

CAH/FLEX

National Tracking Project

FINDINGS FROM THE FIELD

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Medicare Reimbursement for Ambulance Transports and the Critical Access Hospital Community

The Balanced Budget Act of 1997 (BBA), which created the Medicare Rural Hospital Flexibility Program (Flex Program), also created a new national fee schedule for Medicare ambulance transport services. Emergency medical services (EMS) providers serving Critical Access Hospitals (CAHs) were viewed as potentially very vulnerable to Medicare's new fee schedule, as they are likely to be small, Medicare-dependent, and located in areas with the most fragile economic base for providing tax support. To counter these concerns, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 amended the Flex Program to allow Medicare cost-based reimbursement for ambulance transports provided by CAHs. CAH-owned ambulance providers are eligible for this cost-based reimbursement only if no other EMS provider is operating within 35 miles from the hospital.

In 2003, the Walsh Center for Rural Health Analysis fielded a survey of CAH-affiliated EMS providers. Data from this survey provide insights into the potential impact of the Medicare fee schedule on EMS providers serving CAH communities and the relevance of the cost-based reimbursement mileage exclusion for CAH-owned services.

Data Source

- A mail survey of EMS providers serving CAHs was fielded in 2003. The sampling frame was constructed by contacting 133 randomly-sampled CAHs to identify all EMS providers serving the facility; 243 EMS providers completed the survey, for a response rate of 83 percent.
- EMS providers were eligible to complete the survey if they provided emergency transports to the CAH on more than a rare basis. Urban helicopter transport providers and those EMS providers offering only paramedic intercept services to the community were excluded.

What Are The Features of the New Medicare Ambulance Fee Schedule?

In April 2002, Medicare began paying for ambulance services under a new national fee schedule, meeting the BBA mandate. Previously, independent EMS providers were paid on a reasonable-charge basis subject to a national cap; hospital-owned providers were paid on the basis of reasonable costs. The new fee

schedule establishes uniform payment rates for all EMS providers and definitions for seven base transport categories, such as emergency basic life support (BLS) or emergency advanced life support (ALS) transports; additional money is paid for mileage. All EMS providers are newly required to accept Medicare assignment under the fee schedule. In other words, EMS providers may not bill patients for charges above Medicare's reimbursement other than the standard co-payment and deductibles. The architects of the fee schedule were concerned about its potential effects on low-volume rural EMS providers and called for a low-volume adjustment to payment rates (Negotiated Rulemaking Committee on the Medicare Ambulance Fees Schedule, 2000). Although a low-volume adjustment was not included in the final fee schedule, Medicare does pay higher mileage rates for transports originating in rural areas (Federal Register, 2000).

How Do EMS Providers Finance Operations in CAH Communities?

According to conventional wisdom, small, volunteer rural providers are reluctant to bill for ambulance transports and many rely heavily on donations and tax subsidies for their survival. Contrary to expectations, the survey revealed that the vast majority (93 percent) of EMS providers serving CAH communities bill for transports, and that transport fees account for nearly two-thirds (62 percent) of their income. Just under 30 percent of EMS revenue is derived from state or local taxes, leaving about 10 percent of revenue to be derived from other sources. Given the importance of transport revenue, changes in expected Medicare reimbursement are highly relevant to these providers.

What is the Expected Impact of the Medicare Ambulance Fee Schedule on EMS Providers Serving CAHs?

Only 58 percent of respondents that are paid under the Medicare fee schedule had estimated its impact on their revenue. Of these, 59 percent expect their Medicare revenue to decline under the new fee schedule. Thirty percent expect an increase, and 11 percent expect no change in revenue. Hospital-owned providers (which had previously received reasonable-cost reimbursement) were more likely than those not owned by a hospital to expect a decrease in revenue under the Medicare fee schedule (82 percent versus 55 percent). Low-volume providers and those staffed predominantly by paid rather than volunteer personnel were not significantly more likely than other CAH-affiliated respondents to expect a decrease in Medicare revenue under the new fee schedule. The majority of respondents (70 percent) agreed with the statement that Medicare's fee schedule would have a negative impact on rural EMS providers in general, and 77 percent felt a low-volume adjustment should be available for rural EMS providers.

What is the Relevance of Medicare's Cost-based Reimbursement Exclusion?

The majority of EMS providers serving CAH communities operate independently from the CAH; only 12 percent are CAH owned, and 18 percent of these currently receive cost-based reimbursement. For CAH-owned services not receiving cost-based reimbursement, 92 percent said they did not qualify because of the distance requirement. When BIPA was enacted, the potential for receiving cost-based reimbursement was expected to provide an incentive for CAHs to merge operations with their local EMS provider(s). Our survey found, however, that very few independent providers (less than one percent) said they were discussing the possibility of a merger with the local CAH. When these discussions were taking place, the possibility of receiving cost-based reimbursement was the main impetus for the talks.

What Are the Policy Implications of the Findings?

Given that CAH-affiliated EMS providers rely heavily on transport fees, the financial impact of Medicare's ambulance fee schedule is highly salient to CAH communities. Nearly 90 percent of EMS providers serving CAH communities are paid under that mechanism, and nearly 60 percent of respondents to the questions on the fee schedule's impact expect to be adversely affected. Hospital-owned services are significantly more likely to expect to be hurt than are independent providers. Contrary to the goals of the Flex legislation, which encourages closer collaboration between the CAH and its supporting health care network, the fee schedule may encourage hospitals to divest themselves of transport operations unless they can meet the mileage requirement. Legislation currently under consideration calls for increased Medicare payments to rural EMS providers in low population density areas (lowest quartile of population density) if their costs exceed Medicare's reimbursement. One-third of EMS providers serving CAHs are based in low-population density counties.

Policymakers have also put forth changes that would eliminate the mileage requirement so that all first-responder, CAH-owned providers could obtain cost-based reimbursement for their Medicare ambulance transports. This policy change would substantially broaden eligibility for cost-based reimbursement and counter the incentive for hospital divestiture of EMS. There are concerns that this change might also encourage hospitals to enter into direct competition with existing providers and fragment the EMS market. A more limited expansion of cost-based payment eligibility to EMS providers operating in political jurisdictions that prohibit direct competition with another ambulance provider would discourage further market fragmentation without opening the floodgates to cost-based reimbursement. Just under one-fourth of CAH-affiliated rural EMS providers operate in jurisdictions prohibiting direct competition among EMS providers.

References

Federal Register. Medicare program; fee schedule for payment of ambulance services and revisions to physician certification requirements for coverage of nonemergency ambulance services. 2000; 67(39):9099-9135.

Negotiated Rulemaking Committee on Medicare Ambulance Fee Schedule. Committee Statement. Health Care Financing Administration. <http://hcfa.gov/medicare/comstate.html>. 2000. Accessed February 14, 2000.

Where can I get more information?

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About this project: Check our website: <http://www.rupri.org/rhfp-track/>

Background

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

Previous Findings From The Field and Tracking Project Reports

Report:	Rural Hospital Flexibility Program Tracking Project Year Three
Vol. 3, No.2:	A Case Study of Six Critical Access Hospitals
Vol. 3, No.1:	The Role of International Medical Graduates in America's Small Rural "Critical Access" Hospitals
Vol. 2, No. 8:	State Medicaid Payment Policies for Critical Access Hospitals
Vol. 2, No. 7:	State Flex Programs--Perspectives of the Flex Coordinators
Vol. 2, No. 6:	A Critical Access Hospital Update, September 2002
Vol. 2, No. 5:	Reauthorizing the Medicare Rural Hospital Flexibility Grant Program: Lessons from the Field
Vol. 2, No. 4:	Critical Access Hospitals and Community Development
Vol. 2, No. 3:	Administration in Critical Access Hospitals
Vol. 2, No. 2:	Regionalization of Emergency Medical Services: The Experience of Michigan's Upper Peninsula
Vol. 2, No. 1:	Impact of the Rural Hospital Flexibility Program on Rural Emergency Medical Services: Evidence From the First Two Years

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