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JUN 19 2006

06/08/2006

To: Department of Health and Human Services
Attention: CMS-1317-P
PO Box 8017
Baltimore MD 21244-8017

From: Joy E Johncox RN
Director of Resource Utilization
Air Evac EMS Inc.
PO Box 768
West Plains, MO 65775

To Whom It May Concern:

I am requesting that you review the regulations as they refer to SCT in the following areas:
1) delete statement ...transportation of a *critically injured or ill beneficiary.* And utilize the existing statement "*SCT is necessary when a beneficiary's condition requires on-going care that must be furnished by one or more health professionals in an appropriate specialty area, for example nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training*"

Ground services frequently transport a patient that requires advanced care services i.e ventilator, blood administration, specific drugs beyond the paramedic training etc that are not categorized as "critically injured or ill"..These transports should meet SCT definition as the Ground service is utilizing an advanced care team (per physician order) that is beyond the scope of a Paramedic.

2) The SCT definition should include destinations AND origins other than H-hospital. Ground services frequently transport ventilated patients etc that require advanced care per physician order during transport, for example from hospitals to Ventilator specialty facilities. On occasion the reverse is true. To restrict SCT to ONLY H-H does not acknowledge the SCT transports that are currently being carried out by Ground services each and every day.

I thank you for this opportunity to respond and hope that you will re-look at your definition and restrictions on destination and origin.

Thank you

Sincerely,

Joy E Johncox

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SHAWANO AMBULANCE

JUL 3 2006

3 July 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1317-P
P.O. Box 8017
Baltimore, MD 21244-8017

To Whom It May Concern:

Please accept the following comments with regard to CMS1317-P, the proposed revisions to the Payment Policies of Ambulance Services under the Fee Schedule for Ambulance Services:

- First, we strongly object to the proposed change that would require both the origin and destination of an SCT to be hospitals. We are called upon to transport patients with very acute, high level needs to and from nursing homes, dialysis centers, specialist's offices and other locations. Regardless of origin or destination, *the patient's needs* dictate that our caregivers have skills and training that is above and beyond the Wisconsin licensed paramedic scope. Where the patient is being transported to or from is immaterial to the innate care requirements and associated costs of providing such an elevated level of care.

  Furthermore, CMS has not demonstrated any plausible explanation as to why they have chosen to deviate from the Negotiated Rulemaking Committee's position which was arduously arrived at with regard to SCT transports after both CMS and stakeholders agreed to a certain set of universally acceptable concessions. It has been claimed that CMS is merely "clarifying language" in this proposed revision, when in all actuality it is known that the debate involving the hospital-hospital vs. facility-facility definition was a very thorough and very lengthy process that didn't simply end up with the final rule including ambiguous language with regard to this definition.

- Second, we fail to see any reason why
  1) the type of ownership an ambulance vehicle has,
  2) the location of an ambulance vehicle at time of dispatch, and/or
  3) the technology used for placing a call to effect an ambulance dispatch,

  should be considered when determining whether or not a response should be deemed an emergency response. Here again, CMS has indicated they intend to "clarify confusion" with regard to the present rule, however, they have not provided any logical reason for the substance of this proposed change. Rather, the intent of the NRM Committee has again been overlooked, in that additional reimbursement for responses considered "emergencies" was to compensate any ambulance

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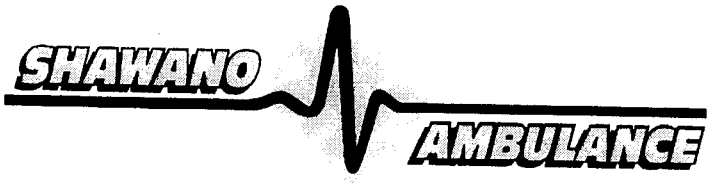

service provider, regardless of how held or organized, for the additional costs to provide seamless, immediate responses to emergency incidents. The addition of these new determinants will surely cause further confusion surrounding the definition of an emergency response.

- Finally, the adoption of Rural Urban Commuting Areas (RCUAs) as part of the most recent Goldsmith modification for identifying rural areas within urban tracts would be premature. The Governmental Accounting Office (GAO) is currently reviewing this issue, as ordered by Congress, and has not yet produced their findings or recommendations. It appears a more prudent course of action would not act upon this proposed change until the GAO findings are made known. In the event said findings suggest a different course of action, adopting the RCUAs at this point would only force another shift in direction later on.

Thank you for your consideration of these comments. Shawano Ambulance Service is a rural provider of both 911 ambulance services and acute interfacility ambulance services. To that end, we are committed to working toward keeping a fair, equitable and efficient process of reimbursement so that the patients we serve can continue to receive appropriate levels of advanced care. Furthermore, we would be happy to discuss any of the issues identified above or provide additional information you or your staff may require. Please feel free to contact me at the address or phone number below.

Sincerely,

Patrick A. Trinko
Director, Shawano Ambulance Service

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Clay County Emergency Ambulance Service
464 Main St.
Clay, WV 25043
304-587-2554

JUL 3 2006

Department of Health & Human Services
Attention: CMS-1317-P
P.O. Box 8017
Baltimore, MD 21244-80117

Dear Sir or Madam:

I am writing to express our deep concern about the Fee Schedule for Ambulance Services, 42 CFR Part 414 (CMS-1317-P) RIN 0938-A011. If the changes to the fee schedule are implemented, it will have a very detrimental effect on county ambulance services throughout West Virginia. With this proposal, you will be in effect designating our county as urban, rather than rural. We serve a county of 10,300 population in an area of 346 square miles, with no emergency medical facilities. The closest Level 1 Trauma Center is approximately 50 miles away. Our county is in the central part of West Virginia, with Charleston being the closest metropolitan area. Given these facts, we are clearly a rural area, not urban in nature.

Most of our residents receive Medicare or Medicaid services and are on fixed incomes. Many times, our citizens have no health insurance at all. We are the only emergency medical service in the county providing specialized care, despite working on a very limited budget with no assistance. Cutting our mileage rates could easily result in lay-offs and cut-backs on staffing for ambulance, which would have a devastating effect on public safety in Clay County.

Our service over the past three years includes 1,028 billed runs for 2003, covering 38,237 miles; 1,423 billed runs for 2004, with mileage of 57,288; and 1,407 billed runs in 2005, with mileage of 55,198. The proposed cuts you are planning, in addition to the disallowed expenses we already sustain, will incur a profound monetary hardship for our organization. The proposed average reduction of $1.97 per mile will reduce our yearly budget by approximately $47,120.43 in mileage alone.

Currently, we provide a 24-hour ALS crew, and a 12-hour BLS day crew. If these cuts come about, we might become more heavily reliant on mutual aid to provide care for our citizens, thereby placing an even greater strain on already overloaded mutual aid areas. Mutual aid services are only accessible when the surrounding systems have the resources available. Even so, this assistance is still 45 to 60 minutes away. Most of the counties that surround Clay County are also struggling, and mutual aid is not always available due to their own staffing and funding shortages.

Clay County Emergency Ambulance Service
464 Main St.
Clay, WV 25043
304-587-2554

Clay County Emergency Ambulance Service has no outside financial support. We are totally self-supporting through revenue we generate from ambulance calls, reimbursements through Medicaid, Medicare, private insurance and self-paid. We receive no financial support from industrial or county tax revenue; nor has the county any bond levy at present to subsidize us in any way.

Based on the above facts, we respectfully request that your agency reconsider your decision on redesignating our area as "urban" rather than what it is, which is rural. As stated above, the projected estimated loss of $47,120.43 for mileage alone resulting from such a change would have an extremely negative effect on our ability to continue operations serving the citizens of Clay County.

Please do not hesitate to contact me if you have any questions or comments about this issue. I can be reached at (304) 587-2382 or (304) 587-2554.

Sincerely,

Beverly King, Director
Clay County Emergency Ambulance Service

CC to: Senator Robert C. Byrd
CC to: Senator John D. Rockefeller
CC to: Congresswoman Shelly Moore Capito

AMERICAN AMBULANCE ASSOCIATION

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McLean, Virginia 22102
1-800-523-4447
Web: www.the-aaa.org

"The American Ambulance Association promotes heath care policies that ensure excellence in the ambulance services industry and provides research, education, and communications programs to enable members to effectively address the needs of the communities they serve."

June 28, 2006

Mark B. McClellan, MD, Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1317-P; Medicare Program; Revisions to the Payment Policies of Ambulance Services under the Fee Schedule for Ambulance Services

Dear Dr. McClellan:

The American Ambulance Association (AAA) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule entitled "*Medicare Program; Revisions to the Payment Policies of Ambulance Services under the Fee Schedule for Ambulance Services*" ("Proposed Rule") 71 Fed. Reg. 30358 (May 26, 2006). The American Ambulance Association is the primary trade association representing ambulance service providers that participate in serving communities with emergency and non-emergency ambulance services. The AAA is composed of more than 600 ambulance operations and has members in every state. AAA members include private, public and fire and hospital-based providers covering urban, suburban and rural areas. The AAA was formed in 1979 in response to the need for improvements in medical transportation and emergency medical services. The Association serves as a voice and clearinghouse for ambulance service providers who view pre-hospital care not only as a public service but also as an essential part of the total public heath care system. The comments submitted herein are on behalf of our members, most of which would be adversely affected by one or more of the proposed changes to definitions.

1. Background

Section 4531 (b) (2) of the Balanced Budget Act of 1997 (BBA) mandated the development of a fee schedule for the reimbursement of ambulance services. This fee schedule was to replace the existing system of reimbursing ambulance services based on the reasonable costs of a provider or the reasonable charges of a supplier. The fee schedule was designed to create a more uniform payment system under Medicare for ambulance services. The BBA further mandated that certain aspects of this ambulance fee schedule be developed through a Negotiated Rulemaking process in consultation with various national

organizations representing individuals and entities which furnish and regulate ambulance services. Included in the charter of Negotiated Rulemaking Committee (NRM Committee) was the task of developing "*definitions for ambulance services that link payments to the types of services furnished.*"

The AAA was selected to participate in the Negotiated Rulemaking process as a member of the NRM Committee on Medicare ambulance fee schedule. The Health Care Financing Administration (HCFA), now CMS, as well as other national organizations representing ambulance interests, was also a member of the NRM Committee.

The Committee Statement (copy enclosed), signed on February 14, 2000, set forth the agreements reached by all members of the NRM Committee with respect to issues addressed in the proposed rule establishing the ambulance fee schedule. The Department of Health and Human Services, through HCFA, agreed to use this Committee Statement, to the maximum extent possible consistent with its legal obligations, as the basis for its Proposed Rule implementing the ambulance fee schedule.

The proposed rule implementing the ambulance fee schedule was issued on September 12, 2000, and was followed by a final rule on February 27, 2002. The ambulance fee schedule was phased-in over a five-year period commencing April 1, 2002. While the final agreement does not contain all of the preferred definitions of the AAA, the AAA was willing to compromise on several issues in order for the negotiated rulemaking to succeed. All members of the committee, including HCFA (CMS), compromised. In the Proposed Rule of May 26, 2006, however, CMS, without adequate explanation, has reneged on its agreement and proposed definitions for "emergency response" and "SCT" that are different from what was agreed to by all NRM Committee members, all of whom compromised for the sake of a successful outcome to the process.

Consistent with the Committee Agreement signed by the members of the NRM Committee on February 14, 2000, the AAA and every other participating national organization honored their commitment to support the definitions developed by the Committee. The AAA reminds CMS of its obligation to do the same. The BBA explicitly mandated that the establishment of definitions for the various types of ambulance services be developed in conjunction with industry representatives as part of the negotiated rulemaking process. For CMS now to abandon the agreement with respect to these definitions flies in the face of the provision in the BBA requiring specifically that definitions be developed through the negotiated rulemaking process.

2. <u>Summary of Comments</u>

The AAA strongly objects to the proposed changes to the definitions of "emergency response" and "specialty care transport (SCT)" that were adopted by the NRM Committee and subsequently incorporated into the Final Rule of January 22, 2002. CMS has not articulated any public policy interest or legal rationale that would require these changes. For that reason its departure from the express terms of the Committee Agreement is arbitrary and capricious and not in accord with law.

Regarding the revised geographic determinations for rural and urban, we commend CMS on adopting Rural Urban Commuting Areas (RUCAs) as part of the most recent Goldsmith modification for identifying rural areas within urban tracts. For the past few years, the AAA has been advocating for RUCAs to be adopted under the Medicare ambulance fee schedule as the sole determination for rural and urban areas. While using the updated Goldsmith modification and thus RUCAs as only a modifier falls short of this objective, it is at least a step in the right direction.

Prior to implementing the new OMB standards for Core-Based Statistical Areas (CBSAs) as the primary determination, we are recommending that CMS take several steps which include mitigating the financial impact on those providers adversely affected by the change and providing the agency an opportunity to review the findings of the pending GAO report. We are hopeful that the GAO will provide the information necessary to determine the most appropriate means for identifying urban and rural areas when it comes to providing ambulance services. Since ambulance services are unique as a health care provider in that they go to the patient to provide care, we want to make sure that CMS adopts a system for designating rural areas that is truly applicable to our industry.

The following are our detailed comments on each provision of the Proposed Rule:

3. **Specialty Care Transport**

The current definition for Specialty Care Transport, found in 42 C.F.R. 414.605, is as follows:

> *Specialty care transport (SCT)* means interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT–Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

The Proposed Rule would change the origin/destination requirement in the definition to allow a SCT transport to be billed only in the case of "hospital-to-hospital" ambulance transports. The definition of SCT currently applies to "interfacility" transports. According to the Proposed Rule, the clarification would not effect a substantive change in policy under the ambulance fee schedule, but rather is only intended to conform the regulation text to the current policy of CMS on SCT. We strongly disagree with this characterization of the proposed change. Every word of this definition was carefully negotiated, especially the fact that the definition would apply to all types of interfacility transports involving specialty care. If current policy is to apply it only to transports

between hospitals, that policy is contrary to the current regulation and totally inconsistent with the definition agreed to during the negotiated rulemaking process.

The Specialty Care Transport level of service was first recognized for a separate level of payment during the Negotiated Rulemaking process. At the time, the NRM Committee concluded that a higher level of payment was warranted where the ambulance service was called upon to provide a level of service beyond that of Advanced Life Support (ALS). This higher level of payment was intended to compensate ambulance services for the costs of providing certain medical equipment and highly trained personnel over and above basic state guidelines for ALS, as well as for the additional costs incurred in training paramedics beyond the basic paramedic curriculum.

Responsibility for creating a definition for SCT was tasked to the Medical Issues Workgroup of the NRM Committee. The Medical Issues Workgroup, in its report delivered December 7, 1999, ultimately recommended to the NRM Committee that SCT be defined as a: "*...a level of inter-facility transport service...*". There was no initial consensus that the SCT level of service be limited to inter-facility transports. The final recommendation was the result of a compromise among the members of the Workgroup. As late as August 1999, the working definition of the Workgroup for SCT included language that it *...might also include scene pick-up and transport of critically ill or injured patients by appropriately staffed specialty transport vehicles or aircraft.*"

The final language, i.e. defining SCT to be a form of "interfacility" transport, was the result of a compromise on this and other issues. Many committee members felt very strongly - and still do - that SCT should be paid when all of the other criteria are met, regardless of the origin and destination. Yet, largely to allay concerns by HCFA that the new level of service would be over-billed, a compromise was reached to limit SCT to "interfacility" transports. HCFA expressly agreed to this definition and understood that it would include transports between a nursing facility and a hospital as well as between two hospitals.

CMS, without explanation, used the word "interhospital" in explaining the SCT definition in the preamble to the Proposed Rule published on September 12, 2000 rule. The proposed regulatory text itself, however, used the correct word, "interfacility". The problem with the explanatory language drew protests from members of the Negotiated Rulemaking Committee who had fought over the definition. We pointed out that the Committee recommendation included transports between nursing facilities and hospitals and we requested HCFA to correct the erroneous terminology in the preamble. As a result, CMS, which must have been aware of the discrepancy because of the comments it had received, retained the word "interfacility" in the definition of SCT in the regulations text in the final rule published on February 27, 2002. It remains that way in the regulation as it exists today. Therefore, it is disingenuous, at best, for CMS to say that it is making a clarifying rather substantive change. 1/

1/ As recently as 2005, when the issue of whether SCT coverage required interfacility vs. inter-hospital transports was brought up in Region V, CMS instructed a contractor (WPS) to pay claims at the SCT level for transports between skilled nursing homes and hospitals. See Medicare Part B Communiqué, Wisconsin

Moreover, other than stating that it is conforming its definition of SCT to its current policy, CMS has not articulated *any* reason why it should adopt such a policy. The Administrative Procedure Act requires an agency to publish a statement of the basis and purpose of any rule it adopts. CMS has failed to articulate a reason in this case, nor could it, for there is simply no good reason for limiting SCT to inter-hospital trips. The transport of a critically ill or injured beneficiary requires the same level of crew training, equipment and supplies regardless of whether that trip originated at a hospital or a nursing home. There are many patients in nursing homes who cannot be transported safely without the additional crew and/or equipment provided by SCT. CMS has not explained why its "current policy" should deny the appropriate level of care to these patients. In addition, restricting SCT to inter-hospital transports would also have the unintended effects of discouraging ambulance services from acquiring the necessary equipment and providing additional training for their paramedics or employing highly trained specialists and clinicians to provide appropriate transports for such patients.

If any clarification were needed to the definition of SCT, it would be to provide better guidance to the Carriers and intermediaries as to the medical conditions of patients warranting SCT. SCT requirements are usually set via medical protocols established on a local and/or state level. Because of this fact, the NRM Committee developed the definition of SCT to default to local requirements rather than attempt to set any type of national standard for when SCT level care would be appropriate or should be required for any type of patient. This is consistent with the general rule followed by the Committee, reflecting Medicare policy for all types of services, of deferring to state and/or local standards of practice on purely medical matters.

Unfortunately, some Carriers are interpreting the current definition of SCT in a manner inconsistent with local protocols. In particular, some carriers may be using a definition of "critically ill or injured" that may not correspond with local protocols. For example, while local standards and protocols may require a SCT level of care to transport a stable but ventilator-dependent patient (i.e., one who would be in dire condition if not for the apparatus on which he or she is dependent), the carrier may determine that because the patient is currently stable, he or she is not "critically ill", and therefore the transport is downgraded. As a result, providers are required by local and state level medical protocols to provide SCT level care for patients but carriers are downgrading the transport to either ALS and even in some cases BLS as they decide individually in their opinions when SCT level care should be required. We believe carriers should refer to local requirements as to when SCT level care is required rather than decide on their own whether or not SCT is appropriate for any given patient. This was the intent of the NRM Committee when it developed the definition of SCT.

Therefore, we recommend that the definition of SCT be clarified by adding ", according to applicable local and/or state standards of practice," after the words "SCT care is necessary when a beneficiary's condition". This change would be consistent with the

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Physicians Service Insurance Corp., June 2005, p.8. Also, this instruction was stated orally by CMS officials on several occasions over the past two years on the Ambulance Open Door Forum Calls.

original intent of the NRM Committee as well as with general Medicare policy of deferring to local standards of medical practice. CMS should continue to monitor this issue to determine whether local standard are sufficiently well-developed to provide adequate guidance to the carriers or whether a national standard should be developed that would require an additional modification of the current definition of SCT.

Another clarification needed to the definition of SCT is that such transport is billable whether or not the specially trained personnel onboard the ambulance actually have to alter or activate, rather than monitor, the equipment required in an SCT transport. Some Carriers are claiming that unless specialty personnel actually have to alter equipment settings or otherwise manipulate equipment used during a transport, simply having medical teams on board with added certification that are clinically capable to monitor the equipment does not constitute the need for SCT level care. For example, ventilator dependent patients in many areas require personnel with specific training to know what to do if intervention is required. These Carriers are claiming that unless this intervention is actually required during the transport, the SCT level care was not required. So, if the personnel on board with additional training are there to monitor the patient during the transport, unless he/she actually has to intervene if something goes wrong, the transport is downgraded to an ALS level – and in some cases – a BLS level transport. This was also never the intent of the Committee in developing the SCT level transport during NRM.

CMS adopted a more enlightened and appropriate policy in the fee schedule of paying for ambulance services based in part on the cost of being ready to provide that service. That should apply to SCT level care as well. Otherwise, ambulance services are encouraged to provide unnecessary services to SCT patients who, fortunately, are transported without incident, or, conversely, to transport critically ill patients without the appropriate personnel and equipment onboard. Therefore, we recommend that the definition of SCT also be clarified by adding the words ", including the monitoring of specialty equipment required by the patient," after the words "requires ongoing care".

In summary, the CMS proposed revision of the definition of "specialty care transport" is not a simple clarification of existing policy, as CMS claims, but rather is fundamentally inconsistent with the definition agreed to by the NRM Committee. Nor has CMS proffered any basis or purpose for this change, as required by the Administrative Procedure Act. Accordingly, it would be arbitrary and capricious for CMS to implement this proposed change, which would be harmful to the best interests of patients and unfair to patients and ambulance providers alike.

4. <u>Emergency Response</u>

During the negotiated rulemaking process, it was agreed that a higher level of payment would be assigned for an emergency response. As the Committee Statement made clear, this higher level of payment was justified in order to compensate the ambulance service for the additional costs incurred in maintaining the readiness to undertake an immediate response. The February 27, 2002 Final Rule essentially adopted the recommendations of the NRM Committee. However, the February 27, 2002 Final Rule added a further

requirement that the ambulance be dispatched pursuant to a 911 call or the equivalent in areas without a 911 system. CMS subsequently agreed that an emergency response could be the result of calls that are received on the private line of an ambulance entity.

The Proposed Rule would change the definition of "emergency response" to:

> "Emergency response means that an ambulance entity (1) maintains readiness to respond to urgent calls at the BLS or ALS1 level of service, and (2) responds immediately at the BLS or ALS1 level of service to 911 calls, the equivalent in areas without a 911 call system or radio calls within a hospital system when the ambulance entity is owned and operated by the hospital"

We fail to understand either the purpose of the proposed change, as set forth in the preamble to the Proposed Rule, or the actual effect of the proposed change to the text of the regulation. As with the proposed change to the definition of SCT, discussed above, the failure of CMS to set forth an adequate basis and purpose for a change to a rule that was mandated to be developed through negotiated rulemaking is arbitrary and capricious. As with the SCT definition, few, if any, provisions of the fee schedule negotiated rule provoked as much debate and hard fought compromise as did the definition of "emergency response." For CMS now to abandon that definition and unilaterally come up with inadequately explained substantive changes amounts to an arbitrary disregard of the negotiated rulemaking process and the good faith efforts and compromises of the participants in that process.

The Proposed Rule states that this revision is intended to clarify confusion over the present definition, and to ensure that the higher level of payment for an emergency response is limited to those situations in which an immediate response is truly warranted. The AAA agrees that a degree of confusion exists with respect to the present definition of "emergency response," particularly with respect to transports that originate at a hospital. However, the Proposed Rule does nothing to alleviate that confusion; it merely compounds it.

As discussed above, the higher level of payment for emergency transports is intended to compensate the ambulance service for the additional costs incurred in maintaining the readiness to respond immediately. The Committee Statement intended to draw no distinction as to the manner in which calls come in. The key is whether an immediate response was needed. Additionally, no distinction was felt to be appropriate as to the ownership of the vehicle that responds. This very issue was discussed in great detail by the NRM Committee. Whether the call came in to a hospital owned, privately owned, publicly owned or volunteer organization, the issue is the cost of readiness - not ownership.

The proposed definition would permit an ambulance service to bill for an emergency response whenever it responds immediately to radio calls within a hospital system when

the ambulance service is "owned and operated by the hospital." We agree with CMS that a 911 call should not be required. However, we would not limit this to ambulance services owned and operated by hospitals. It is common for calls to be received on private lines to arrange for transports, including emergency transports. The manner in which the call is received (911, 311, radio call, private line, computer, etc.) should not matter for purposes of determining an emergency response. Technology dictates how these calls are most effectively made and the technology is constantly changing.

The discussion contained in the preamble of the Proposed Rule indicates that the intent of the rule change is to preclude billing for an emergency response in most cases when a beneficiary is transported from the emergency department of one hospital to the emergency department of a second hospital. We agree that an emergency response often would not be justified in situations where the beneficiary was stabilized at the first hospital prior to transport and no emergency condition exists. However, we do not understand how the Proposed Rule would accomplish the objective, nor can we agree that an emergency response would never be justified for ED to ED transports.

The Proposed Rule adds a reference to "radio calls within a hospital system when the ambulance entity is owned and operated by the hospital" to the types of dispatches permitted. Additionally, the proposal eliminates the requirement in the current regulation that "the ambulance entity begins as quickly as possible to take steps to respond to the call." How those two changes address the issue of hospital ambulances billing inappropriately for hospital-to-hospital transports is not explained in the Proposed Rule; nor is it apparent.

The condition of the beneficiary, *as reported to the ambulance dispatcher,* not actual or eventual condition, should determine whether an emergency response is warranted. That is the effect of the current rule and we believe it should not be changed. The example in the Proposed Rule seemingly would impose a requirement that the ambulance service determine the actual condition of the beneficiary at the time of dispatch (i.e. stabilized vs. unstabilized). Such an inquiry would be inconsistent with the purposes underlying the higher level of payment for an emergency response. As stated in the February 27, 2002 Final Rule "the purpose of the higher payment for emergency response is to recognize the additional costs required in order to be prepared to respond immediately to a call.....without regard to the condition of the beneficiary."

Finally, no distinction should be made as to where the vehicle is located at the time it is dispatched or the point of pick-up of the patient. The Proposed Rule suggests that an ambulance that is stationed at a hospital could not meet the requirement for an emergency response. However, consider, for example, an inpatient at a psychiatric, rehabilitation, or long-term care hospital that goes into cardiac arrest. In this instance, an emergency response would clearly be justified. Another example is a life threatening emergency brought to an emergency department, but, whether stabilized or not, emergency treatment is needed that the hospital ED cannot provide (e.g. on diversion, physician specialist not available, equipment not available, etc.). In these cases, an emergency response to take the patient to another hospital ED is clearly warranted. The mere fact that the ambulance happens to be stationed at the hospital does not alter the nature of the response. Nor does it

relieve the ambulance entity of the cost of being prepared to respond immediately to such calls, the costs of which CMS has clearly indicated justify payment at the emergency level of services.

We do not believe the Proposed Rule would dispel any confusion that may exist with respect to emergency billing for hospital-to-hospital transports and we urge CMS to abandon this approach. The result of this regulation will only be greater confusion. We suggest that, if the case can be made for the need for clarification, CMS call the parties to the negotiated rulemaking together to obtain their input regarding the nature of the problem and possible regulatory or interpretive solutions thereto. Anything short of that would be inconsistent with the obligations of CMS under the Committee Agreement, and would likely lead to further confusion.

5. **CBSAs-Revised OMB Metropolitan Area Definitions and RUCAs**

The AAA commends CMS for its decision to adopt Rural Urban Commuting Areas (RUCAs) as part of the most recent Goldsmith modification for identifying rural areas within urban tracts. We are also pleased that the Office of Management and Budget Core-Based Statistical Areas (CBSAs) standard identifies Micropolitan Statistical Areas as being non-urban. However, we are concerned about the immediate effect that the resulting reclassification of certain areas from rural to urban will have on providers of ambulance services in those areas.

The NRM Committee was concerned that the system that it developed for recognizing the additional cost of providing ambulance services in low-volume rural areas was imperfect at best. CMS vowed to continue to review the cost and demographic problems presented by this issue to improve the degree to which its payment system for ambulance services recognizes these additional costs. The Government Accountability Office (GAO) has also been asked by Congress to review this issue, and its report is expected to be issued in the near future. Finally, the concerns of Congress about the adequacy of ambulance payments was demonstrated by the enactment in the Medicare Modernization Act, P.L. 108-173 (MMA) through several provisions designed to provide temporary relief until the studies have been completed and a more reasonable system enacted (e.g., the adjustment for certain long trips, assistance for providers in low population density areas, and the two-percent increase in payment rates for rural areas).

Given the uncertainty surrounding the appropriate payment rate for rural ambulance services in general, we believe the implementation of these statistical area changes for those areas that would lose their rural designation should be tempered by the following steps:

1) Ambulance trips in rural areas that obtained some form of relief that was enacted in the MMA should continue to be treated in accordance with the terms of those provisions for the period specified by Congress, regardless of their new classification.

2) Ambulance services should be provided the same protections that CMS provided to hospitals adversely affected by the CBSA and RUCA changes in the Inpatient Hospital Final Rule for 2005. 2/ Specifically, any area (list of areas enclosed) that would lose its rural designation because of these changes should be protected by a three-year hold harmless to allow providers to adjust their budgets and business practices to the rate changes.

3) Although no formal reclassification process exists for ambulance providers, CMS should put in place a process by which providers could present data and other information justifying why particular areas should continue to be classified as rural. Because the urban/rural distinction for ambulances services is totally a creature of regulation, rather than statute, such a process would clearly be within the authority of CMS.

4) CMS should consider whether, in light of all the uncertainties discussed above, the adoption of the new OMB CBSA classification system should be postponed until after the GAO study has been completed and CMS and the Congress have had an opportunity to adopt any recommendation that are appropriate.

6. Conversion Factor/Air Ambulance Rates

The AAA has no objection at this time to eliminating the annual reviews of the conversion factor and air ambulance data.

7. Conclusion

Thank you for your consideration of these comments. The AAA remains committed to working with CMS toward the establishment of a fair and efficient ambulance fee schedule. To that end, we would be happy to provide any additional information that you or your staff may require. We are also prepared to meet with CMS at any time to discuss these comments in more detail. If it is determined that the NRM Committee should be consulted to resolve any of the issues raised by the Proposed Rule, we look forward to the opportunity to participate in that process.

If you or your staff should have any questions regarding our comments, please contact myself or Tristan North, AAA Vice President of Government Affairs, at 703-610-9018.

Sincerely,

Robert L. Garner
President

enclosures

2/ 69 Fed. Reg. 48916, 49032 (Aug. 11, 2004).

United States Department of Health and Human Services

Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule

Agreement

The Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule considered the technical and policy issues in establishing a fee schedule for ambulance services. See section 1834(l) of the Social Security Act.

The parties whose signatures appear on this document agree that:

1. The individual signing this agreement is authorized to commit the party to the terms of this agreement.

2. The party concurs in the attached written statement dated February 14, 2000 (Committee Statement), when considered as a whole.

3. The Department of Health and Human Services, through the Health Care Financing Administration, agrees to use the Committee Statement as the basis of a proposed rule to the maximum extent possible consistent with the Department's legal obligations.

4. Each party agrees not to file negative comments on the proposed rule or on its preamble or regulations text to the extent the rule, preamble, and regulation text have the same substance and effect as the Committee Statement, on any matter.

5. The Health Care Financing Administration, consistent with its obligations under the Federal Administrative Procedures Act, will consider all relevant comments submitted on the proposed rule and will make such modifications in the regulations and preamble as are necessary when issuing final regulations. After the close of the comment period on the proposed rule, the facilitator will consult with the Committee to determine whether the Negotiating Committee will reconvene to consider the comments.

6. Each party agrees not to take any action to inhibit the adoption of the proposed rule as final to the extent the final regulations and their preamble have the same substance and effect as the Committee Statement.

7. No party is bound under Article 4 or Article 6 of this Agreement with respect to any matter that is not addressed in the Committee Statement.

United States Department of Health and Human Services
Negotiated Rulemaking Committee on
Medicare Ambulance Fee Schedule

Agreement
Page Two

Representative
American Ambulance Association

Representative
American College of Emergency Physicians
National Association of EMS Physicians

Representative
American Hospital Association

Representative
Association of Air Medical Services

Representative
Health Care Financing Administration

Representative
International Association of Fire Fighters

Representative
International Association of Fire Chiefs

Representative
National Association of Counties

Representative
National Association of State Emergency
Medical Services Directors

Representative
National Volunteer Fire Council

Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule

Committee Statement

February 14, 2000

The Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule has concurred in the following recommendations, considered as a whole, on the content of a proposed rule (and its preamble) pursuant to section 1834(l) of the Social Security Act. In its negotiations, the Committee took into account the factors listed in the Act. Some of these factors are explicitly mentioned in the Committee Statement. Others are implicitly reflected in the recommended provisions. The Committee accepted the advisory report from the Medical Workgroup.

Section 1834(l) of the Social Security Act requires that, in developing the Medicare ambulance service fee schedule, the Committee consider the following issues regarding:

- Definitions that link payment to the type of services furnished.
- Appropriate regional and operational variations.
- Methodology to phase-in the revised payment in an efficient and fair manner.
- Mechanisms to control increase in expenditures for ambulance services.
- Adjustments to account for inflation and other factors.

I. Ambulance Service Level

A. Definitions

The Committee defined seven levels of ambulance service:

1. Basic Life Support (BLS): Where medically necessary, the provision of basic life support (BLS) services as defined in the National EMS Education and Practice Blueprint for the EMT-Basic including the establishment of a peripheral intravenous (IV) line.

2. Advanced Life Support, Level 1 (ALS1): Where medically necessary, the provision of an assessment by an advanced life support (ALS) provider and/or the provision of one or more ALS interventions. An ALS provider is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as a procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

3. Advanced Life Support, Level 2 (ALS2): Where medically necessary, the administration of at least three different medications and/or the provision of one or more of the following ALS procedures:

- Manual defibrillation/cardioversion.
- Endotracheal intubation.
- Central venous line.
- Cardiac pacing.
- Chest decompression.
- Surgical airway.
- Intraosseous line.

4. Specialty Care Transport (SCT): Where medically necessary, in a critically injured or ill patient, a level of inter-facility service provided beyond the scope of the Paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (nursing, medicine, respiratory care, cardiovascular care, or a paramedic with additional training).

5. Paramedic Intercept (PI): These services are defined in 42 CFR 410.40. They are ALS services provided by an entity that does not provide the ambulance transport . Under limited circumstances, these services can receive Medicare payment.

6. Fixed Wing Air Ambulance (FW): Fixed wing air ambulance is provided when the patient's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. In addition, fixed wing air ambulance may be necessary because the point of pick-up is inaccessible by land vehicle, or great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities.

7. Rotary Wing Air Ambulance (RW): Rotary wing air ambulance is provided when the patient's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. In addition, rotary wing air ambulance may be necessary because the point of pick-up is inaccessible by land vehicle, or great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities.

B. Emergency Response Modifier

For the BLS and ALS1 levels of service, an ambulance service that qualifies as an emergency response will be assigned a higher relative value to recognize the additional costs incurred in responding immediately to an emergency medical condition. An immediate response is one in which the ambulance provider begins as quickly as possible to take the steps necessary to respond to the call. There is no emergency modifier for PI, ALS2, or SCT.

II. Regional and Operational Variations

A. Operational

No operational differences will be recognized. All types of providers will be paid under the same fee schedule. Thus, the same payment will be made for a comparable service provided by a private, volunteer, municipal, or hospital ambulance.

B. Regional Variations

1. Cost of Living Differences

An adjustment will be made to recognize the cost of maintaining an ambulance supplier in various geographic areas. While not specifically directed at the expenses of ambulance suppliers, the Committee agrees that the most appropriate available index to use for this purpose is the practice expense (PE) component of the geographic practice cost index (GPCI) as used in the Medicare physician fee schedule. The Committee agrees that the index is applied to 70 percent of the ground and water ambulance base rate amount and 50 percent of the air base rate amount. This modifier is applied based on the location from which the beneficiary is transported.

2. Rural Services

The Committee agrees that an adjustment needs to be made to the rates paid for ambulance services provided in rural areas with low population density to recognize the higher costs per transport incurred by those suppliers. However, the Committee was informed that none of the options for recognizing geographic disparities other than MSA/non-MSA could be easily adopted and implemented by HCFA. In order to compensate for these costs, while recognizing the inadequacy of the methodology to properly address this problem, the Committee agrees that an additional adjustment will be made to the mileage rate if the location from which the beneficiary is transported is located in a rural area. The definition of a rural area is an area outside a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA) or an area within an MSA identified as rural, using the Goldsmith modification. The calculation of this modifier is discussed below as part of the Fee Schedule.

The Committee recognizes that this rural adjustment is a temporary proxy to recognize the higher costs of low-volume suppliers. It believes that, as soon as possible, a methodology needs to be developed that more appropriately addresses payment to low-volume rural ambulance suppliers.

III. Medicare Ambulance Fee Schedule

The ambulance fee schedule payment equals a base rate payment plus a payment for mileage. Ground and water ambulance services are paid using the same fee schedule. The Committee agrees that HCFA will set the amount of the base year (CY 1998) expenditures to be used for determining the payment levels for air ambulance services between $134,827,792 and $158,000,000.

A. Base Rate

The relative value unit (RVU) scale for the ambulance fee schedule is as follows:

Ground or Water

Service Level	RVU
BLS	1.00
BLS-Emergency	1.60
ALS1	1.20
ALS1-Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75*

Air Service Level

FW and RW---- HCFA sets the RVUs based on the amount of base year expenditures.

Loaded Mileage

Grounded or water	$5.00 per statute mile
Air (FW)	$6.00 per statute mile
Air (RW)	$16.00 per statute mile

* The base rate RVU for PI services is equal to the difference between the RVUs for ALS2 and BLS.

B. Geographic Modifier

Ground or Water: The practice expense (PE) portion of the physician GPCI applied to 70 percent of the base rate.

Air: The PE portion of the GPCI applied to 50 percent of the base rate.

C. Rural Modifier

Ground or Water: A 50 percent add-on to the mileage rate (that is, a rate of $7.50 per mile) for each of the first 17 miles. The regular mileage allowance will apply for every mile over 17 miles.

Air: The modifier is applied to the total payment for the services (that is, the sum of the base rate adjusted by the geographic modifier and the mileage). The value of the modifier is dependent on the air base year expenditures as follows:

Base Year Expenditures	Modifier Percentage
Less than $145 million	25
$145 million to less than $150 million	35
$150 million or greater	50

IV. Implementation Methodology

The ambulance fee schedule will be phased in over a 4-year period. The payment during the transition period will be based on a combination of the fee schedule payment and the amount the carrier would have paid absent the fee schedule. Payment in the first year of the transition will be the sum of 20 percent of the fee schedule and 80 percent of the former payment methodology. The fee schedule percentage will increase by 30 percentage points for each of the second and third years, with the former payment percentage decreasing by the same percentage points during that time. The fee schedule becomes fully implemented at 100 percent in the fourth year. Implementing payment under the fee schedule at only 20 percent in the first year is intended to give ambulance providers a period of time to adjust to the new payment amounts, which for some providers may be substantially lower than current payments. Thus, the transition is as follows:

	Fee Schedule Percentage	**Former Payment Percentage**
Year One	20	80
Year Two	50	50
Year Three	80	20
Year Four	100	0

V. Mechanisms to Control Increases in Expenditures for Ambulance Services

Unlike other Medicare services that have become subject to a fee schedule, the ambulance industry cannot arbitrarily increase the number of services it furnishes in order to circumvent lower payments per service. Therefore, the Committee has not suggested mechanisms to control expenditures.

VI. Adjustments to Account for Inflation and Other Factors

The Committee acknowledges that the statutory provisions regarding annual updates, as stated in section 1834(l)(3)(B) of the Social Security Act, will be the adjustments to account for inflation. That section provides for an annual update based on the percentage increase in the consumer price index for all urban consumers (CPI-U; U.S. city average) for the 12-month period ending with June of the year previous to its application to the fee schedule. For 2001 and 2002, the increase in the CPI-U is reduced by 1.0 percentage points for each year. Other than the Geographic and Rural adjustments, the Committee agrees not to make any other adjustments to the fee schedule.

Total Zip Codes

Zip Codes--MSA Under Current Policy

State	Zip Code	Carrier	Locality	Urban (Blank)/ Rural (R)/ Super Rural (B)
AL	35034	00510	00	R
AL	35035	00510	00	R
AL	35038	00510	00	R
AL	35042	00510	00	R
AL	35045	00510	00	R
AL	35046	00510	00	R
AL	35063	00510	00	R
AL	35074	00510	00	R
AL	35085	00510	00	R
AL	35130	00510	00	R
AL	35148	00510	00	R
AL	35171	00510	00	R
AL	35184	00510	00	R
AL	35188	00510	00	R
AL	35501	00510	00	R
AL	35502	00510	00	R
AL	35503	00510	00	R
AL	35504	00510	00	R
AL	35549	00510	00	R
AL	35550	00510	00	R
AL	35554	00510	00	R
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AL	35573	00510	00	R
AL	35578	00510	00	R
AL	35579	00510	00	R
AL	35580	00510	00	R
AL	35584	00510	00	R
AL	35587	00510	00	R
AL	36091	00510	00	R
AL	36310	00510	00	R
AL	36313	00510	00	R
AL	36314	00510	00	R
AL	36316	00510	00	R
AL	36317	00510	00	R
AL	36318	00510	00	R
AL	36340	00510	00	R
AL	36344	00510	00	R
AL	36345	00510	00	R
AL	36349	00510	00	R
AL	36353	00510	00	R
AL	36373	00510	00	R
AL	36375	00510	00	R
AL	36477	00510	00	R
AL	36750	00510	00	R
AL	36790	00510	00	R
AL	36792	00510	00	R
AL	36793	00510	00	R

Zip Codes--CBSA Under Proposed Rule

State	Zip Code	Carrier	Locality	Urban (Blank)/ Rural (R)/ Super Rural (B)
AL	35034	00510	00	
AL	35035	00510	00	
AL	35038	00510	00	
AL	35042	00510	00	
AL	35045	00510	00	
AL	35046	00510	00	
AL	35063	00510	00	
AL	35074	00510	00	
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WV	26764	00884	16	R
WV	26808	00884	16	R
WV	26817	00884	16	R
WV	26823	00884	16	R
WV	26824	00884	16	R
WV	26852	00884	16	R
WV	26865	00884	16	R

Total Rural Zip Codes=12,113
Total Super Rural Zip Codes=7,835
Total Urban Zip Codes=22,800

WV	26714	00884	16	
WV	26716	00884	16	
WV	26722	00884	16	
WV	26755	00884	16	
WV	26757	00884	16	
WV	26761	00884	16	
WV	26763	00884	16	
WV	26764	00884	16	
WV	26808	00884	16	
WV	26817	00884	16	
WV	26823	00884	16	
WV	26824	00884	16	
WV	26852	00884	16	
WV	26865	00884	16	

Total Rural Zip Codes=10,893
Total Super Rural Zip Codes=7,835
Total Urban Zip Codes=24,020