

MEDICARE AMBULANCE PAYMENTS

A Framework for Change

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PURPOSE

To summarize findings from past Office of Inspector General (OIG) reports and offer suggestions for the development of a fee schedule for Medicare-covered ambulance services.

INTRODUCTION

Current Medicare Coverage and Payment for Ambulance Services

Ambulance services are a covered benefit under both Part A and Part B of the Medicare program. Part A covers these services when a hospital inpatient is transported to and from another hospital for specialized treatment. Payment for these services is included in the hospital's prospective payment for the patient's stay. Medicare Part B covers ambulance services when Part A coverage is unavailable and the following criteria are met: (1) the vehicle and crew meet certain requirements, (2) the transport is medically necessary, and (3) the trip, as a general rule, stays within certain distance and destination limitations.

Medicare payments were approximately \$1.8 billion in 1997. (This does not include Medicare beneficiary co-payments.)

The type of vehicle used to transport the patient affects payment, which is based on an ambulance supplier's historic charges. Medicare pays for two levels of ambulance services--basic life support (BLS) and advanced life support (ALS). The two levels generally are distinguished by the credentials of the staff on board the vehicle. Medicare does not cover other forms of transportation, such as a wheelchair or stretcher van.

Medicare uses a reasonable charge methodology to pay for ambulance services. Medicare pays 80 percent of the reasonable (i.e., allowed) charge, and the beneficiary is responsible for the remaining 20 percent. Under the reasonable charge methodology, payment is based on the bill from ambulance suppliers. Carriers, the contractors that process Part B claims, develop separate base rates for BLS and ALS ambulances that reflect customary and prevailing charges in an area as well as separate rates for suppliers' other charges, including mileage and supplies. For example, the maximum reasonable charge for mileage is the lowest of (1) the supplier's actual charge, (2) the supplier's customary charge for mileage, or (3) the prevailing charge for mileage in the area. The Health Care Financing Administration (HCFA) authorizes carriers to raise or lower the reasonable charge based on the concept of "inherent reasonableness." For example, if charges are inflated because of lack of competition or the charges are significantly higher than acquisition costs, carriers may lower reimbursement.

The HCFA permits ambulance suppliers to bundle or unbundle their various charges, which generally include a base rate, a mileage charge, and a charge for supplies. Suppliers typically unbundle their charges and bill separately for their base rates and mileage, which is the single biggest ancillary charge. In 1997, Medicare paid approximately \$300 million, or 18 percent of total spending for ambulance services, for mileage. Suppliers may bill different amounts for ALS and BLS mileage.

Recent Legislation--Fee Schedule and Demonstrations

The *Balanced Budget Act of 1997* requires HCFA to develop a fee schedule for ambulance services effective January 1, 2000. The law requires HCFA to use negotiated rulemaking and states that payments under the new fee schedule should not exceed payments under the old system. The HCFA decided to delay implementation of the fee schedule in order to focus on completing Year 2000 programming changes on time. Negotiations on the fee schedule began in February 1999.

In addition to mandating a new payment system, Congress authorized HCFA to establish up to three demonstration projects, which would permit local government agencies to experiment with alternative models for the delivery and payment of ambulance services.

Problems with the Current Reimbursement System

The OIG has highlighted problems with the current reimbursement system for ambulance services for years (please refer to the bibliography for a complete list of OIG reports). In 1987, we reported that growth in Medicare payments for ambulance services was far outstripping inflation rates and recommended that carriers use their inherent reasonableness authority to limit payments.

Later reports highlighted the problem of inconsistencies among carriers in their claims processing practices and allowed charges as well as the failure of the payment system to recognize the cost differences between scheduled and unscheduled ambulance trips. A 1994 report concluded that the payment system does not take advantage of the lower costs associated with high-volume, scheduled ambulance transports.

In addition to documenting the problems with payment practices, OIG studies have shown that Medicare's limited transportation benefit is highly vulnerable to abuse. In a 1994 report, we found that 70 percent of sampled dialysis-related claims did not meet Medicare requirements for medical necessity. A 1997 report showed that Medicare payments were continuing to grow rapidly. More importantly, it pointed out unexplainably wide variations in payments for similar services and described the payment system as one lacking in common sense and particularly vulnerable to fraud and abuse.

More recently, a December 1998 report showed that two-thirds of the trips for a select group of beneficiaries were medically unnecessary. The trips for these beneficiaries were suspect, because the patients were not admitted to the hospital or nursing home or treated in the emergency room on the same day as the transport.

Finally, the OIG attempted to compare Medicare payment rates to those of commercial and other Federal payers. The January 1999 report found that such comparisons were not possible due to the complexity of the payment methods of both Medicare and other payers. The study also revealed that the current payment methods of all these entities are not based on reliable cost data. Instead, they simply reflect historical charges.

FRAMEWORK FOR CHANGE

We prepared this report to offer advice to the HCFA and industry negotiators who are now engaged in the difficult task of developing the fee schedule mandated by the *Balanced Budget Act*. We base this advice on the work we have done on Medicare ambulance services as well as other aspects of the Medicare program.

With this broader perspective in mind, we offer the following suggestions for consideration when developing and eventually refining the fee schedule.

I. SIMPLIFY THE PAYMENT SYSTEM

A 1997 OIG report detailed the complexity of Medicare's payment system for ambulance services. According to the report, the number of procedure codes that ambulance suppliers submitted had increased almost 35 percent in a one-year period to 240 codes. In addition to the 37 specific ambulance codes that HCFA established, suppliers may bill separately for medical supplies, injections, and other services. The 37 ambulance codes alone contribute to the complexity of the payment system, because suppliers may bundle or unbundle their various charges, and HCFA created different codes for ALS versus BLS services, emergency versus nonemergency transport, and specialized versus nonspecialized services.

We believe that the complexity of the current payment system is one of its major vulnerabilities. Therefore, we strongly urge that a much simplified structure be used for the new fee schedule. There are many ways to do this; we suggest the following:

- ▶ **Pay one rate for emergency transportation and one rate for nonemergency transportation.**
- ▶ **Bundle all charges into the base rate, including mileage up to 10 miles.**
- ▶ **Allow additional payments for miles above 10.**

General Considerations. We base this proposal on a number of considerations. First, the concept of bundling expenses into a single prospective rate is consistent with improvements made in Medicare payments for hospitals, nursing homes, home health services, and a variety of other Medicare program components. It avoids vulnerabilities, particularly the opportunity to game the program by billing for excessive numbers and kinds of services whose review by Medicare carriers is impractical due to their number and small dollar value relative to the entire Medicare budget.

More specifically regarding ambulance services, the distinction between emergency and nonemergency services appears particularly relevant to pricing. Emergency ambulance services are costlier than nonemergency services, regardless of the type of vehicle. Because time and skill affect medical outcomes when an emergency occurs, local communities regulate response times and staffing for emergency transportation. To meet short response times for emergency calls, ambulance suppliers must station personnel and vehicles throughout a given area. Stringent response times and the use of paramedics, the highest level of emergency medical technician, increase the cost of emergency transportation.

Medicare payments are now based on the type of vehicle (i.e., ALS or BLS) and type of service (i.e., emergency or nonemergency). Our proposal would eliminate payment distinctions based on type of vehicle. We believe that Medicare should pay for the kind of service rendered, not the type of vehicle used. Paying by type of vehicle creates incentives for using a more expensive vehicle rather than incentives to organize services according to the kind of care rendered. As noted above, it is the entire system--vehicles, locations, standby capacity, response time expectations, training, and the like--that drives costs, not just the vehicle. The majority of emergency medical service systems (with the exception of very rural areas) provide ALS exclusively and require ambulance suppliers to use ALS ambulances for medical emergencies.¹ Thus, while eliminating the ALS/BLS distinction would align Medicare reimbursement with the actual cost of delivering ambulance services, it would not jeopardize the financial condition of emergency service systems.

The standards for ALS and BLS ambulances vary locally, and the actual cost differences between ALS and BLS ambulances are unknown. In fact, in a recent final rule (with comment period), HCFA eliminated specific staffing requirements for ALS and BLS ambulances and deferred to State or local requirements. Since the standards for ALS and BLS ambulances vary, we believe the type of vehicle is an inappropriate basis for payment in a national program such as Medicare.

¹The Emergency Medical Services Administrators' Association of California, *Issue Paper Regarding the Health Care Financing Administration Negotiated Rulemaking Process for the Establishment of an Ambulance Fee Schedule*, September 1998.

Mileage Rates for Urban and Rural Suppliers. Medicare historically has allowed suppliers to bill separately for miles, and we believe that many ambulance suppliers do so to compensate for what they perceive as an inadequate base rate. Commercial insurers commonly bundle a specific number of miles in the base rate, and bundling would simplify administration of the ambulance benefit.² Also, since payments for mileage are the biggest single ancillary charge, bundling miles may save money without penalizing rural suppliers that must travel great distances. Based on our analysis of HCFA data, we estimate that bundling 10 miles would cover 78 percent of the ambulance trips in metropolitan statistical areas (MSAs) and 56 percent of the trips in non-MSAs.

Allowing reimbursement for miles greater than a minimum number (e.g., the 10 miles we propose to be included in the base fee) provides a convenient way to compensate rural providers for their greater operational costs without overly complicating the fee schedule. In a 1991 report, Project HOPE found that mileage costs greatly contributed to higher total costs for rural ambulance companies, which generally travel greater distances than urban ambulance suppliers.³ In 1997, rural suppliers continued to travel farther than urban suppliers as a general rule, but long trips for Medicare beneficiaries were atypical in both urban and rural areas.⁴ For example, 78 percent of the trips in rural areas and 95 percent of the trips in urban areas were 25 miles or less. The median number of miles per trip for rural suppliers was eight; the comparable number for urban suppliers was five (the figures reflect trips in both ALS and BLS ambulances). Viewed another way, the mean number of miles per trip for rural suppliers was 17; the mean for urban suppliers was eight.

II. BASE THE FEE SCHEDULE ON ACTUAL COSTS, NOT HISTORICAL CHARGES

Historical charge data contain distortions and variations that undermine their usefulness as a basis for the new payment system. We documented these anomalies at length in our 1997 report. We found many examples where Medicare paid more for nonemergency transportation than emergency transportation as well as tremendous variation in payments for mileage. The report concluded that the reasonable charge methodology results in inflated payments for some ambulance services and motivates suppliers to unbundle their charges and upcode to maximize reimbursement. The current system also fails to reflect the lower costs associated with high-

²We obtained information from seven commercial health plans about their rates for ambulance transportation, including the number of miles bundled in the base rate.

³*Project HOPE Report--Study of Payments for Ambulance Services under Medicare, Final Report*, Project HOPE, October 21, 1991.

⁴We defined urban areas as counties that are Metropolitan Statistical Areas, or MSAs. Rural areas are defined as non-MSAs.

volume, scheduled transports. One industry analyst estimates that the cost of scheduled transport is 50 to 67 percent less than the cost of unscheduled transport.⁵

The current reimbursement system drives billing patterns but does not reflect actual costs in the ambulance industry. For example, Medicare allows suppliers to bill separately for their various charges, which may include supplies, oxygen, and mileage. Ambulance suppliers, however, incur nominal costs for supplies and oxygen. Direct labor is by far the biggest component of ambulance expenses (63 percent), followed by profit (10 percent), and administrative support (9 percent). Medical supplies comprise only 2 percent of expenses.⁶

As noted earlier, our most recent report comparing Medicare payments to those of commercial and other Federal payers concludes that these other payment systems also are based on unreliable historical data. Furthermore, we were unable to locate any sources of cost data that we could use to determine the reasonableness of Medicare rates overall. As far as we can tell, this type of information is not widely available, even in the ambulance industry. For example, we understand that the American Ambulance Association (AAA), which represents 750 ground ambulance suppliers, does not have such cost data and has contracted with Project HOPE to survey AAA members and evaluate the cost of ambulance services.

The *Balanced Budget Act* requires that the fee schedule be budget neutral when compared to payments under the current methodology, subject to interim payment reductions. Thus, the total amount to be spent on Medicare ambulance benefits already is determined. The task, then, is to weight the elements of the fee schedule to achieve the budget neutrality prescribed by the law. We recognize that it may be necessary initially to base these weights on a professional assessment of what can be gleaned from currently available data. But at best, this will be a rough approximation.

For the longer run, we suggest 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 and program changes and**
- ▶ **verify the data and concepts underlying the model before it can be used to adjust Medicare payments.**

III. USE DEMONSTRATIONS TO TEST INNOVATIVE DELIVERY AND PAYMENT SYSTEMS

⁵Telephone conversation with Richard A. Keller, Partner, Fitch & Associates, July 27, 1998.

⁶We obtained this information at a December 1997 conference organized by Kaiser Permanente and attended by Western Region Emergency Medical Service Directors, Kaiser Permanente medical and administrative staff, and OIG staff.

The *Balanced Budget Act*, which authorizes three local government demonstration projects, offers a way to experiment with alternative models for the delivery and reimbursement of ambulance services.

It should be possible to systematically develop and evaluate innovative payment systems for ambulance services which will promote more cost effective services. This is especially true for recurring nonemergency services. For example, we have recommended the use of preferred providers, competitive bidding, rebate agreements, add-ons to composite Medicare payment rates for dialysis facilities, and specialized fee schedules for end-stage renal disease patients. (See OIG's March 1994 report, *Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Payment Practices*.) Other approaches to pay for nonemergency services based on practices of State and local Medicaid agencies, approaches used by managed care organizations, and ideas of other interested parties might be of interest.

At the same time, caution needs to be exercised to avoid the danger of implementing promising approaches without ensuring their feasibility or measuring their costs. Thus, we suggest that HCFA:

- ▶ **promptly initiate demonstrations of innovative practices, as authorized by the *Balanced Budget Act*, but**
- ▶ **avoid adopting any changes to Medicare's scope of coverage for ambulance services or widespread adoption of innovative approaches (other than the fee schedule itself) until their feasibility has been tested and their costs or savings have been evaluated through demonstration projects.**

IV. IMPROVE ADMINISTRATION OF THE MEDICARE AMBULANCE BENEFIT

The method by which the fee schedule will be administered is an important element of its success. For example, under the approach which we are suggesting, it will still be necessary to distinguish emergency from nonemergency services and for Medicare carriers to ensure that claims for additional miles are properly documented and are verifiable. Numerous other facets of administration will need to be considered to reduce the susceptibility of the new system to fraud and abuse. We suggest that HCFA:

- ▶ **consider centralizing claims processing for ambulance services to one or several carriers with specialized capacity for reviewing ambulance claims and**
- ▶ **choose one carrier, or some other appropriate contractor, to aggregate and analyze data.**

In our studies we have repeatedly documented inconsistent claims processing practices and payments among the carriers. The implementation of a new payment system is an opportune time to standardize claims processing for ambulance services. The HCFA has centralized claims processing in the past for other Medicare benefits, notably medical equipment and supplies and home health care. Centralized processing may facilitate verification of medical necessity, a major concern for nonemergency ambulance transportation. We wish to clarify that we are not necessarily suggesting that a distinct and separate carrier be chosen for this function. Although that approach certainly has merit, one or more of Medicare's current carriers could be used to handle Medicare ambulance bills in addition to their normal workload. This latter approach could avoid the cost of creating an additional carrier just for ambulance services.

A statistical analysis unit could play a crucial role in ensuring the integrity of Medicare payments. This is now being done for medical equipment and supply claims. This function could be organized in any one of several different ways. For example, it could be performed by one of the existing carriers or even one of the specialized ambulance carriers which we are suggesting. But also it could be performed by a program integrity contractor, either one specializing in ambulance services or one with a broader scope of responsibilities.

BIBLIOGRAPHY OF OIG REPORTS

Medicare Payments for Ambulance Services--Comparisons to Non-Medicare Payers, OEI-09-95-00411, January 1999.

Medical Necessity of Medicare Ambulance Services, OEI-09-95-00412, December 1998.

State Ambulance Policies and Services, OEI-09-95-00410, February 1998.

Medicare Ambulance Payments, OEI-05-95-00300, November 1997.

Follow-Up to Review of Medical Necessity for Ambulance Services, A-01-94-00528, June 1995.

Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Medical Necessity, OEI-03-90-02130, August 1994.

Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Payment Practices, OEI-03-90-02131, March 1994.

Review of Medical Necessity for Ambulance Services, A-01-91-00513, October 1992.

Medicare Part B Ambulance Services, OAI-03-86-00012, March 1987.