

July 2000

RURAL AMBULANCES

Medicare Fee Schedule Payments Could Be Better Targeted



GAO

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Abbreviations

ALS	advanced life support
BBA	Balanced Budget Act of 1997
BLS	basic life support
EMS	emergency medical services
EMT	emergency medical technician
GPCI	geographic practice cost index
HCFA	Health Care Financing Administration
ICD	International Classification of Diseases, 9th revision
IIC	inflation-indexed charge
MSA	Metropolitan Statistical Area
RVU	relative value unit



B-283274

July 17, 2000

The Honorable Thomas A. Daschle
United States Senate

Dear Senator Daschle:

Ambulance services are essential to an effectively functioning emergency medical services (EMS) system. Ambulance providers must be ready to supply services rapidly and at all times, otherwise services may be of little value. Maintaining this capacity may be particularly difficult in some rural areas because rural providers are likelier than others to have a relatively low volume of ambulance trips in relation to significant overhead costs. In addition, the population they serve is dispersed, raising the direct costs of ambulance trips, known as transports. Some freestanding ambulance providers in rural states believe that Medicare payment for their services is not adequate and that their claims for payment are too often denied by Medicare.¹

In an effort to ease administrative burdens for both the Health Care Financing Administration (HCFA) and providers, offer predictable rate increases, and incorporate payment incentives for providers to improve their efficiency, the Medicare program has begun to change its payment system for ambulance services. In the Balanced Budget Act of 1997 (BBA), the Congress mandated that by January 1, 2000, HCFA develop an ambulance fee schedule that reflects the different types of ambulance services provided.² However, development of the fee schedule has been delayed and, according to HCFA, the fee schedule will be implemented January 1, 2001.

Currently, Medicare payments for ambulance services are determined using a complex method based on historical charges for freestanding providers and reasonable costs for hospital-based providers. The fee schedule will standardize payment rates across provider types and will be based on

¹The term freestanding is used to describe ambulance providers that are not affiliated with a hospital or other health care facility.

²P.L.105-33, 4531(b), Stat. 251, 450-52.

national rates for particular services. In this context, you asked us to address the following questions: (1) What are the challenges faced by rural ambulance providers? (2) How will the upcoming fee schedule affect rural providers relative to their current situation? (3) What factors have affected claim denial rates for ambulance services?

To answer these questions, we interviewed ground and air ambulance providers, local and state government officials, and other knowledgeable individuals. We also interviewed officials from HCFA; observed meetings of the Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule; reviewed pertinent laws, policies, and regulations; and observed a contractor's claims processing system. In addition, we analyzed Medicare claims data for ambulance services provided in calendar years 1997 and 1998. We performed our work in accordance with generally accepted government auditing standards between January 1999 and June 2000. (See app. I for more information about our methodology.)

Results in Brief

Because many rural ambulance providers serve a large geographic area with a low population density, they face a set of unique challenges. Unless they rely on volunteers, they tend to have high per-trip costs because of the lower volume of transports as compared to urban and suburban providers. Rural providers also tend 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. In addition, because rural residents may have fewer alternatives for transportation to hospitals, ambulances may transport some beneficiaries whose conditions do not allow for Medicare reimbursement. Furthermore, revenue sources are changing for rural providers with an increasing reliance on Medicare revenues. Moreover, maintaining volunteer staffs, which are more common in rural than urban areas, is becoming more difficult.

The proposed Medicare fee schedule will alter the way rural ambulance providers are paid. Much of the variation in payment rates among similar rural providers will be eliminated. Some providers that now are paid more than the national average are likely to receive lower payments under the fee schedule. Others, including rural South Dakota providers, that are paid less than the national average are likely to receive increased payments. In addition, providers that transport beneficiaries in rural areas will receive enhanced payments intended to help sustain essential ambulance service in sparsely populated areas. However, this adjustment does not sufficiently

distinguish the providers serving beneficiaries in isolated areas and may not be applied appropriately. Therefore, we recommend that HCFA refine the payment adjuster to better target the necessary fixed costs of essential providers in isolated areas. HCFA agreed with this recommendation and said it would take action to obtain the information needed to enable better targeting in the future.

Our review of 1998 claims data shows that payment denials have varied widely among carriers, which are the contractors that process claims for freestanding ambulance providers. Such variation can result in unequal coverage for Medicare beneficiaries. Different practices among carriers, including increased attention to potential fraud, differences in local policies, and carriers' failure to apply the coverage criteria appropriately, may have contributed to the variation in claims denials. Claims have also been denied because providers did not properly fill out forms. Additionally, 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 information to carriers in a way that facilitates review of claims.

Background

Medicare is the nation's largest health insurance program, with nearly 40 million beneficiaries. It includes almost all persons 65 years of age and older and certain disabled persons. Medicare's Part A, the hospital insurance program, covers inpatient hospital, some home health, skilled nursing facility, and hospice services. Part B, the supplemental insurance program, covers physician, outpatient hospital and laboratory services, and an array of other services, including ambulance service.

HCFA, the agency that administers the Medicare program, contracts with more than 50 insurance companies to process and pay Medicare claims. These contractors include both fiscal intermediaries and carriers. Fiscal intermediaries process inpatient hospital and skilled nursing facility claims under Part A as well as certain services covered under Part B, such as ambulance claims submitted by hospital-based providers. Carriers process other Part B claims, including ambulance claims submitted by freestanding providers. Before paying claims, the contractors must ensure that the claims meet Medicare's coverage criteria that identify whether Medicare will pay for a service, and they must deny inappropriate claims. They are also responsible for supplying information to providers (through educational workshops, newsletters, or other methods) about coverage policy and required procedures.

Medicare Coverage of and Payment for Ambulance Services

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. (For more information on Medicare's coverage criteria, see app. II.)

Between 1987 and 1995, Medicare payments to freestanding ambulance providers more than tripled from \$602 million to almost \$2 billion, an average annual increase 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.

Currently, Medicare uses different payment methods for hospital-based and freestanding ambulance providers. Hospital-based providers are paid based on their reasonable costs, and freestanding providers are paid based on a reasonable charge system, which includes an upper limit. (For more information about the reasonable charge system, see app. III.) For freestanding providers, Medicare pays a base rate, and providers can bill separately for mileage and certain supplies.³

Diverse Ambulance Industry

In 1997, 11,135 freestanding and 1,119 hospital-based providers billed Medicare for ground transports.⁴ Approximately 10 percent of Medicare ambulance providers are hospital-based.⁵ The freestanding providers are a diverse group, including private for-profit and 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

³This is true for 99 percent of all freestanding ground ambulance transports. The payment for the remainder is a base rate that includes mileage.

⁴Project Hope, "Results from the National Survey of Ambulance Providers," presented by Penny Mohr to the Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule (Dec. 1999).

⁵Penny E. Mohr, Michael Cheng, Curt D. Mueller, and others, "Findings from the 1999 National Survey of Ambulance Providers," *Final Report*, Project Hope (Mar. 2000).

private operations using paid staff operating independently or contracting their services to local government. About 34 percent are managed by local fire departments. In several communities a quasi-government agency owns the ambulance equipment and contracts 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.⁶

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.

Medicare Fee Schedule Being Developed

The BBA required that a fee schedule be developed for all ambulance services to replace the current charge- and cost-based reimbursement systems.⁷ Although the fee schedule was to have applied to services furnished on or after January 1, 2000, HCFA does not expect to implement it until January 1, 2001.

The BBA stated that the fee schedule for ambulance services should include

- mechanisms to control increases in expenditures,
- definitions linking payments to the type of services provided,
- consideration of regional or operations differences in costs,
- payment adjustments to account for inflation and other relevant factors, and
- an efficient and fair phase-in period.

⁶Estimated number of air ambulance companies is from *Report of Findings From the National Air Ambulance Cost Study*, Ernst & Young LLP (Dec. 1999), p. 3. Estimated percentage of Medicare air transport payments is from the Association of Air Medical Services.

⁷Section 4531(b) of the BBA established a new subsection 1834(l) of the Social Security Act. 42 U.S.C. 1395m(1).

The law also stipulated that total payments under the fee schedule for ambulance services in 2000 should not exceed essentially what total payments would have been under the old payment system. This requirement is known as a budget neutrality provision.

As required by BBA, HCFA is developing the fee schedule using a negotiated rulemaking process, which involves a committee made up of representatives from different interested parties. The Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule was charged with developing recommendations for HCFA that are to be used as the basis of the fee schedule. The committee had a series of meetings beginning February 1999, completed its work in February 2000, and published recommendations for the fee schedule. If HCFA's resulting payment proposal adheres to the committee's recommendations, the members agree not to oppose it. HCFA will use those recommendations as the basis of the proposed fee schedule to the maximum extent possible. (See app. IV for a listing of all the organizations participating in the Negotiated Rulemaking Committee and app. V for details of the report.)

Rural Ambulance Providers Face Multiple Challenges

Several factors characterize rural ambulance providers and may need consideration in implementing an appropriate payment policy. Some of these factors may affect providers' per-transport costs, such as low volume of transports and the long distances traveled in rural areas to provide ambulance care. The lack of alternative transportation in rural areas results in some providers transporting beneficiaries whose conditions do not meet Medicare coverage criteria. Increasing reliance on Medicare revenue and changing staff composition are other characteristics of rural providers. More specifically, the issues are as follows:

- *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. According to Project Hope, rural providers—both freestanding and hospital-based—average fewer than 1,200 transports per year while urban providers average over 14,000 transports per year.⁸ Yet, rural providers must meet many of the same basic requirements as other providers to maintain a responsive

⁸Project Hope (1999).

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. Among the freestanding ground providers that bill Medicare, rural ground providers had more than 10 times as many transports of 50 miles or greater than their urban counterparts and at least four times as many trips of 20 to 49 miles as urban providers. (See table 1.) Current Medicare payment policy generally allows freestanding providers to be reimbursed for their mileage costs. 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.

Table 1: Characteristics of Medicare Ambulance Transport by Urban and Rural Freestanding Providers, 1998

Transport type	Number of transports		Transports of 20-49 miles (percentage)		Transports of 50+ miles (percentage)	
	Urban	Rural ^a	Urban	Rural ^a	Urban	Rural ^a
Ground nonemergency	2,405,524	580,130	3.2	11.3	0.5	5.3
Ground emergency	2,404,369	802,412	2.1	10.7	0.2	3.6
Air (emergency and nonemergency)	427	459	3.8	5.2	4.2	36.8

^aDefined as rural if the address of the beneficiary who was transported was not in a metropolitan statistical area (MSA).

Note: Figures from this table represent all claims in which mileage was billed separately.

Source: HCFA, *National Claims History 100% Nearline File, 1998* (June 1999).

- *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. According to one expert, rural elderly beneficiaries may call the emergency number (911) because they have no other transport options. 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 end up transporting a Medicare beneficiary whose need for transport does not meet Medicare coverage criteria and, consequently, they must seek payment from the beneficiary or another source.

- *Increasing reliance on Medicare revenue.* Medicare payments account for an increasing share of revenue for rural providers that bill Medicare. Among these providers, 44 percent of their annual revenue, on average, was from Medicare, in contrast to an estimated 15 percent in 1989, according to Project Hope.⁹ (Urban providers' reliance has risen from 31 to 37 percent.) For some rural providers, this is because, to some extent, other revenue sources—such as subsidies from local tax revenues, donations, or other fundraising efforts—have not kept up 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. According to Project Hope, half of the providers based in nonmetropolitan counties rely on volunteer staff, compared to 24 percent of providers based in metropolitan counties.¹⁰ Volunteer staff can make a substantial difference in cost for rural providers. Rural ambulance providers that rely on volunteers had lower costs per transport than their nonrural counterparts, according to a 1991 study by Project Hope. However, if the rural providers used paid staff, their average costs per transport were higher than those of providers in more densely populated areas. Some communities are having difficulty recruiting and retaining volunteers and may have had to hire paid staff, which increases the costs of providing services. To support volunteer services, some state governments have intervened. For example, North Dakota, a predominantly rural state, will provide a total of \$940,000

⁹Current data reflect the providers' most recent fiscal year, which for most is 1998, and were provided to GAO by Penny Mohr, Project Hope (personal communication, Jan. 11 and 14, 2000). Data for 1989 are from a Project Hope survey of 206 ambulance providers in four states (California, Massachusetts, Michigan, and Texas), which were chosen because they represented different regions of the country.

¹⁰Volunteer providers are defined by Project Hope as those with volunteer staff composing 80 percent or more of the total staff. Nonmetropolitan is the designation used to identify rural providers.

during fiscal years 2000 and 2001 to help volunteers maintain their certification as EMTs and paramedics.

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

HCFA is developing a fee schedule for ambulance payments based on recommendations from the Negotiated Rulemaking Committee and has agreed to follow the committee's recommendations to the maximum extent possible. Therefore, even though the fee schedule details have not been finalized, it is clear that Medicare payments for ambulance services will change as a result. A fee schedule will eliminate the current wide variation in payments that exists across similar providers for similar services. It will also eliminate the different payment methods used for freestanding and hospital-based providers. Under the likely proposal, all providers who transport beneficiaries in rural areas will receive a supplement to their mileage payment. However, the higher payment is not targeted to transports by low-volume providers in isolated areas but rather applies to all transports involving rural residents. Implementation of a fee schedule will increase payments for those providers who historically have received low payments and reduce them for those with relatively high payments.

Fee Schedule Will Reduce Wide Variations in Payments

The design of the new fee schedule will be substantially different from Medicare's current payment method for ambulance services. Under the present system, there are considerable variations in payments to similar providers for the same type of services. The fee schedule, which will likely be phased in over 4 years, will assign one payment amount for each type of ambulance service. This amount will vary across geographic areas to account for labor and other cost differences across the country. The amount will also vary based on whether the beneficiary was transported from an urban or rural location. (See app. V for details about the fee schedule.)

In the rural states that we surveyed, we found that the current system has led to widely varying payments to freestanding providers for similar services. For example, emergency providers in rural South Dakota had much lower reimbursement rates in 1999 for ambulance services and associated mileage than providers in neighboring rural states—North Dakota, Wyoming, and Montana (see table 2). The variation stems from the way providers are paid under the reasonable charge system. Under this system, payment amounts are limited to a maximum allowable amount, which is based on 1985 charges that have been updated for inflation.¹¹ These charges were billed during a time when providers may have had proportionally higher subsidies from local or state governments or more volunteer staff and, therefore, had lower charges than those of an unsubsidized, fully professional service. While the situation of the provider may have changed—particularly with regard to subsidies or volunteer staff—the Medicare payment has been updated only to account for inflation. Consequently, the maximum allowable amounts may vary because of underlying historical charges. They also may not reflect the current costs of delivering services.

Table 2: Maximum Medicare Payments to Freestanding Ambulance Providers by Service in Selected Rural Areas, 1999

Ambulance service	Maximum payment amount in rural areas (in dollars)			
	South Dakota	Montana	North Dakota ^a	Wyoming ^a
BLS, emergency	\$85	\$189	\$150	\$144
ALS, emergency	137	231	347	138
ALS, emergency, specialized services	167	231	350	227
BLS per-mile payments	2.17	4.00	3.00	4.00
ALS per-mile payments	2.17	5.67	4.13	6.00

^aUnlike South Dakota, the maximum payment amount in Montana, North Dakota, and Wyoming is the same for urban and rural areas.

Note: Except for per-mile payments, amounts are rounded to the nearest dollar.

Source: GAO analysis of 1999 carrier reasonable charge data provided by HCFA.

¹¹For more information about the current payment method for freestanding providers, see app. III.

The shift to the fee schedule will narrow the wide variation in payments to freestanding providers for similar services. Under the likely proposal, payments to providers in rural areas for the same service will be adjusted only to account for geographic cost differences, such as for wage rates. This adjustment will likely be based on the practice expense component of Medicare's geographic practice cost index (GPCI), which is used for the physician fee schedule. The practice expense component of the GPCI measures the relative cost differences of nonphysician labor and overhead costs in physician practices across the country. Under this method, payments will vary at most by about 2 percent in the four states we examined.¹² This variation is considerably smaller than the current range of maximum allowable amounts for services among the four states. For example, payment for emergency BLS is about 120 percent greater in Montana than in South Dakota, and payment for emergency ALS is about 150 percent greater in North Dakota than in South Dakota.

Current variations in maximum payment rates do not necessarily reflect expected differences in provider costs. For example, the maximum payment amounts for emergency ALS with no specialized services and for ALS with specialized services are the same in Montana and are almost the same in North Dakota. By contrast, the payment levels differ for these two types of service in Wyoming and South Dakota, where both services are paid at much lower levels. Some of Wyoming's rates are anomalous; for example, the maximum payment amount for a BLS emergency is higher than for an ALS emergency, which requires a higher skill level of care.

¹²The practice expense component of the GPCI is relative to 1.0, so values below 1.0 reduce payments below the average and values above 1.0 raise payments. The states we examined have lower costs than the national average. The GPCI for South Dakota is 0.873 (45th among the 50 states) compared to 0.877 for North Dakota (42nd), 0.877 for Montana (41st), and 0.895 (34th) for Wyoming. Only 10 states (not including metropolitan areas that have separate GPCI values) have a GPCI practice expense number above 1.0. The GPCI will be applied to 70 percent of the base payment rate.

Under the current system, payments to hospital-based providers, which represent 26 percent of providers in rural areas and 12 percent in urban areas, also may vary substantially.¹³ Hospital-based providers are paid under a system separate from freestanding providers with payments based on their reported costs.¹⁴ The fee schedule is not likely to distinguish between types of providers for payment purposes. Therefore, for the same service, payments to hospital-based and freestanding providers in the same area will be identical.

The fee schedule will eliminate the payment differences based on individual ambulance provider costs or historical charges. Most likely, there will be 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.

Likely Rural Adjuster Does Not Target Essential Providers in Low-Density Areas

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 the higher costs associated with low-volume providers and to ensure adequate ambulance services. The proposed adjustment is an additional mileage payment for the first 17 miles for all transports of beneficiaries in rural areas. HCFA intends to define rural as any area outside of a metropolitan statistical area (MSA) and areas within MSAs that are identified as rural. (See app. V for details about the rural adjuster.)

An adjustment based on a non-MSA classification treats all providers in a range of rural areas identically. However, characteristics of rural areas may vary greatly. Some are near metropolitan areas and have relatively large populations, while others are sparsely populated and far from any urban centers. This variety among rural areas is illustrated by the U.S. Department of Agriculture's rural-urban continuum code. The code classifies rural counties based on the size of their urban population and proximity to an MSA. There are six categories for nonmetropolitan

¹³*Project Hope* (Mar. 2000).

¹⁴During any given year a hospital receives an interim payment based on its costs from the previous year. The final payment is determined at the end of the hospital's fiscal year, as part of a year-end cost settlement process. The determination of the final payment may also include an audit by fiscal intermediary staff of the reported costs.

counties, ranging from counties with an urban population of 20,000 or more and adjacent to a metropolitan area to those with less than 2,500 urban population and not adjacent to a metropolitan area. The latter are defined as completely rural.

Furthermore, HCFA's intended definition of rural does not target providers that offer the only ambulance service for residents in an isolated area. This may have two results. First, some providers may receive the payment adjustment when they are not the only available source of ambulance service. Second, the adjustment may be too low for the truly isolated providers because it was extended to a larger group. For example, payments to rural health clinics were modified in an attempt to ensure access to primary care in rural, underserved areas. However, our previous work showed that because of the overly broad eligibility criteria, the supplemental payments benefited well-staffed, financially viable clinics in suburban areas. Furthermore, we found that sparsely populated, underserved communities still needed help and were not receiving it.¹⁵

Medicare has recognized the need to develop targeting mechanisms that extend beyond the MSA/non-MSA distinction. For example, Medicare's "sole community hospital" designation aims to identify facilities located in geographically isolated areas. These hospitals are defined as the sole providers of inpatient, acute-care hospital services in a geographic area. This definition is based on distance and travel time to other facilities, severe weather conditions, market share, or some combination of those factors. Not all of these sole providers are rural, and not all rural hospitals qualify as sole community hospitals.

There are indications that the rural adjustment in the ambulance fee schedule may not be sufficiently targeted. The Negotiated Rulemaking Committee members were not satisfied with the definition that HCFA intends to use for rural areas, which they believe does not sufficiently target the low-volume, isolated rural providers. They accepted the definition because no other option could be easily adopted and implemented by HCFA, and they did not want this issue to delay implementation of the fee schedule. However, they stated that the currently proposed rural adjustment should be temporary and expressed their belief

¹⁵*Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas* (GAO/HEHS-97-24, Nov. 1996).

that a new methodology needs to be developed that more adequately targets the low-volume, isolated rural areas.

In addition, the intended rural adjustment will be 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 essential providers. For that reason, adjusting the base rate rather than the mileage rate would better account for their higher per-transport fixed costs.

Fee Schedule Will Boost Payments for Some Providers and Reduce Them for Others

Even though the actual payment amounts have not yet been finalized, 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. For example, the maximum payment in 1999 for ALS emergency services in North Carolina was \$106, compared to \$347 in North Dakota. Payments for ALS emergency services in North Carolina were about 70 percent less than those in North Dakota. However, the practice expense component of the GPCI for North Carolina exceeded that of North Dakota by about 5 percent.¹⁶ Under the likely design of the fee schedule, for the same distance transport, the payment to a rural provider in North Carolina will be about 4 percent higher than the payment for a rural provider in North Dakota.¹⁷

¹⁶The practice expense component of the GPCI is 0.924 for North Carolina (26th among the 50 states for their nonmetropolitan areas), compared to 0.877 for North Dakota (42nd).

¹⁷It is about 4 percent higher because the GPCI will be applied only to 70 percent of the base rate payment.

Because the geographic wage and price adjuster for all non-MSA areas varies 43 percent between the lowest and highest areas, payments under the likely fee schedule will move closer together.¹⁸ For example, in Colorado, the maximum payment to freestanding providers for BLS emergency in 1999 was about 320 percent higher than the payment for the same service in South Dakota. Yet, the geographic payment adjustment under the fee schedule will likely result in a payment that is only 11 percent greater for Colorado providers than for South Dakota providers.¹⁹

In conjunction with the fee schedule, all ambulance providers will be required to accept Medicare's allowed payment amount as payment in full (known as accepting assignment), which could affect whether providers' payments go up or down under the fee schedule. Providers that accept assignment receive 80 percent of the allowed amount from the Medicare program and bill the beneficiary for the remaining 20 percent of the Medicare-allowed amount.²⁰ Providers that do not accept assignment can bill beneficiaries for the balance of their charge above the Medicare-allowed amount up to a limit. (This is known as balance billing.) Currently, ambulance providers may choose whether or not to accept assignment. Eliminating the balance billing option may not affect the Medicare revenues of providers in low-payment areas because their fee schedule rates will be higher than their historic payments. For others, in cases where the fee schedule is considerably lower than current rates, their payments may decrease even more after implementation of the fee schedule if they have generally billed the beneficiary above the Medicare-allowed amount. Because HCFA intends to require providers to accept assignment at the beginning of the 4-year transition to the fee schedule, providers in low-payment areas that have not accepted assignment may see decreased payments in the short term.²¹

¹⁸This percentage is based on the range of non-MSA GPCI (from 0.828 to 1.183) for all states.

¹⁹The GPCI is 0.873 for South Dakota (45th among the 50 states). The GPCI is 0.97 for Colorado (15th).

²⁰Providers that accept assignment receive a higher payment from Medicare and can be paid directly by Medicare. If providers do not accept assignment, Medicare payment is sent to the beneficiary, who must then pay the provider.

²¹According to HCFA, the law requires that assignment take effect when the fee schedule is first implemented.

Claims Denials Vary Considerably Across Carriers

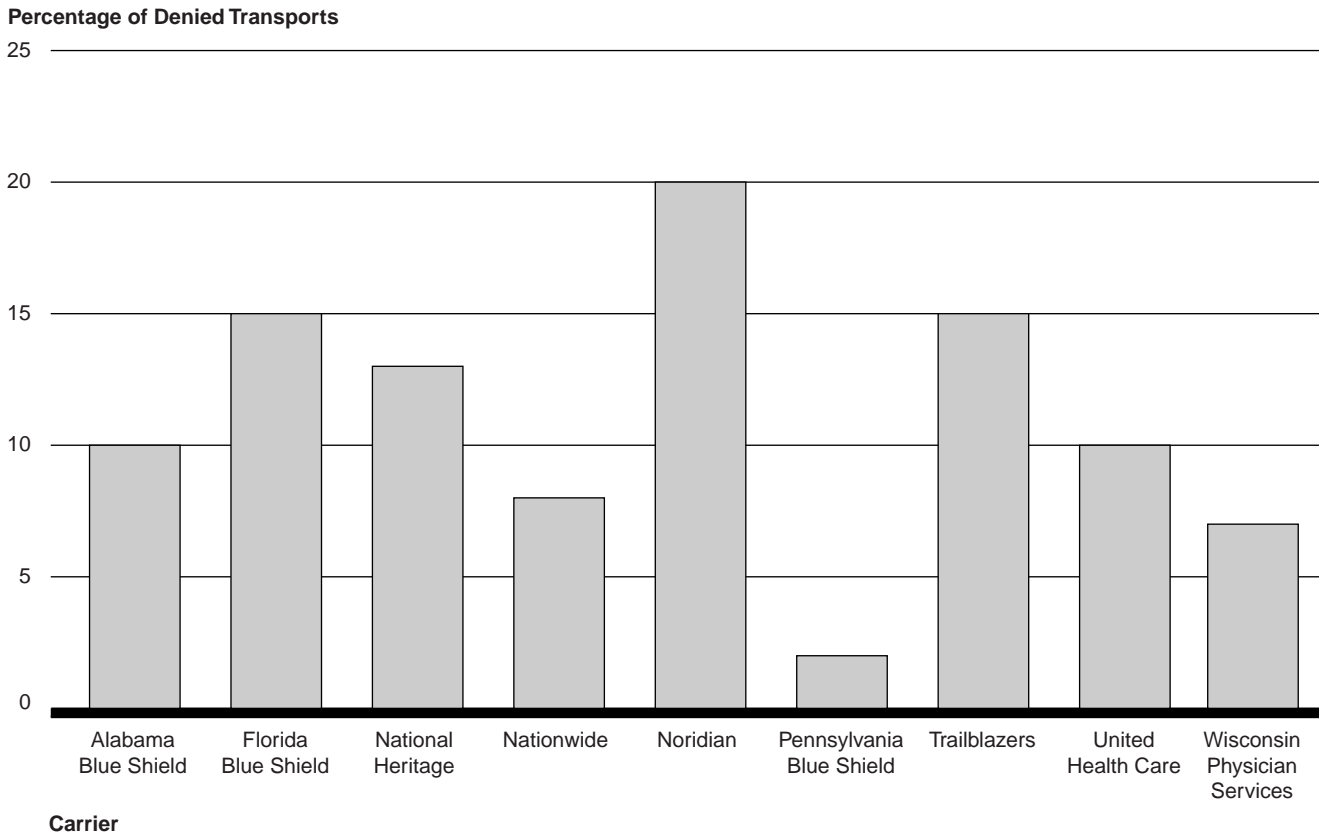
Whether a claim for ambulance transport is approved varies among carriers, and these discrepancies can translate into unequal coverage for beneficiaries. Different practices among carriers, including increased scrutiny due to concerns about fraud, may explain some of the variation in denial rates. In addition, some variation in denials may result from providers in certain areas lacking information about how to fill out electronic claim forms correctly. Claims review difficulties 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 (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.

Denial Rates Among Carriers for Ambulance Transports Varied Substantially

For both emergency and nonemergency ambulance transports, the denial rates in 1998 varied from about 9 to 26 percent for the nine carriers that processed two-thirds of all ambulance claims.²² For emergency transports, denials ranged from about 2 to 20 percent (see fig. 1). Noridian, the carrier serving 11 states including North Dakota and South Dakota, had the highest denial rate for emergency ambulance transports and, along with Trailblazers, the highest overall denial rate.

²²These denial rates are based on our analysis of HCFA's *National Claims History 100% Nearline File* database and include all 1998 claims that were paid prior to June 1999.

Figure 1: Denied Emergency Ambulance Transports for the Nine Carriers, as a Percentage of Total Submitted Claims, 1998



Source: GAO analysis of HCFA National Claims History 100% Nearline File, 1998, as of June 1999.

Carriers' Practices Affect Denial Rates

Variation among carriers in their efforts to combat fraud and abuse may have resulted in some carriers scrutinizing claims more carefully than others, and more closely than previously. A June 1996 National Fraud Alert from HCFA focusing on nonemergency ambulance transports may have resulted in carriers giving individual claims greater scrutiny. Studies conducted by the Office of the Inspector General of the Department of Health and Human Services have shown that ambulance services can be susceptible to abuse. One study indicated that about \$52 million was paid in the first 6 months of 1996 for ambulance transports that did not meet Medicare coverage criteria.²³

Noridian's claim denial rates in North Dakota and South Dakota increased substantially between 1996 and 1997. The percentage of denied claims rose from about 11 to 24 percent in North Dakota and from about 16 to 34 percent in South Dakota. Providers in those two states have complained of high claim denial rates.²⁴ A HCFA representative suggested that the increased denial rates could reflect increased scrutiny of these claims. Noridian also attributed the increase in claims denial to an effort to get providers to properly use their provider identification numbers.

Another possible reason for the variation in denial rates is that national coverage policy exists only for some situations. Providers have complained, and 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. For example, in 1998, the carrier covering ambulance providers in New Jersey and Pennsylvania, where local ordinances mandated ALS as the minimum standard of care for all transports regardless of the beneficiary's medical condition, reimbursed transports at ALS levels. However, an ambulance provider in Fargo, North Dakota, had many of its ALS claims reduced to BLS payment rates even though a local ordinance required ALS services in all cases. The carrier's policy has changed since then. Now, if a provider

²³Office of Inspector General, *Medical Necessity of Medicare Ambulance Services*, OEI-09-95-00412 (Washington, D.C.: Department of Health and Human Services, Dec. 1998).

²⁴There are three sequential levels of appeal for a denied Medicare claim. The first appeal is a second review of the claim conducted by an employee of the contractor who did not review the claim initially. If that employee decides to uphold the initial denial, the decision can be appealed to a Hearing Officer employed by the contractor. If the claim denial continues to be upheld, the denial can be appealed to an Administrative Law Judge.

sends an ALS-level vehicle and personnel, the carrier will not reduce the claim to the BLS payment level.

In addition, some carriers may be applying criteria inappropriately, particularly for nonemergency transports. For example, Medicare coverage of a nonemergency ambulance transport requires that a beneficiary be bed-confined. This requirement does not apply to emergency transports because that coverage is based on the need for immediate medical care.

(For more information about criteria for emergency and nonemergency transports, see app. II.) Noridian was applying bed-confined criteria to both emergency and nonemergency transports. During the course of our review, HCFA became aware of this situation and in September 1999, Noridian consolidated the bed-confined policies for the 11 states for which it administered Part B claims to conform to national policy.

Furthermore, some providers are concerned that carriers sometimes determine medical necessity using the patient's ultimate diagnosis, rather than the patient's condition at the time of transport. HCFA officials have stated that the need for ambulance services should be based on the patient's medical condition at the time of transport, not the diagnosis made later in the emergency room or hospital.

Inaccurate information on what services particular hospitals offer may result in inappropriate partial denials, in which the carrier may allow payment for some but not all of the mileage, contending that the beneficiary should have been transported to a closer facility. Carriers are responsible for determining whether the beneficiary was taken to the nearest appropriate facility, as required for Medicare reimbursement. At least some of the carriers use surveys from hospitals in their states to determine what services a hospital offers and, thus, whether it 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. Although these denials can be appealed, doing so requires additional time and work. Furthermore, these partial denials can have a more serious effect on rural ground and air ambulance providers than on urban providers because of the potential for a larger number of disallowed miles.

Providers' Unfamiliarity with Claims Processing Affects Denial Rates

In addition to carrier practices, other factors, such as incorrectly filled-out claim forms, contribute to denials. According to Noridian officials, some providers have put insufficient information on the claim form to determine if a patient's condition warranted an ambulance transport. Providers in South Dakota, North Dakota, and Wyoming told us that Noridian has not provided sufficient instructions or provider education to enable them to fill out claims correctly. However, Noridian provided a manual on Medicare ambulance services to ambulance providers to help them better understand how to fill out a claim form. In addition, because the South Dakota EMS Director was concerned about denied claims, the state paid to have carrier staff conduct provider education classes.

Volunteer staffs in particular may have difficulty filling out Medicare claim forms, and an improperly filled-out claim form increases the possibility of a denial. According to one state EMS director, volunteers do not have the time to learn about the Medicare reimbursement process. Consequently, some volunteer providers have not billed Medicare because they lack the expertise to file claims. Other volunteer companies have addressed the problem by hiring billing agents that charge from 12 to 17 percent of the collected amount to fill out their claims. North Dakota recently conducted a pilot program to help volunteer staffs by hiring a professional ambulance billing company to file volunteer company claims.

Rural ambulance providers in certain states appear to have difficulty with electronic claims filing. Medicare policy states that electronic claims will be paid more quickly than paper claims. In 1997, 80 percent of Part B claims were submitted electronically. In stark contrast, in South Dakota, North Dakota, and Wyoming, more than 98 percent of the claims submitted in 1997 and 1998 by freestanding ambulance providers were paper claims. Some of the providers we spoke with in those states did not understand how to use the electronic form to provide all the information carriers needed to determine whether a transport met the coverage criteria. Some incorrectly believed that they were limited to 22 characters to describe a patient's condition. Some said that they filed paper claims because, when they had filed claims electronically in the past, they were later required to submit the trip report, which cannot be submitted electronically. However, if the providers had known that they could include additional information electronically about the beneficiary's condition and done so, the trip report might not have been requested.

Absence of National Coding System Contributes to Claims Review Difficulties

Unlike the billing information required for physician services, the medical information required for ambulance claims is not conveyed consistently to carriers. Some carriers require providers to use a system of medical condition codes called ICD-9 (International Classification of Diseases, 9th revision). Other carriers simply rely on individual providers' descriptions to explain the beneficiary's condition at the time of transport. Such explanations may require considerable interpretation by the carrier. Inadequate information on claim forms hinders carriers' ability to determine whether the transport meets Medicare criteria for medical necessity and whether the appropriate level of service—ALS or BLS—was provided. If the information is questionable or insufficient, the carrier may be obliged to suspend or deny the claim.²⁵

HCFA believes that a standardized, mandated coding system would be helpful, and has proposed a coding system for claims using ICD-9 codes, since these are an accepted set of diagnostic and symptomatic codes used for payment of medical bills. According to HCFA, using these codes would promote consistency in the processing of claims and reduce the uncertainty for providers regarding claims approval because using the codes would help in filing claims properly.

While they agree that a coding system would be helpful, a number of ambulance providers are opposed to using the ICD-9 codes as the basis of the system. One concern is that the ICD-9 codes are based on diagnosis, yet EMTs and paramedics are not trained to diagnose patients. The Negotiated Rulemaking Committee has developed an alternative coding system and given it to HCFA for consideration. That system identifies medical conditions and links them to the levels of services provided. HCFA has not yet made a final decision on the use of that coding system.

Conclusion

Implementation of a national fee schedule is likely to benefit those rural freestanding ambulance providers whose payments are currently below the national average because fee schedule payments will be based on average payment amounts. For rural freestanding providers that receive lower-than-average payments currently, such as those in South Dakota, payments will

²⁵When a claim is suspended, the carrier requests additional information before deciding whether to approve or deny the claim. If a claim is denied, the claim must be appealed for the carrier to give it additional consideration, and more information is provided to the carrier at that time.

likely increase. Overall, the fee schedule will improve the equity of Medicare's payment for rural ambulance providers. However, the system will need to be refined after it is implemented. The Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule concluded that a payment adjustment would be appropriate for ambulance providers transporting beneficiaries in low-population, isolated areas; yet the adjuster that will likely be used does not adequately target these providers or their higher fixed costs per transport.

Concerns about claims denials need to be addressed separately from development of the fee schedule. Under the current system, coverage policy can vary from carrier to carrier, which can lead to differences in whether similar claims are paid. In addition, some rural providers may need additional education about how to file claims. A uniform coding system for ambulance claims is likely to improve claims processing and lead to more transparent decisions about claims payment.

Recommendation

We recommend that the HCFA Administrator develop a more refined payment adjuster that better targets the ambulance providers that serve isolated, rural areas where their services are essential to ensuring that Medicare beneficiaries have access to ambulance transports. The rural adjuster should also be structured toward providers' high fixed costs incurred because of the low volume of transports in these isolated areas.

Agency Comments and Our Evaluation

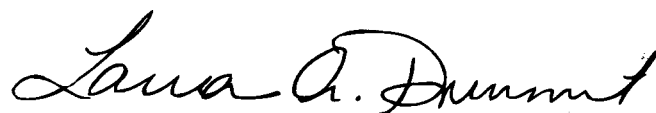
We provided HCFA and Noridian an opportunity to comment on a draft of this report. HCFA agreed with our findings and recommendation (see app. VI). In its comments, HCFA said that assuring and enhancing access to quality care for rural beneficiaries was an agency priority and discussed its efforts to do so, particularly with regards to the new ambulance fee schedule. HCFA agreed with our recommendation that a more refined payment adjuster is needed for ambulance providers that serve isolated rural areas. However, given the time frame for putting the fee schedule in place and the limited available data, HCFA will follow the consensus of the committee on the payment adjuster. HCFA said that this was a temporary approach and that it would work with the ambulance industry to identify and collect relevant data to refine adjustments to the fee schedule. HCFA also highlighted its efforts to clarify ambulance coverage criteria and provide guidance to contractors and providers so that claims are properly

submitted by providers and paid by carriers. Noridian provided some technical comments, which we incorporated where appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to Nancy-Ann Min DeParle, Administrator of HCFA, and make copies available to others upon request.

If you or your staff have any questions, please call me at 202-512-7119 or Sheila Avruch at 202-512-7277. Other major contributors were Deborah Spielberg, Robert Sayers, Tom Taydus, and Wayne Turowski.

Sincerely yours,

A handwritten signature in black ink that reads "Laura A. Dummit". The signature is written in a cursive style with a large, looping initial "L".

Laura A. Dummit
Associate Director, Health Financing
and Public Health Issues

Scope and Methodology

To do this work, we met with more than 50 ground and air ambulance providers, both freestanding and hospital-based, in North Dakota and South Dakota and received comments by telephone or in writing from freestanding and hospital-based ambulance providers located in Minnesota and Wyoming. We also interviewed the state Emergency Medical Services (EMS) Directors in North Dakota, South Dakota, and Wyoming.

We attended meetings of the Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule and met with the major groups whose members are involved in providing ambulance services. We obtained information from the Health Care Financing Administration (HCFA) and reviewed studies prepared by Project Hope on the costs of providing ambulance services, including the costs specific to rural ambulance providers. In addition, we examined 1999 prevailing charge data from HCFA and paid ambulance claims data for calendar years 1997 and 1998. The data represent claims processed as of June 30, 1999. We did not independently test the reliability of HCFA's data. However, we note that a 5 percent sample of this database, which includes all Medicare Part B claims, is often used by researchers investigating important issues in health economics and policy.

We visited Noridian, where we observed the ambulance claims processing system and appeal process for freestanding providers and interviewed staff about the ambulance claims processing system. We also contacted by telephone the fiscal intermediary that determines the payments for hospital-based providers in South Dakota and Iowa.

Medicare Coverage Criteria for Emergency and Nonemergency Ambulance Transports

Medicare covers ambulance services only when the use of other transport methods would be harmful to the beneficiary's health. Medicare coverage includes both emergency and nonemergency ambulance transports. The coverage is available when the beneficiary

- was transported in an emergency situation, for example, as a result of an accident, injury, or acute illness;
- was unconscious or in shock;
- needed to be restrained;
- required oxygen or other emergency treatment on the way to the destination;
- had to remain immobile because of a fracture that had not been set or the possibility of a fracture;
- sustained an acute stroke or myocardial infarction;
- was experiencing severe hemorrhage;
- was bed-confined before and after the ambulance trip; or
- could be moved only by stretcher.

Emergency Transports

Emergency ambulance transports are provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the beneficiary's health in serious jeopardy,
- Serious impairment of the beneficiary's bodily functions, or
- Serious dysfunction of any bodily organ or part.

Nonemergency Transports

Medicare also covers nonemergency transports—both scheduled and non-scheduled—if the beneficiary is bed-confined or meets other medical necessity criteria, listed below. Bed confinement is defined as when the beneficiary is unable to get up from bed without assistance, to ambulate, or to sit in a chair or wheelchair.

Nonemergency nonscheduled ambulance transport requirements include the following:

- For beneficiaries in a facility—such as a nursing home—and under the direct care of a physician, ambulance providers must obtain a written order from the beneficiary's attending physician within 48 hours after the transport certifying that the medical necessity requirements for bed

Appendix II
Medicare Coverage Criteria for Emergency
and Nonemergency Ambulance Transports

confinement were met. This is not a requirement for a beneficiary residing at home or in a facility where he or she is not under the direct care of a physician.

- Ambulance providers must obtain a written order from the beneficiary's attending physician certifying that the medical necessity requirements for bed confinement are met.
- The certification must be dated no earlier than 60 days before the date the service is furnished.

Medicare Payment Method for Freestanding Ambulance Providers

Payments to freestanding ambulance providers are based on the reasonable charge method. The Medicare-allowed amount (payment) for a specific ambulance service is set at the lowest of the following:

- actual submitted charge;
- provider's customary charge, which is the median charge for a procedure by the particular provider in the prior year;
- prevailing charge in the locality, which is the 75th percentile of the prior year's customary charges, arrayed from low to high, weighted by frequency that the charge occurs; or
- the inflation-indexed charge (IIC), which is the lowest of the provider's actual charge, customary charge or prevailing charge in the locality from the previous year, updated for inflation.

The IIC was implemented in 1985 as a cost containment measure and limits the amount of annual increase. Since then, providers cannot receive payment for actual, customary, or prevailing charges that are higher than the lowest charge in any of the four categories from the previous year. That lowest charge updated for inflation becomes the IIC for the current year. In four states we examined—Montana, North Dakota, South Dakota, and Wyoming—the IIC is the amount paid for the majority of services.

Organizations Represented on the Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule

American Ambulance Association
American College of Emergency Physicians and National Association of
EMS Physicians
American Hospital Association
Association of Air Medical Services
Health Care Financing Administration
International Association of Fire Fighters
International Association of Fire Chiefs
National Association of Counties
National Association of State Emergency Medical Services Directors
National Volunteer Fire Council

Recommendations From the Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule

The committee agreed on the major points regarding the fee schedule, which will be the basis for the payment regulations being developed by HCFA. Services will be paid in relation to a base rate in a relative value system, as is done for physician services. The committee defined the levels of ambulance assistance and assigned relative value units (RVUs) for ground ambulance services, as shown in table 3.

Table 3: Levels of Ambulance Assistance

Service level ^a	RVU
BLS	1.00
BLS—emergency	1.60
ALS1	1.20
ALS1—emergency	1.90
ALS2	2.75
Specialty care transport	3.25
Paramedic intercept ^b	1.75

^a 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 (EMTs). Advanced life support (ALS1) is provided by paramedics or EMTs with advanced training. ALS2 is provided by the same staff as standard ALS but involves additional equipment. Specialty care transport is provided by health professionals in an appropriate specialty area such as nursing, medicine, or cardiovascular care or by a paramedic with additional training.

^b Paramedic intercept is ALS service provided by an entity that does not provide the ambulance transport. Under limited circumstances, these services are reimbursable by Medicare.

HCFA will determine the total amount of money available for ambulance payments and a dollar amount conversion factor that is multiplied by the RVU.¹ The following example illustrates how the RVUs will be used once the dollar amounts are determined: if the conversion factor were \$100, the ALS1 would be \$120 (\$100 x 1.20 RVU).

To account for wage and overhead cost differences across the country, 70 percent of the base rate for ground ambulance will be adjusted by the

¹BBA stipulated that total payments for ambulance services during the first year of the fee schedule should not exceed what total payments would have been under the current system. Therefore, HCFA must determine the amount that would have been spent under the existing system before assigning a dollar conversion factor to be used with the relative value units.

Appendix V
Recommendations From the Negotiated
Rulemaking Committee on Medicare
Ambulance Fee Schedule

practice expense portion of the geographic practice cost index (GPCI) used to adjust payments to physicians. The GPCI will be applied to 50 percent of the air ambulance base rate.

The committee agreed that all ground ambulance miles, regardless of the level of service provided, should be paid \$5 per mile. For air transports, the committee agreed on \$6 per mile for fixed-wing and \$16 per mile for rotor-wing (helicopter) transports.

The committee agreed to a payment adjustment that will increase by 50 percent the mileage rate for the first 17 miles for all ground transports of beneficiaries picked up in a non-MSA area.²

For air transports, HCFA will set the RVUs and the conversion factor based on Medicare expenditures attributed to air ambulance services in the base year. The rural adjustment will be applied to the total payment. (The actual percentage adjustment will be determined after the base year expenditures for air transport are established.)

²According to the committee statement, the definition of a rural area is an area outside of a Metropolitan statistical area (MSA), a New England County Metropolitan Area, or an area within an MSA identified as rural, using the Goldsmith Modification. The Goldsmith Modification is used to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features.

Comments From the Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

JUN 22 2000

The Administrator
Washington, D.C. 20201

TO: Laura A. Dummit
Associate Director
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator

SUBJECT: GAO Draft Report: "Rural Ambulance Providers: Medicare Fee Schedule Payments Could Be Better Targeted" (GAO/HEHS-00-115)

Thank you for the opportunity to review and comment on the above mentioned report.

Assuring and enhancing access to quality care for rural beneficiaries is a priority for the Health Care Financing Administration (HCFA). About one in four Medicare beneficiaries lives in rural America, and we understand that rural providers face unique challenges in serving the medical needs of their beneficiaries. That is why we have taken a number of steps to help rural providers. For example, we have created a Rural Health Initiative within our agency to increase and better coordinate attention to rural issues. As part of this effort, we are continuing to closely monitor how laws and regulations governing our programs affect rural beneficiaries and providers. Also, we have enhanced our relationship with our colleagues at the Small Business Administration to ensure we consider the special needs of small health care providers in all of our programs, policies, and guidance.

Among providers, rural ambulance organizations serve a critical role and face special challenges. Your report accurately reflects that the costs of rural ambulance providers may be, in some cases, higher than their urban and suburban counterparts. This fact is of special importance given that Congress, through the Balanced Budget Act of 1997 (BBA), mandated the establishment of a fee schedule for payment of all Medicare ambulance services.

As you know, the Medicare program currently pays for ambulance services of independent suppliers on a reasonable charge basis. For years, Congress has been moving towards fee schedules and prospective payment systems for Medicare payment determinations. In the case of ambulance services, the reasonable charge methodology has resulted in a wide variation of payment rates for the same service depending on location. In addition, this payment methodology is administratively burdensome, requiring substantial record keeping.

In order to establish the ambulance fee schedule, the BBA required that HCFA develop the proposed fee schedule through a negotiated rulemaking committee. In addition to the Federal government, this committee included the American Ambulance Association, the American Hospital Association, the Association of Air Medical Services, the International Association of Fire Fighters, the International Association of Fire Chiefs, the National Volunteer Fire Council, the National Association of Counties, the National Association of State EMS Directors, and the

**Appendix VI
Comments From the Health Care Financing
Administration**

Page 2 -- Laura A. Dummit

National Association of EMS Physicians. We are preparing a notice of proposed rulemaking that describes implementation of the Medicare ambulance fee schedule developed as a result of the negotiated rulemaking process. We are committed to follow the consensus items reached in the negotiations; HCFA cannot unilaterally make decisions regarding the proposed rule.

The negotiated rulemaking committee focused on a number of complicated issues, including how to assure adequate payments to isolated, essential ambulance suppliers (that is, when there is only one ambulance service in a given geographic area) that experience higher costs per trip due to a low volume of transports resulting from a small population base. To address this, the committee recommended several changes in Medicare payment for ambulance services. For example, the committee recommended reducing the current variation between payment rates for the same service in different geographical locations. The committee also recommended paying a higher mileage rate for rural ambulance transports than for urban transports. The definition of a rural area would be an area outside a Metropolitan Statistical Area (MSA), or a New England County Metropolitan Area or an area within an MSA identified as rural, using the Goldsmith modification.¹

We agree with your recommendation that a more refined payment adjuster is needed for ambulance providers that serve isolated areas. However, given the limited available data on rural ambulance services, the consensus of the rulemaking committee is that this is the best approach now feasible to account for the higher costs of certain low-volume rural suppliers. Because of data limitations, we recognize that the negotiated rule committee's rural adjustment is a only a temporary, first step. In fact, as HCFA indicated during the negotiations over the rule, we intend to consider suggested alternative methodologies that would more appropriately address payment to isolated, essential, low-volume rural ambulance suppliers.

We will work with the ambulance industry to identify and collect relevant data so that appropriate adjustments can be made in the future. This data collection effort should focus on resolving some of the more complicated issues, including:

- Appropriately identifying an ambulance supplier as rural, considering that suppliers can have multiple locations and can dissolve and reorganize under different names;
- Identifying the supplier's total ambulance volume (since Medicare only has a record of their Medicare services); and,
- Identifying whether the supplier is isolated, given that some suppliers may not provide services for Medicare (i.e., Medicare would have no record of their existence) and one of these suppliers may be located near an otherwise seemingly "isolated" supplier.

Your report also discusses the concerns of some ambulance suppliers that there are discrepancies in claims denial practices by the Medicare carriers. Using data on the 1998 calendar year, the report suggests that carriers vary in their review rates and that this variation may be attributable in part to the absence of national coverage policies for some aspects of ambulance services.

¹The Goldsmith modification identifies census tracts located within a large metropolitan county of at least 1,225 square miles that are so isolated by distance or physical features that they are more rural than urban in character.

**Appendix VI
Comments From the Health Care Financing
Administration**

Page 3 -- Laura A. Dummit

As part of our efforts to ensure the integrity of the Medicare program, HCFA contractors must constantly perform data analysis on billing practices and review claims. HCFA has been, and will continue, working with Medicare's contractors and the ambulance industry to ensure that the program functions in the best possible way. In fact, we have already taken steps to improve the functioning of the program. For example, in January 1999, HCFA published the final regulation on coverage of ambulance services. Based on industry comments, that regulation updated and clarified Medicare's ambulance coverage criteria, including minimum vehicle and staffing requirements, a standard definition of "bed-confined", and the allowed destinations for transport of beneficiaries with end-stage renal disease to a dialysis facility. The final regulation also implemented a provision of the Balanced Budget Act of 1997, which authorized direct payment under certain circumstances to paramedics who operate separately from an ambulance supplier. Through the ambulance negotiated rulemaking process, we will continue to clarify other aspects of the claims process.

In addition, to help providers understand the process, HCFA and our contractors regularly issue guidance and hold meetings to educate providers and receive feedback. For example, in November 1999, we issued documents to Medicare's contractors helping to explain important aspects of the January 1999 final rule. In addition, we have responded to several requests for further guidance and clarification on other related issues. Finally, HCFA has released two sets of questions and answers, in March 1999 and October 1999, regarding questions we have received on the final rule. These responses are available at <http://www.hcfa.gov/medicare/ambmain.htm>. We are confident that the new guidance, coupled with our outreach efforts, will improve the claims denial process.

We look forward to continuing our work with Congress, the GAO, and the ambulance industry to fulfill our commitment to ensuring that isolated rural ambulance providers receive appropriate payment so that beneficiaries have access to the high quality care they deserve.

We appreciate the effort that went into this report and look forward to working with GAO on this and other important issues.

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