers have tripled or quadrupled the costs of these supplies to ambulance providers yet the fee schedule does not provide for additional reimbursement. New drugs that are now being used in EMS systems around the country such as thrombolitics, (clot busters) which have received wide acclaim within the medical community will be will be denied to Medicare beneficiaries because no reimbursement is available for the $ 2,000 drug in the fee schedule.

Senate Bill 1350 will significantly change the proposed Medicare fee schedule for ambulance services by increasing the base reimbursement for services from $ 165 to $245 providing badly needed additional funds for ambulance service reimbursement.

In view of recent events in the New York, Washington D.C. and Pennsylvania, the importance of building a strong network of emergency medical services throughout our Nation is greater now than ever before. The Missouri Ambulance Association strongly encourages the Senate Committee on Governmental Affairs to act immediately to save the Nation's EMS system and pass Senate Bill 1350.

Sincerely,

Mark Alexander, President
Missouri Ambulance Association

Statement on behalf of the State Advisory Council on Emergency Medical Services

The State Advisory Council on Emergency Medical Services is a group of individuals from the EMS community appointed by the Governor of Missouri and confirmed by the Senate. This body is charged with the responsibility to advise the Governor, General Assembly, and the Department of Health/Bureau of EMS on issues and concerns affecting the delivery of pre-hospital care and transport of the ill and injured in the State of Missouri. Additionally, this council reviews all proposed legislation and regulation before implementation or action is taken.

The Missouri State Advisory Council urges a delay and review of the revised Medicare fee schedule as proposed. The Council supports and urges the passage of any federal legislation that would provide greater Medicare funding of ambulance service.

Recent cutbacks in Medicare funding and the advent of managed care has created a situation in the hospital portion of emergency medical care that reduces the capacity of the system to absorb any "surge" of increased patients. This is evident in an increase in ambulance diversions from emergency departments that are under-staffed, under-funded, and therefore easily overwhelmed by sudden increases in patients they must administer to.

The State Advisory Council is concerned that the proposed fee schedule further reduces the capacity in the emergency medical system by further reducing funding to ambulance services. This reduction not only threatens day-to-day response to medical emergencies, but also the ability of the total emergency medical system to respond to disasters or acts of terror.

Emergency Medical Services are an important part of this nation's healthcare and homeland defense. Now is not the time to reduce funds. It is the opportunity to realize the need to increase funding.

Respectfully Submitted

Randall Joe Davis, Member
Missouri State Advisory Council
62 Pearl Drive
Hillsboro, MO 63050-5031

Statement of behalf of Kansas Emergency Medical Services Association (KEMSA)

The Kansas Emergency Medical Services Association represents the ground ambulance services and the personnel that provide emergency medical services in Kansas.

Presently there are 185 ambulance services and over 10,000 paramedics and EMT's in Kansas.

During the spring of 2001 KEMSA created a committee to study the impact of the Medicare fee schedule on the ambulance services in Kansas. While the committee could not conduct any formal studies we were able to gather enough information to conclude that the impact of the fee schedule will be dramatic.

KEMSA believes that Medicare has failed to adequately evaluate the cost of providing ambulance services in rural areas.

The demographics of Kansas show a large, and growing number of elderly in rural areas of Kansas. The growing number of Medicare patients in rural Kansas is already taxing our ability to recruit and retain staff yet now we are concerned about the proposed cuts in Medicare funding.

Many communities in Kansas report large numbers of Medicare patients. McPherson and Newton report that over 60% of their patient load is Medicare patients. To cut the Medicare payments for this large volume of their patient load will significantly cut the total revenues into these ambulance services.

The Medicare cuts are essentially a cost shifting from the federal government to local governments. A survey was done that established that the average cost per transport in the state of Kansas is 402 dollars. This amount is much larger than the base rate of the new Medicare schedule of only $162.51. The remaining cost for providing services will be carried by the local unit of government, which owns the local ambulance service.

Butler County EMS reports " Health care to all citizens is a priority for everyone. Any loss of funding for ambulance services will result in a decrease of services and health care especially in rural areas."

KEMSA supports the passage of SB 1350 and HB 3109. KEMSA is concerned over the potential impact of the drastic Medicare cuts to the basic funding of EMS in Kansas, which will threaten our ability to respond in a time of crisis

Jason White
Vice President KEMSA
November 13, 2001
4521 Metropolitan KCK 66106

STATEMENT OF
THE HONORABLE DON WESELY
MAYOR OF LINCOLN, NEBRASKA

"OVERSIGHT Of THE CENTERS FOR MEDICARE AND MEDICAID SERVICES: MEDICARE PAYMENT POLICIES FOR AMBULANCE SERVICES"

HEARING IN THE
UNITED STATES SENATE COMMITTEE ON GOVERNMENT AFFAIRS
NOVEMBER 15, 2001

Chairman Lieberman, Senator Thompson, and distinguished Committee members, thank you for the opportunity to submit comments for the record on your recent hearing on Medicare payments for ambulance services.

The City of Lincoln, Nebraska, currently provides emergency and non-emergency ambulance services for both the City of Lincoln and rural areas of Lancaster County. We are concerned that as the Centers for Medicare and Medicaid services (CMS) develops an ambulance fee schedule for Medicare reimbursement rate that the schedule is reasonable and fair to both providers in rural and urban areas. Medicare reimbursements represent a significant portion of the revenue that the City of Lincoln collects in order to maintain our ambulance services for the community and a fair and realistic rate is vital to the continued financial viability of this essential activity.

The City of Lincoln supports the objectives as outlined by the American Ambulance Association with regard to reimbursements, as summarized below:

- Reimbursement fee schedules should be based on the relative cost of providing various covered ambulance services;
- the fee schedules should take into account the various factors that affect those costs for particular types and locations of services, and
- ambulance providers should be compensated for the costs associated with maintaining a required state of readiness.

We believe that if these objectives are met, then a fair and equitable schedule will be developed that would not require the ambulance operator -- whether they be public or private -- to subsidize the true cost of providing ambulance service to Medicare patients. We do not believe it is appropriate or affordable for a local ambulance provider to subsidize such services.

Oregon State Ambulance Association

November 8, 2001

The Honorable Joseph Lieberman
Chair, Senate Governmental Affairs Committee
United States Senate
Washington, DC 20510

Dear Senator Lieberman,

I understand that your Committee will be hearing Medicare ambulance issues on November 13. I am writing on behalf of emergency ambulance services throughout Oregon -- public as well as private -- to ask for your support of S.1350, the Medicare Ambulance Payment Reform Act of 2001, introduced by Senator Mark Dayton.

Passage of S.1350 is vital for our efforts to continue quality service to our patients, especially in the large rural areas of our state. S.1350 contains four key provisions for Oregon ambulance providers and those of the entire nation.

- Require the Secretary of HHS to set fee schedule payments at a rate based upon the average incurred by full cost ambulance suppliers.
- Require Medicare to adopt US Government Accounting Office recommendations regarding defining rural ambulance providers.
- Require Medicare to adopt coding systems for ambulance suppliers based upon patient conditions.
- Implement a prudent layperson standard for emergency ambulance claims.

Congressional action resolving these issues will ensure that our emergency medical system is available and functioning for Medicare beneficiaries and all patients when emergencies happen.

Thank you,

Shawn Baird, EMT-P
President, Oregon State Ambulance Association

National Association of State EMS Directors
111 Park Place • Falls Church, VA 22046-4513 • www.nasemsd.org
703-538-1799 • fax 703-241-5603 • nasemsd@aol.com

November 20, 2001

The Honorable Joseph I. Lieberman
Governmental Affairs Committee
Dirksen Senate Office Building 340
Washington, DC 20510

Dear Senator Lieberman:

The National Association of State EMS Directors (NASEMSD) is interested in assuring the adequate support of emergency medical systems of care. Without adequate reimbursement, many communities may find themselves without the requisite emergency medical services to meet community needs.

We participated in the Negotiated Rule Making (NRM) process to establish a national fee schedule for Medicare reimbursement of ambulance services, but the NRM process did not allow Medicare reimbursement to be based on the necessary cost per transport of ambulance services. Neither did the NRM process adequately address reimbursement of additional cost per transport for transports originating in rural areas.

Condition codes designed specifically to be tied to the new Medicare ambulance service levels are necessary and desirable to understand and better allocate these scarce health care resources.

Therefore, the NASEMSD supports the introduction and passage of the Medicare Ambulance Payment Reform Act of 2001 (S.1350/HR.3109) and the Medicare Rural Ambulance Relief Act (S.1367 and its House companion to be introduced), or a bill which combines their provisions.

Sincerely,

Dia Gainor

Dia Gainor
NASEMSD President

eba:D:\docs\nasemsd\Resolutions\Medicare cvr ltr.doc\

Resolution 2001-03

National Association of State EMS Directors
111 Park Place • Falls Church, VA 22046-4513 • 703-538-1799 • www.nasemsd.org

Support of Medicare Reform Acts

Whereas the National Association of State Emergency Medical Services Directors (NASEMSD) participated in the Negotiated Rule Making (NRM) process to establish a national fee schedule for Medicare reimbursement for ambulance services, and;

Whereas, the NASEMSD is interested in assuring the adequate support of EMS systems of care, but does not have a direct financial interest in reimbursement levels and payments, and;

Whereas, without adequate reimbursement, many communities may find themselves without emergency medical services to meet community needs, and;

Whereas, the NRM process did not allow Medicare reimbursement to be based on the necessary cost per transport of ambulance services, and;

Whereas, the NRM committee voted with unanimous support for condition codes designed specifically to be tied to the new Medicare ambulance service levels, and,

Whereas, the NRM process did not allow the committee to apply a prudent layperson standard of what constitutes a medical emergency to ambulance services provided to Medicare patients, and,

Whereas, the Medicare Ambulance Payment Reform Act of 2001 (S.1350/HR.3109) would solve the aforementioned issues that were not adequately addressed in the proposed rule for a national fee schedule for Medicare reimbursement of ambulance services, and;

Whereas, the NRM process was not able to adequately address reimbursement of additional cost per transport for transports originating in rural areas, and;

Whereas, the Medicare Rural Ambulance Relief Act of 2001(S.1367) offers rural services the flexibility to select reimbursement methodology least jeopardizing to the safety net services they provide, and;

Whereas, S.1350/HR.3109 does not address such relief for rural services until at least 2004 by when "additional cost per transport for rural transports" is to be defined;

Now therefore be it resolved that the National Association of State EMS Directors supports the introduction and passage of the Medicare Ambulance Payment Reform Act of 2001 (S.1350/HR.3109) and the Medicare Rural Ambulance Relief Act (S.1367 and its House companion to be introduced), or a bill which combines their provisions, and will convey its support to Senator Mark Dayton of Minnesota, Representatives Amo Houghton of New York and Tom Allen of Maine, and Senators Susan Collins of Maine and Russ Feingold of Wisconsin, and;

Be it further resolved that NASEMSD encourages its individual members to contact their Congressional representatives to educate them on these issues and encourage the passage of the legislation.

Adopted this 20th day of October, 2001.

Dia Gainor
NASEMSD 2001-02 President

Bill Stevenson
NASEMSD 2001 Secretary

National Association of EMS Physicians
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November 21, 2001

Ms. Darla Cassell
Chief Clerk
Committee on Governmental Affairs
Senate Office Building
Washington, DC 20510

Dear Ms. Cassell

The National Association of Emergency Medical Services Physicians (NAEMSP) is an organization of physicians and other professionals who provide leadership and foster excellence in out-of-hospital emergency medical services. Our organization participated in the Negotiated Rule Making Process through our delegate, Robert Bass, MD, FACEP who is an emergency physician and Maryland's State EMS Director.

During the course of the fee schedule negotiated rulemaking process, a Medical Issues Workgroup (chaired by Dr. Bass and composed of emergency physicians, carrier medical directors, nurses and billing experts) developed an innovative list of medical conditions that more accurately describes the full range of circumstances in which ambulance transportation is required. The purpose of this effort was to provide a means by which ambulance crews could relate the condition of the individual they transport to the appropriate service level under the new fee schedule. This provides a simple and effective means to accurately code and bill the ambulance service at the appropriate payment level.

CMS participated in and contributed to the development of this system. It has been widely distributed over the past two years, and has been universally acclaimed by Medicare carriers and providers alike, who believed it would be an essential component of the new fee schedule. CMS even included the medical conditions list as an addendum to its publication of the proposed rule in the Federal Register, and solicited public input on the need for such a list. However, CMS has not indicated that it intends to implement the medical conditions list at the time it implements the fee schedule. This flies in the face of expert opinion and has the support of all key stakeholders. There needs to be a coding system

by which the new fee schedule can operate, including a means for providers to be able to justify in their claims the level of service they provide. Likewise, carriers will need a means to determine whether the condition of the transported individual warrants payment at the level claimed. The Negotiated Rulemaking Committee based the service level definitions for the fee schedule on the medical conditions list, and it would not be possible to implement one without the other. The entire Committee, including CMS, agreed that without a medical condition coding list, the new fee schedule couldn't be effectively administered. We ask that CMS implement the fee schedule with the implementation of the medical conditions list. With the proposed April 1, 2002 effective date there still remains enough time to implement the conditions codes. Otherwise, there will be billing and claims processing chaos when the fee schedule goes into effect.

Respectfully,

Richard C. Hunt, MD, FACEP
NAEMSP President

COMMENTS OF

LIFELINE AMBULANCE SERVICES, INC.

ON OVERSIGHT OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES: MEDICARE PAYMENT POLICIES FOR AMBULANCE SERVICES

United States Senate

Committee on Governmental Affairs

November 14, 2001

VIA ELECTRONIC MAIL

Senator Joseph Lieberman, Chairman
The United States Senate
Committee on Governmental Affairs
340 Dirksen Senate Office Building
Washington, District of Columbia 20510

Senator Fred Thompson, Ranking Member
The United States Senate
Committee on Governmental Affairs
340 Dirksen Senate Office Building
Washington, District of Columbia 20510

Re: Hearing on Oversight of the Centers of Medicare and Medicaid Services: Medicare Payment Policies for Ambulance Services

Dear Senators:

Lifeline Ambulance Services, Inc. ("Lifeline") is pleased to submit these comments relating to your November 15, 2001 hearing on the above-referenced matter. While Lifeline generally supports the Centers for Medicare and Medicaid Services ("CMS") and its implementation of certain payment policies for ambulance services, Lifeline also expresses concern regarding application of these payment policies through CMS's contractors, known as carriers. Specifically, carriers have applied inconsistent policies with respect to payment for Medicare services and Lifeline has received less Medicare reimbursement than appropriate under the Social Security Act (the "Act").

Lifeline is an ambulance supplier providing emergency and non-emergency medical transportation services to residents of the Commonwealth of Virginia, including Medicare beneficiaries. In particular, Lifeline provides basic life support, advanced life support, and specialized life support services within Virginia. Under the Medicare program, Lifeline's carrier is responsible for ensuring that Lifeline is properly reimbursed for services provided to Medicare beneficiaries.

Historically, ambulance services delivered to Medicare beneficiaries were reimbursement on a "reasonable cost" basis pursuant to Part B of the Medicare program. See 42 U.S.C. § 1395x(s)(7). Beyond the reasonableness requirement, reimbursable ambulance services also must be necessary. See Medicare Carriers Manual ("MCM"), HCFA-Pub. 14-3, §§ 2120.2, 2303. Further, ambulances must be equipped with customary patient care equipment and supplies. See id. § 2120.1. While there is no standard method for ambulance companies to bill for their services, companies may bill separately for additional services provided to a beneficiary during transport. See id. §§ 5116, 5116.2. Moreover, carriers are instructed to reimburse an

ambulance supplier's cost exceeding customary and prevailing levels when unusual circumstances exist. See id. § 5116.6.

Generally, federal law recognizes two types of ambulance vehicles: basic life support and advanced life support. See id. § 5116. Virginia state law, however, authorizes and licenses specialized life support vehicles. This is in part due to the requirements imposed on hospitals and physicians under the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Essentially, EMTALA requires that a transferring physician ensure that qualified personnel and appropriate life support equipment are provided to treat an individual's present medical condition, as well as any reasonably foreseeable complication or event that may arise during transport.

As a licensed provider of specialized life support services in Virginia, Lifeline submitted multiple claims to its carrier for specialized life support services delivered to Medicare beneficiaries. These services were rendered in accordance with the Act, EMTALA, Virginia state law, and all regulations promulgated thereunder. Lifeline's carrier, however, improperly rejected Lifeline's claims for additional reimbursement. Moreover, Lifeline is aware of other carriers who routinely reimburse providers for specialized life support services rendered to Medicare beneficiaries. Consequently, CMS should instruct its carriers to consistently reimburse providers for specialized life support services delivered in accordance with applicable federal and state laws and regulations.

On behalf of Lifeline, I appreciate your consideration of our comments. Please contact me at (540) 382-1813 if I can provide the Committee on Governmental Affairs with any additional information.

Sincerely,

James C. Jones
Chief Executive Officer

AMERICAN MEDICAL RESPONSE

Testimony of Steven Murphy
American Medical Response

Chairman Lieberman, Ranking Member Thompson, Senator Dayton and members of the Senate Committee on Governmental Affairs, thank you for the opportunity to submit these written comments into the record of testimony for the Hearing on Oversight of the Centers for Medicare and Medicaid: Medicare Payment Policies for Ambulance Services being held on November 15, 2001. My name is Steve Murphy and I am the Chief Executive Officer of National Products and Services for American Medical Response.

American Medical Response ("AMR") is the nation's largest provider of emergency and non-emergency ambulance services. We operate in 35 states and provide ambulance services to approximately 4 million persons annually, roughly 2 million of which are Medicare beneficiaries. AMR plays a huge role in delivering vital pre-hospital emergency medical services to hundreds of counties, cities and towns throughout the United States of America.

Impact of the Proposed Ambulance Fee Schedule on American Medical Response

We'd like to take this opportunity to outline the effects of the proposed ambulance fee schedule on our company and our continuing ability to provide the high quality service to the communities we currently operate within. We have been directly involved in the fee schedule development process and have been pleased with the response we have received from the current staff of the Centers for Medicare and Medicaid Services ("CMS"). However, we are deeply concerned that certain aspects of the September 12, 2000 Proposed Rule will result in a drastic and immediate reduction in reimbursement for ambulance services in parts of the country that include a high percentage of the nation's population. These precipitous reductions will jeopardize the ability of many ambulance suppliers to continue rendering the high quality EMS that is now recognized and expected as the national standard of care.

We believe that the payment reductions that will result from the Proposed Rule are inconsistent with Congress' intent in enacting Section 4531 (b)(2) of the Balanced Budget Act of 1997 ("BBA") in three major respects.

Two Major Payment Reductions are not phased in as required by the BBA, and the Impacts of those Reductions have not been evaluated.

By following the methodologies outlined in the Proposed Rule, CMS will fail to phase in the fee schedule in a "fair and efficient manner" as mandated in the BBA. According to the Proposed Rule, CMS intends upon the first day of implementation of the fee schedule to both eliminate the payment for an Advance Life Support (ALS) response provided as a result of local ordinance and to institute the requirement under the fee schedule to accept assignment on all claims. By failing to phase in the elimination of current Medicare policy regarding ordinances that mandate an ALS response, CMS will inflict immediate reductions on many providers that far exceed the reasonable

reduction Congress intended. Notwithstanding the phase-in set forth in the Proposed Rule, some of our AMR operations will experience an immediate reduction of more than 50% from the first day of implementation. The intent of CMS to immediately require providers to accept assignment will exacerbate this problem by also eliminating, as of the first day of the fee schedule's implementation, other revenues that some providers currently depend upon to compensate for the inadequacy of Medicare's reimbursement levels.

Given the magnitude of these two changes, CMS should have assessed its impact on affected providers to ensure that access to EMS and the quality of services will not be adversely affected. CMS has not conducted such an assessment and therefore apparently does not know whether access or quality will be affected. CMS should correct this deficiency by conducting such a review, and the results should be released for public comment BEFORE any final policy decisions are made in this area. Unless the results of this review demonstrate otherwise, the elimination of the current ALS reimbursement policy and implementation of mandatory acceptance of assignment should be delayed until the fee schedule is fully phased in. At a minimum, the reductions arising from this policy change should be phased in at the same rate as the fee schedule itself.

The Conversion Factor should be recalculated in a Manner Consistent with Budget Neutrality

Congress intended for the fee schedule to be implemented in a budget-neutral manner. We are aware that CMS has worked with our industry on several issues that have been brought to their attention since the publication of the Proposed Rule and they claim to have made adjustments to the baseline as a result of these discussions. However, we believe that there are still several issues that remain unresolved related to the accurate calculation of the conversion factor. The most critical of these issues is the unwillingness of CMS to use the most current data available to calculate the baseline pot of money. Initially, the fee schedule was scheduled for a January 2000 implementation. At that time, the most current data available to develop the baseline amount of funds was data from the calendar year 1998. Since the fee schedule implementation has been delayed and is now scheduled to be instituted sometime in the year 2002, it is only logical to assume that CMS should use the most current data available today which would be from the calendar year 2000. It is our understanding, that due to time constraints, CMS plans to move forward with the fee schedule implementation using the 1998 data to calculate the fees despite the fact that this data will be four years old. Many changes have occurred in our industry that cause us to believe that the 1998 data is very outdated and inaccurately reflects the dollars spent and the volume of services rendered which are the two most critical elements used to derive the base fee of the fee schedule. We believe that using the more current data could mean an increase of as much as 9 – 10% to the published conversion factor in the Proposed Rule. This difference could mean a great deal to operations such as our AMR operations in Connecticut, Massachusetts, California, Oregon, and Washington which are among the most sophisticated and highly clinical EMS systems in the nation. Unfortunately, they are also among those that will experience the largest negative financial impact from the fee schedule as proposed currently. These systems remain at significant risk because of the negative financial impact anticipated with the currently proposed fees.

The Medical Condition Codes should be implemented immediately

Congress required that the new system "link payments to the type of service provided". If the Proposed Rule is implemented without the immediate inclusion of the medical condition codes developed by the Medical Issues Work Group during the Negotiated Rule Making process, carriers will be permitted to use outdated and inappropriate criteria when deciding how to reimburse for the new transport classifications specified in the Proposed Rule. Many carriers will likely classify transports at a lower payment level than warranted, which will exacerbate the reductions in revenue caused by the factors already discussed.

Since the service level definitions developed by the Negotiated Rule Making Committee are directly linked to the condition codes, we believe it will be impossible to implement the fee schedule without the new set of codes. If one is implemented without the other, massive claims processing problems and confusion will surely be the result and providers and beneficiaries will suffer accordingly.

Denials of Ambulance Claims

Medicare reimbursement currently accounts for over one third of our total revenue at American Medical Response. As a result, it is critical that the transports we provide for our Medicare beneficiaries are reimbursed in a consistent and timely fashion to avoid huge shortfalls in operating cash flow. When problems arise, it is essential that they are identified and rectified quickly. Based on our experience, we believe the following issues should be addressed related to current claims administration problems.

CMS Policies Should be Drafted in a Specific and Consistent Manner to Prevent Inconsistent Carrier Interpretation and Implementation Problems

Because of our size, AMR is uniquely qualified to speak to claims administration issues on a nationwide basis. We currently submit Medicare claims to 19 different carriers in the different localities that we serve. Our largest claims processing issue, as a company, is the widely inconsistent manner in which CMS policies are implemented at the individual carriers that service our claims. Since we have regional billing centers handling our claims submission who often submit claims to several different carriers, it is common for employees responsible for submitting Medicare claims for payment to employ completely different billing requirements depending upon the carrier the claim is submitted to for payment. It is also a common occurrence for us to receive a totally different outcome on the same type of claim submitted to different carriers, or sometimes even within the same carrier. Regulations and policies are often drafted by CMS in a very ambiguous manner, which leaves the interpretation of these policies open to huge variations, by carrier personnel. Because of our size, AMR struggles on a regular basis with these different interpretations. If CMS were to draft their policies in a much more concise and direct fashion, most of these claims processing variations and problems that arise as a result of these varied interpretations would be resolved.

Carriers should be required to follow a Standardized Process to Communicate with Providers when a Perceived Problem is discovered

Unfortunately, we usually learn that there is a perceived problem with Medicare claims submission totally by accident. There is no standard requirement for a carrier who thinks they have identified a problem to communicate with them that such an issue has been discovered. As a result, the carrier often begins to mass deny claims or will place an operation on immediate prepayment review. Often, claims submission anomalies can be very easily explained and a simple discussion between the carrier and our billing personnel could resolve the issue immediately. Because this does not usually occur, the result of the carrier's drastic action can cause huge claims delays and cash flow shortages which have a direct impact on our ability to serve the beneficiaries that count on us for high quality ambulance service. CMS should require that carriers contact a provider when a perceived problem exists and discuss the issue BEFORE taking any punitive action against the provider's future claims submissions.

CMS Should Ensure that Carriers are Fully Prepared and Ready to Process Claims Timely and Accurately <u>BEFORE</u> Implementing the Proposed Fee Schedule

We have experienced firsthand the drastic problems that can occur when carriers are forced to implement policies that they are not prepared for and have not made the necessary system changes to accommodate. As an example, our AMR operations providing service throughout Southern California have lived through devastating cash flow shortfalls during the past year when

a new carrier began processing their claims in December of 2000. There have been continuous system problems that have caused with inappropriate claims denials since this change occurred. This type of bad experience has been a common occurrence when small policy changes have been implemented or carriers have changed hands. As a result, we can only surmise what the potential for problems will be when the entire payment system changes upon implementation of the proposed fee schedule. We urge you to ensure that CMS has ample time to make every effort possible to allow carriers to adequately prepare, implement and test the changes that are required to systems and claims processing functions ***BEFORE*** the industry has to totally rely on this new payment system to work. Because of the volume of Medicare patients transported and the amount of cash flow Medicare reimbursement comprises in our revenue mix, our very survival depends upon timely and efficient processing and payment of our claims. Full implementation should NOT occur until the system has been fully tested and carriers and providers are comfortable that the new system can begin in a smooth and efficient manner.

Implementation of Condition Codes Would Resolve the Vast Majority of Claims Denials and Processing Problems

We believe strongly that implementation of the new condition code system developed during Negotiated Rule Making would resolve the majority of the claims denials and processing issues which arise currently. We have been forced to communicate the medical reason for ambulance transportation to carriers by using a coding system, which does not adequately reflect the treatment of our patients. Currently, we must submit each claim to Medicare with an ICD9-CM diagnostic code in order to receive payment for the service. Since we do not diagnose our patients and treat patients solely upon the condition and symptoms presented to us at the time of the transport, we have been trying to fit a square peg into a round hole for decades. The condition codes are far more reflective of the manner in which we treat and transport our patients and will finally allow us to accurately communicate what we really see during our patient encounters.

The new service level definitions developed by the Negotiated Rule Making Committee are directly linked to the list of condition codes. If the fee schedule is implemented without the use of the condition codes, carriers will have no clear guideline to use to properly process and pay our claims. Denials and appeals will become even more of a problem and the entire nation's EMS systems could be seriously degraded as a result. The codes were unanimously agreed upon by the Negotiated Rule Making Committee, and have since received positive reviews from Medicare Carriers and Medical Directors around the country. Hence, we do not understand why CMS plans to move forward with implementation of the fee schedule without the use of the condition codes. We strongly believe that this would be a huge mistake that could cause significant claims processing problems. The condition codes MUST be implemented simultaneously with the rest of the fee schedule.

Conclusion

Once again, thank you for allowing me to provide this written testimony to you on behalf of American Medical Response. I would be happy to respond to any questions and can be reached at (303) 614-8536 at your convenience.

United States Senate
Governmental Affairs Hearing
November 15, 2001

Testimony presented by:

Brian J. Connor

Chairman,
Emergency Medical Coalition of Ambulance Providers

President,
Massachusetts Ambulance Association

Chief Executive Officer,
Armstrong Ambulance Service

Thank you for affording me the opportunity to offer testimony to the Senate Governmental Affairs Committee on this critical issue – Medicare Payments to Ambulance Providers.

My name is Brian Connor and I have been involved in emergency health care services for over 20 years. I am currently the Chief Executive Officer of Armstrong Ambulance Service, one of the largest privately-held ambulance services within Massachusetts. I am also the President of the Massachusetts Ambulance Association and the founder and acting Chairman of the Emergency Medical Coalition of Ambulance Providers (EMCAP). EMCAP is a new organization, comprised of state ambulance associations and ambulance providers. EMCAP's mission is to protect the future of this nation's emergency health care network, through the passage of legislation to assure adequate funding and through the promulgation of rational and meaningful regulations.

The proposed Medicare ambulance fee schedule is inadequate. The methodology for computing payments is flawed and will drive ambulance providers across the country out of business. Massachusetts' ambulance providers will see a 40 percent decrease in overall revenue; ambulance providers in 32 other states will face similar decreases in Medicare revenues.

Some ambulance trade associations see the problem as simply one of budget assumptions. The budget assumptions used to compute ambulance payments (in particular in computing the national base rate or conversion factor) are inadequate. But the problem goes beyond budget assumptions. The underlying payment methodology simply doesn't protect our communities and our patients.

The members of EMCAP believe they have a responsibility to the communities they serve, and the future of ambulance providers is part of that responsibility.

Over the last two months, members of this body and health care professionals have questioned whether our health care system and our emergency health care system are prepared for a terrorist attack and, in particular, bio-terrorism. These are important questions, and questions we as a nation must confront. It would be easy to wrap the need for more funding for ambulance

providers in the mantle of national security, but the reason to protect the future of our nation's ambulance providers goes beyond the threat of terrorism.

On September 11th, ambulance providers responded to the tragedies in New York City and Washington. Some emergency medical staff gave their lives. But we should not forget that every day, ambulance providers and other emergency health care personnel respond to the medical need of the communities they serve. Ambulance providers are an essential part of the emergency healt care system. We cannot let the proposed fee schedule destroy the viability of ambulance services across the country.

The proposed ambulance payment methodology fails in a number of areas.

Does CMS Understand the Nature of Ambulance Services?

It is not clear whether the Centers for Medicare and Medicaid Services (CMS) understands the nature of ambulance services.

First, CMS believes that some ambulance services are not health care providers. CMS classifies ambulance providers operated by institutional health care providers – such as hospitals, nursing homes or home care agencies – as health care providers. However, CMS does not classify ambulance providers operating independently of an institutional health care provider as health care providers. They classify these ambulance providers as ambulance suppliers, akin to a supplier of medical devices.

If officials from CMS would leave Washington for just one day and spend that day with an ambulance provider not operated by a hospital or nursing home, they would soon learn that all ambulance providers are health care providers – regardless of corporate sponsorship or affiliation.

While this may sound like a trivial matter, this distinction permeates the proposed ambulance payment methodology. This classification scheme allows CMS to undervalue some ambulance

services. It creates a payment methodology that fails to recognize that ambulance providers are an important part of our health care delivery system.

Second, the maintenance of ambulance services is very similar to the maintenance of hospital emergency departments. Hospital emergency departments are very expensive to maintain. Even during slow periods, hospitals must maintain expensive staff, equipment and supplies. In reimbursing hospitals for emergency services, the Medicare program recognizes the validity of these fixed costs. The proposed methodology for reimbursing ambulance providers does not recognize that, like hospital emergency departments, ambulance providers have a large proportion of fixed costs.

Emergency vs. Non-Emergency payment categories

This problem is most evident in the proposed payments for emergency and non-emergency services. Under the proposed methodology, the Medicare program would pay providers substantially less for non-emergency ambulance services than for emergency ambulance services. While there are some differences in the cost of emergency and non-emergency ambulance services, the differences are minimal.

CMS may want to believe it costs substantially less to transport non-emergency patients, but in the real world, many communities and ambulance providers use the same equipment and staff to provide emergency services as they do for non-emergency services. These communities know that the hourly wages of staff, medical supplies or malpractice insurance does not cost less for non-emergency services.

While the real world may not fit CMS' theories, the proposed fee schedule must recognize these real world costs.

In some parts of the country, the proposed regulations will decrease Medicare payments for non-emergency services by as much as 70 percent. Massachusetts ambulance providers transport

1,034,000 patients a year. Medicare categorizes fifty percent, or 517,063 patients, as needing emergency or immediate services and fifty percent, or 517,533 patients, as needing non-emergency or non-immediate services. The proposed fee schedule would reduce Medicare payments for non-emergency services by 26 percent. Medicare payments to Massachusetts ambulance providers will decline by approximately $22.8 million dollars annually. This reduction in payments will make it difficult, if not impossible, for many ambulance providers to offer services seven days a week, 24 hours a day.

CMS must recognize the implications of their proposed payment methodology and develop a fair and reasonable method of paying for ambulance services.

Rural Ambulance Providers

The problem of stand-by or fixed costs is most acute for rural ambulance providers. Many rural communities simply do not have the population base to efficiently support an ambulance provider. Ambulance providers in these communities have a low volume of services coupled with having to travel long distances. In the preamble to the proposed payment methodology, CMS wrote, "we recognize the inadequacy of the proposed methodology to completely compensate (rural providers) for these costs..." CMS goes on to say that the proposed methodology is "temporary" and some time in the future they will fix it. Ambulance providers in many rural communities can not afford to wait for CMS to fix the problem "some time in the future."

A number of rural ambulance groups recently proposed that CMS reimburse rural ambulance providers the greater of the amount due under the current payment methodology or the amount due under the proposed fee schedule. We believe this approach to be fair and equitable.

Computation of the National Base Rate or Conversion Factor

The methodology CMS used to determine the national base rate or conversion factor is flawed. For example, in many instances, CMS' computation of total Medicare spending for ambulance

services excluded the cost of supplies and additional services, the cost of services provided by some public or community ambulance providers, and the cost of mileage in some states or for ambulance providers billing separately for mileage. There are many indications that in computing the average cost of ambulance services, CMS overestimated the number of ambulance services provided and as a result underestimated the average cost of each service.

Similarly, CMS' methodology does not reflect new medical standards. For example, the American Heart Association recently established a new standard of care for cardiac arrest patients, requiring the administration of the drug amiodarone by ambulance providers in the field. At $150 per dose, the current baseline expenditures do not account for the purchase of this new medication. We estimate the total additional industry-wide cost to be $15 million.

Is There a Remedy?

CMS' proposed ambulance payment methodology is an experiment, and by their own admission not yet a successful one. Ambulance services are too important to be left to what could turn out to be a failed experiment. Can our emergency health care network survive this experiment?

Senator Dayton recently introduced the Medicare Ambulance Payment Reform Act of 2001 (S. 1350) to correct some of the problems with the proposed payment methodology. We applaud Senator Dayton and support his bill. While Congress should enact Senator Dayton's legislation, I would strongly urge Congress to delay implementation of the proposed Medicare payment methodology.

Today more than ever, our nation can ill afford the destruction of the emergency health care system.

QUESTION FOR TOM SCULLY, ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES

Answer for the Record to an Additional
Question Submitted by Ranking Member Fred Thompson
From the Hearing on
"Oversight of the Centers for Medicare & Medicaid Services:
Medicare Payment Policies for Ambulance Services"
Held on November 15, 2001

Q: On September 12, 2000, the Health Care Financing Administration published a proposed rule establishing a fee schedule for ambulance services. The proposed rule was a product of a negotiated rulemaking process in which the emergency medical services community participated. Included in the new fee schedule is an in-county mileage rate for Part B ambulance services. This in-county mileage rate will significantly boost Medicare payments to the emergency medical services providers in my state of Tennessee, which have been consistently underpaid by Medicare. It is my understanding that the Medicare carriers will not begin paying the in-county mileage rate to providers until the proposed fee schedule becomes effective. It is also my understanding from the ambulance industry that because their participation in the negotiated rulemaking process was limited in scope, the proposed fee schedule is flawed. I am concerned that any effort to address these flaws may lead to a delay in the implementation of the in-county mileage rate.

Mr. Scully, is there any reason why CMS cannot instruct the Medicare carriers to begin paying the in-county mileage rate for Part B ambulance services immediately? If there is a delay in the implementation of the fee schedule beyond January 1, 2002, would CMS be willing to implement the in-county mileage rate immediately to provide relief to ambulance providers in states such as Tennessee?

A: We expect the ambulance fee schedule final rule to be published imminently, with phased-in implementation to begin on April 1, 2002. At that time, separate payment for mileage under the fee schedule will also begin on a phased-in basis, including extra mileage payments for ambulance services provided in rural areas.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) included a provision exempting mileage payment from the fee schedule phase-in for suppliers in States in which, prior to the fee schedule, the carrier did not pay separately for in-county mileage (applicable to North Carolina and Tennessee). These suppliers will be paid the full fee schedule mileage amount from the date the fee schedule begins rather than blended mileage payment during the phase-in period.

As to whether the accelerated mileage payments mandated by BIPA could begin prior to the fee schedule's implementation, this question is currently in litigation and it would therefore not be appropriate for CMS to comment on it further at this time.

The design of the ambulance fee schedule closely follows the consensus agreement signed by all members of the negotiated rulemaking committee. Representatives of all aspects of the ambulance industry participated fully in the negotiations, including urban, rural, volunteer, independent, hospital-based, ground, and air ambulance service providers, as well as emergency physicians.