US Senate Governmental Affairs Committee Testimony
November 15, 2001

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Mr. Chair and Members of the Committee:

My name is Gary Wingrove. I am a paramedic and manager at Gold Cross Ambulance. We are a unit of Mayo Medical Transport, a non-profit division of the Mayo Foundation for Medical Education and Research based in Rochester, Minnesota. I am here today representing the Minnesota Ambulance Association (MAA). MAA president Buck McAlpin is also present.

There are two major problems facing the ambulance industry in Minnesota and throughout the nation. These include a severe increase in the number of denied Medicare emergency ambulance claims and the impact of the proposed fee schedule.

Denied Medicare Ambulance Claims:

I would like to tell you about some Minnesotans who have used ambulance service.

- A gentleman was traveling the wrong direction down the freeway. After some time, the Minnesota State Patrol was able to get the vehicle stopped. The driver of the car was confused and did not know where he was. The officer summoned an ambulance to transport him to the hospital. Among other treatment, the paramedics started an IV.
- A woman had an implanted defibrillator that failed to function. She was in cardiac arrest. The paramedics were summoned and successfully resuscitated her using an external manual defibrillator.
- A gentleman went to the grocery store. He became unconscious while still driving his car in the parking lot. His car slammed into a light pole and the tires were burning black smoke as his foot was still against the accelerator. The police and paramedics were summoned. He was conscious when the paramedics arrived and he was treated with high concentrations of oxygen, and an IV and was transported to the hospital.
- A woman was moving a mattress in her apartment. She lost her balance. The mattress fell on top of her and she couldn't breathe. She screamed for help and her

neighbor called 9-1-1. The paramedics arrived and removed the mattress. She had excruciating back pain and couldn't move.

While two of these people live in urban areas and two in rural areas, they all have a few things in common. They are all over 65. They all have Medicare as their primary health care insurance. They were all transported to hospitals for physician evaluation, diagnosis and treatment. Medicare paid all of their hospital, physician, lab and diagnostic bills. Yet, all of their ambulance claims were denied. The reason given by the contractors was that the ambulance was "not medically necessary." We disagree, and like the beneficiaries, we are outraged that this occurred.

In July 2000, the General Accounting Office (GAO) notified CMS and some members of Congress that there is a problem with Medicare contractors denying emergency ambulance claims.[1] The GAO described variation in payment policy by contractors by saying "these discrepancies can translate into unequal coverage for beneficiaries."

Denied emergency ambulance claims place ambulance services and beneficiaries in a tough position. When Medicare contractors determine an ambulance is unnecessary, the beneficiary is liable for the entire claim. Many beneficiaries do not understand why Medicare thought the ambulance was unnecessary. Next time they think twice before calling 9-1-1. On the urging of ambulance services, for those that do decide appeal their denied claim, we find that 90% of the claims are paid on the first appeal attempt[2]. One of our members reports that they frequently have to fax pages from the carrier's ambulance billing manual back to them because they give wrong information over the telephone both to the provider and to beneficiaries.

Some Minnesota ambulance companies who bill through Medicare's carrier are experiencing 70% claim denial rates on the first submission. Often times, on identical ambulance trips with two different beneficiaries who have identically coded claims, one claim is paid and the other isn't. We have even seen cases where a beneficiary has been to the hospital and discharged and had to return for the same medical problem, and on identically coded claims (except for the date) for the same beneficiary, one is paid and the other is denied.

In January of this year, the Medicare contractor processing hospital-based ambulance claims in our state put those ambulance services on "focused review." This means they suspended 100% of the claims and required the provider to submit both the ambulance run form and hospital records before they would process the claims. This is not an easy task to complete. Hospitals do not simply photocopy private medical records because an ambulance service asks them to. The ambulance service must locate the beneficiary and get a release for their medical records and then make the request of the hospital the patient was treated at to obtain the records. This was confusing to our members, because the contractor that processes these ambulance claims also processes all the hospital claims in our state. They already have what records they should need to pay the ambulance claim, because they have the records to process the hospital claim. By the middle of 2001, one of our hospital-based providers had over 1,500 unpaid Medicare claims totaling over $6 million. This Medicare contractor is also over-riding the decisions of physicians

who determine that air ambulances are necessary and instead are sometimes paying air claims at ground rates.

Last year the GAO commented that "… HCFA officials agree, that the national medical coverage criteria for ambulance services are vague. Generally, Medicare coverage policies are set by individual carriers rather than nationally by HCFA. Consequently, similar claims may be treated differently across carriers." [3]

Mr. Chair and Members of the Committee, we submit that the only person who should be allowed to determine whether a medical emergency exists is the person who decides whether or not to dial 9-1-1. It definitely should not be a non-medical clerk in a contractor's office.

There are two things Congress can do to fix this problem. First, Congress should establish a Prudent Layperson standard for the payment of emergency ambulance claims. Secondly, beneficiaries, providers and the contractors should have the tools necessary in advance to know if any claim is going to be paid by Medicare, whether emergent or not. This can be done if Congress directs CMS to adopt the condition coding system they participated in developing as part of the Ambulance Fee Schedule Negotiated Rulemaking process.

Paramedics do not diagnose, yet the only coding system we are allowed to use today was developed for physician use and is diagnosis-based. By adopting this new condition coding system, beneficiaries, providers and contractors would all know in advance whether an ambulance transport would meet the medical necessity test. If the beneficiary's condition matches a code specified in this set at the time of transport, the test of medical necessity is met. This condition coding system also links conditions to levels of ambulance service. For those cases where a beneficiary legitimately needs an ambulance but there isn't a condition code that matches their condition, then the contractor can process those claims manually to determine medical necessity. For those cases where the beneficiary didn't need an ambulance at all but wanted to use one for their convenience, the Medicare contractor will appropriately deny those claims in the future because the provider will have coded them for denial.

The Medicare Ambulance Fee Schedule

Ambulance service in the United States is a complex public trust. The application of EMS is provided to communities throughout the U.S as a health care service through diverse models including for-profit and non-profit, volunteer and paid, government services (police, fire and third service), hospitals, private entities, healthcare organizations, entrepreneurs and publicly traded companies.

EMS is a system containing a variety of components that include 9-1-1 telephone access, first responders, trained ambulance personnel and hospitals. Today's system was largely developed with the passage of the federal EMS Support Act of 1973. In this provision Congress appropriated funding for the development of EMS systems. With the exception

of providing for federal agency programs, there has been little funding for EMS systems provided by Congress since that initial Act in 1973. Consequently, EMS systems vary widely in the United States in terms of their organization, operation, quality and access.

The federal Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) has described the current Medicare ambulance payment methods as "not based on reliable cost data. Instead they simply reflect historical charges."[4] The Medicare program has reimbursed ambulance service in a fee-for-service model since 1965. While the Medicare program went through structural reimbursement changes over time, ambulance service charges were capped in 1985 and reimbursement switched to the inflation-index model using a reasonable charge methodology. These payments were based on historical charges that were averaged geographically. Since then, reimbursement rates have consistently been limited to levels that fall below the cost-of-living index.

Some states used to cap, or even prohibit, volunteer ambulance services from seeking reimbursement for their costs. Many volunteer ambulance services that were highly subsidized followed the practice of charging "token" amounts of $25. These $25 "bills" were averaged with the bills of full-cost full-time providers to come up with average payments that would apply to a specific geography. This explains why many states with large rural geography ended up with lower reimbursement levels. The "token bills" of volunteer providers and subsidized bills of heavily tax-supported providers significantly dropped the average charge of all providers.

The OIG, when recommending 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," has concluded that such "historical charge data contain distortions and variations that undermine their usefulness as a basis for the new payment system."[5] The OIG continues, "we were unable to locate any sources of cost data that we could use to determine the reasonableness of Medicare rates… this type of information is not widely available."

Since 1965 most health care providers have transitioned through one or more reimbursement methods. Physicians and physical therapists, among others, have moved to a fee schedule structure. Hospitals are reimbursed in a variety of methods today, depending on the service provided. **In each of these cases, however, the formula for restructuring reimbursement has always started from a full-cost model**. This is not true for ambulance service. The BBA required CMS to develop a fee schedule for ambulance service providers that is **revenue-neutral** using a negotiated rule-making (NRM) proceeding. Those proceedings occurred between February 1999 and February 2000. The proposed rule evolving from these sessions will begin implementation in April 2002.

We do not know the actual number of ambulance services in the US that are either tax subsidized or reliant on the contributions of volunteer labor. But to illustrate this problem of not starting with a full-cost model, we could estimate that one-third of the ambulance providers are full-cost, one third of the providers are tax subsidized and one-third of the providers are volunteer. In this scenario, one-third of the providers are billing the full-cost of ambulance service (the full-cost providers), one-third are billing perhaps 50% of the cost (the tax subsidized providers) and one-

third of the providers are billing perhaps 20% of the cost (the volunteers). In this example, Medicare is only being billed little more than 50% of the actual cost of providing service.

The average ambulance service in Minnesota has a payor-mix that is 50% Medicare. We are predicting a 50% decrease in reimbursement in our state as a result of the combination of mandatory Medicare assignment and the implementation of the proposed ambulance fee schedule. This means that the average Minnesota ambulance service will lose 25% of its total revenue (50% of the payment on 50% of the transports). The ambulance industry in Minnesota bills approximately $140 million per year, and we are predicting a decline in revenue of $37 million due to the adoption of the fee schedule and mandatory Medicare assignment.

While the anticipated payment rates are inadequate for urban providers, the situation is much worse for rural providers. Many rural government-operated ambulance services predict financial insolvency. Some ambulance services are anticipating reduction in service provided to Medicare beneficiaries from paramedic-level ALS to EMT-level BLS. A letter from the Minnesota Emergency Medical Services Regulatory Board (EMSRB) warns local and state elected officials expressing concern due to the impact of the BBA. The letter says, "As the state board responsible for regulating licensed ambulance services, we are concerned that a significant reduction in reimbursement and mandatory assignment of payment may impact the quality of pre-hospital emergency care provided the citizens and the visitors within Minnesota communities." The letter continues, "we strongly recommend that public and private policy makers vigorously plan for this coming fiscal impact on ambulance operations …" It also warned that these changes may result "in significant financial shortfalls for ambulance services, because many already operate on a very small margin or even at a loss. It is possible that some ambulance services will fail."[6] (Emphasis added). The EMSRB issued a second similar letter to local and state elected officials and included our members of Congress this year when the implementation of the fee schedule was delayed.

Even though the fee schedule has not yet been implemented, some ambulance services around the country are already in dire financial straits. According to the January 2001 edition of the EMS Insider (a publication related to the Journal of Emergency Medical Services) the following have events already occurred. The article says, "Stories gleaned from local U.S. papers offer evidence that many EMS providers—private, hospital-based, public and volunteer—have recently had to cut their services or even close their doors. *The causes:* Shrinking revenues, rising costs, disappearing volunteers, closing hospitals and combinations of those."

- Prestonburg, Ky., disbanded its five-year-old municipal ambulance service in November 2000 because it had lost money every year.
- Webster County, Ky. reported its ambulance service has lost $9,529 a month and expects matters to worsen as coal companies, which have helped subsidize the ambulance service, close down.
- Citing financial problems, Southern Hill County Ambulance Service, Hubbard, Texas, went out of business last summer, forcing several small cities to rely on services more than 25 miles away.

- East Texas Medical Center, which provides EMS to dozens of rural communities in west Texas, notified residents of Honey Grove, Texas, that it would cease providing 24-hour coverage to the town. Beginning Dec. 1, 2000, ETMC will station a unit in Honey Grove only from 7 a.m. to 4 p.m. on Tuesday through Saturday; at other times it will send an ambulance from a town 20 miles away. The town has no first-responder service.
- Huron Hospital of East Cleveland, Ohio, announced on Oct. 13 that it was losing $250,000 to $400,000 annually by providing ambulance service and asked the city to take over EMS by April 1. East Cleveland, which has been in a state-declared fiscal emergency since 1983, said it would explore its options.
- Redlands, Calif., Mayor Pat Gilbreath said the city would likely cut paramedic service after voters failed to approve an increase in the annual per-household assessment.

Though greater Minnesota makes up 47% of the state's population, it has 97% of the geography[7] and includes 57% (367,261)[8] of Minnesota's Medicare beneficiaries. Greater Minnesotans are older and poorer than the state as a whole, with both rural families and the rural health care system disproportionately dependent on the Medicare program. Many counties in greater Minnesota have a higher proportion of elderly than the state average. Some counties have twice as high a percentage of elderly residents (25%) as the state average of 12.5%. Of the 84,450 Minnesotans age 85 or older, 58.4% are in greater Minnesota.

Medicare beneficiaries make up approximately 32% of the health care business in urban Minnesota, and Medicaid is about 3%. In greater Minnesota Medicare is about 45% and Medicaid is about 10%. In rural Minnesota, Medicare is 70-80% and Medicaid is about 10-15%. Ambulance services must be available to meet the public's need for service 24 hours a day. In an urban core environment like downtown Minneapolis a single ambulance can reasonably be expected to perform 12-15 transports in 24 hours. In greater Minnesota locales it takes 3 full-time ambulances to complete 15 transports in 24 hours because of the way the calls come in, large distances traveled for each call and because of the need for complete long-distance hospital transfers. In rural Minnesota, one ambulance must be on duty 24 hours a day, but only 15 transports may occur in a week. While the cost per hour is almost identical in greater Minnesota as urban Minnesota, the revenue per day must either cover 3 units instead of one, or the ambulance service must make one day of urban reimbursement last an entire week. The problem of under-funding Medicare ambulance reimbursement is disproportionately rural.

We are not suggesting that Congress abandon the fee schedule. The disparity of payments between states[9] for ambulance service is just as wide as the disparity in AAPCC rates. The payments should be nationalized. Congress must recognize, however, this fundamental flaw in the historical way ambulance service has been reimbursed. Payments for rural ambulance services must be higher than urban payments. We suggest that Congress set the urban ambulance payment rates at a level consistent with the national average cost of providing service and require CMS to adopt rural payment adjustments next year in a manner yet to be determined by the General Accounting Office.[10] The proposed 4-year implementation plan works well for

Minnesota, since we are a state that will see substantial revenue declines.

Thank you for the opportunity to address the Committee.

[1] United States General Accounting Office, *Rural Ambulances: Medicare Fee Schedule Payments Could Be Better Targeted*, GAO/HEHS-00-115 (Washington, DC, July 2000).

[2] There are three levels of appeal. The first appeal is a second review of the claim by an employee of the contractor who did not participate in the initial determination. If that employee upholds the denial, the decision can be appealed to a Hearing Officer employed by the contractor. If the claim denial is upheld, it can be appealed to an Administrative Law Judge.

[3] Ibid, page 20.

[4] *Medicare Payments for Ambulance Services – Comparisons to Non-Medicare Payers*, OEI-09-95-00411, January 1999.

[5] *Medicare Ambulance Payments: A Framework for Change*, OEI-12-99-00280, April 1999.

[6] A letter from the Minnesota Emergency Medical Services Regulatory Board to State Senators, State Representatives, County Board Chairs and City Mayors, July 14, 1999.

[7] Population and geography figures are based on 1998 estimates by the Minnesota State Demographer's Office.

[8] Source: Minnesota Department of Human Services.

[9] We estimate that ambulance service Medicare payment rates under the fee schedule will improve over IIC payments in 12 states and territories, will average relatively the same in 8 states, and diminish for the majority of providers in 32 the remaining states and territories. Today some states have multiple payment rates.

[10] The Benefits Improvement and Protection Act of 2000 requires the GAO to report to Congress on rural ambulance service costs in June 2002.