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

The Need for an Ambulance Fee Schedule

Payment for ambulance services from health insurance carriers including Medicare is and has historically been linked to "medically necessary" patient transport. In order to obtain payment for emergency medical care services provided to a Medicare beneficiary, providers must bill in conjunction with ambulance transport. The levels of payment vary widely across the United States for the exact same service. For example, the prevailing rate of payment for advanced life support care provided in conjunction with emergency transport in parts of California is $541 while the exact same service billed the same way in the District of Columbia has a prevailing payment amount of $113. Using another billing method whereby all services, mileage, and supplies are bundled and billed together in Pennsylvania is $321 and the exact same service using the same billing method in Delaware has a prevailing billing amount allowable of $175. This payment system was and remains unfair to providers throughout the country.[1]

In June 1997, the Health Care Financing Administration (now the Center for Medicare and Medicaid Services) proposed to revise the Medicare ambulance regulations (42 CFR 410.40) to base Medicare payment on the level of service required to treat a beneficiary's condition; clarify and revise policy on coverage of non-emergency services; and to set national vehicle, staffing, billing, and reporting requirements. The Health Care Financing Administration efforts to draft policy were derailed however by strenuous opposition from certain industry groups.
Because of this opposition, and in order to meet the requirements of the Balanced Budget Act of 1997, HCFA established a negotiated rulemaking process to determine the rules addressing Medicare payment for ambulance services. This brought emergency medical services (EMS) industry stakeholders together to negotiate regulations specifying how ambulance services are reimbursed under Medicare. The process of negotiated rulemaking was intended to allow affected parties to hammer out their respective issues and break regulatory gridlock. A neutral facilitator assisted the negotiations. The goal was to reach consensus on the language and issues

involved in the final rule.
This negotiated rulemaking effort took place over a thirteen-month period and included input from all major industry representatives. The negotiating team considered the aspects of the Medicare provision as instructed in the Balanced Budget Act of 1997. The negotiating rulemaking process resulted in a number of successful outcomes. Definitions were established for the levels of prehospital emergency medical care. These definitions included both advanced and basic life support care levels categorized as emergent or non-emergent and critical care transport. The fee schedule also provided for payment for advanced life support (ALS) treatment separate from transport under certain circumstances using the paramedic intercept designation. Additionally, relative value units were determined for each level of patient care in association with ambulance transport.

IAFF Position During Negotiated Rule Making
During the negotiated rulemaking process it was the stand of the International Association of Fire Fighters (IAFF) to assure that the negotiating committee recognize and propose a solution to the discrepancy in payment amounts regionally and to assure equal distribution of Medicare funds allocated to ambulance services based on service provided regardless of type of provider or location. As a successful result of the work of the committee, a single payment amount was established for each level of care provided in conjunction with patient transport.
The payment amounts established considered various aspects of service provision including associated labor and operations costs, historical call volume, historical payment for like services, level of service provided, and community type. Additionally, air and ground ambulance transport categories were thoroughly discussed and provided for in the fee schedule. The committee reached consensus on the resultant fee schedule. The base amounts and relative value units were established for each service level and were intended to apply throughout the United States with an adjustment for labor and operations costs using the Geographic Practice Cost Index (GPCI). The GPCI is an index regularly used by Medicare for adjustment of physician costs associated with geographic practice differences. Finally, the committee agreed that the fee schedule should be implemented over a four-year period so as to ease the adjustment of provider services and emergency response systems into the new payment scheme.

IAFF Position on Fee Schedule Implementation
It is the position of the IAFF that the fee schedule be implemented as it was intended and voted on by the negotiating committee. The base fees were established based on information provided by the Health Care Finance Administration and the expertise of industry representatives on the committee. The IAFF believes that it is the responsibility of local government to build and fund local emergency medical response systems and that Medicare is intended to pay for use of the system by a beneficiary *not* to be the base funding for the entire system. Therefore we do not agree that the base fee should be increased or otherwise adjusted except for normal inflationary adjustments.
The IAFF also believes that denial of claims and the inconsistent application of standards with regard to claims are indeed problematic. Medicare Carriers and Fiscal Intermediaries must be given sufficient direction and resources by which they may judge and pay ambulance service claims without delay. Though this is a substantial problem at this time, it will likely be resolved with universal implementation of the fee schedule as negotiated and voted by the agreement of industry representatives in February 2000.

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

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