TESTIMONY OF
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ON
MEDICARE PAYMENTS FOR AMBULANCE SERVICES
BEFORE THE
SENATE GOVERNMENT AFFAIRS COMMITTEE

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

Currently, Medicare pays for ambulance services based on the amount providers historically charged for their services. This payment system is outdated, and has led to large discrepancies in payments in different geographic areas, which are unrelated to providers' actual current costs. Years ago, we began moving all of the other major Part B services toward payment based on fee schedules, which more accurately reflect the resources used in providing services. Fee schedules also are able to reflect regional cost differences, limit inappropriate price increases, and adjust prices appropriately for inflation, along with other benefits. In the Balanced Budget Act of 1997 (BBA), Congress wisely mandated that Medicare also pay for ambulance services based on a national fee schedule. Since then, we have been working to develop an ambulance fee schedule that is fair and that most effectively advances our goal of ensuring that Medicare beneficiaries receive the high quality care they deserve while safeguarding taxpayer dollars by paying appropriately for these services.

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

are in the last stages of finalizing the rule.

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

BACKGROUND

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

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

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

AMBULANCE FEE SCHEDULE

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

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

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

- Ensure the aggregate payment to ambulance providers and suppliers during the fee schedule's first year does not exceed the aggregate amount that would have been paid that year under the old methodology;
- Establish ways to control increases in expenditures for ambulance services;
- Establish definitions for ambulance services that link payments to the type of services provided;
- Consider appropriate regional and operational differences that impact the cost of caring for Medicare beneficiaries;
- Consider adjustments to payment rates for inflation and other relevant factors;

- Phase-in the fee schedule in an efficient and fair manner; and,
- Require ambulance suppliers and providers to accept assignment, which means accepting Medicare's allowed payment amount as payment in full. This protects Medicare beneficiaries from being billed for any part of the ambulance service other than unmet Part B deductible or coinsurance amounts.

The committee began negotiating in February 1999, and for an entire year the members considered a wide variety of complex issues. In February 2000, once the negotiations were complete, all of the committee members signed a consensus agreement. In that agreement, the committee provided for:

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

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

- Revised requirements for physician certification of non-emergency services, making it easier for ambulance suppliers to document that the service they provided was eligible for Medicare coverage;
- Inclusion of certain services, which currently may be paid separately, in the fee schedule's base rate. This change eliminates the need for ambulance suppliers to bill separately for items such as oxygen, drugs, extra attendants, and EKG testing;

- Payment based on the patient's medical needs regardless of state or local ordinances creating all-advanced life support systems. This policy adheres to the Medicare statutory requirement to link payments to the types of services provided; and,

Implementation of mandatory assignment when the fee schedule phase-in begins, as required by BBA.

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

CONCLUSION

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