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Health Care Financing Administration
Department of Health and Human Services
Attn: HCFA-1002-P
PO Box 8013
Baltimore MD 21244-8013

Re: Comments on Medicare Ambulance Fee Schedule Proposed Rule-HCFA-1002-P

Dear Health Care Financing Administration:

There are a number of important issues regarding the above captioned rule, which, if implemented without major change, will seriously and adversely affect the ability of our EMS system in New Jersey to deliver advanced life support services to Medicare beneficiaries. **These issues are so major that they threaten to destabilize our entire EMS system, and ultimately cost Medicare significantly more money, while providing a lesser level of service than is provided at the present time.**

Currently, pre-hospital care in NJ is provided by a two-tiered system. Basic life support [BLS] is provided primarily by volunteer first aid squads staffed by EMTs who treat and transport patients in their ambulances at no charge to the patient. Added to this is an advanced life support [ALS] system provided primarily by paid hospital-based professional paramedics. The paramedics work together with the volunteers, providing advanced care to the most ill patients en-route to the hospital. These paramedics, under direct physician medical direction, administer many life-saving medications and are able to provide advanced airway support. Essentially, they bring the emergency department to the patient. The paramedics, however, do not transport patients; they work with the BLS crews in the ambulances provided by the local first aid squads as the volunteers provide the transport network. These ALS patients encompass about 15% of all pre-hospital transports. This system has been in place in NJ for more than 20 years and provides BLS and ALS coverage to 100% of our citizens that is both cost effective [since BLS is free] and of extremely high quality [since each ALS unit is staffed by two highly trained paramedics under strict medical control]. **No other state provides this two-tiered level of high quality medical care to 100% of its citizens.**

The following issues apply specifically to our New Jersey EMS system:

Appropriate Regional and Operational Differences

Section 4531 (b) (2) of the Balanced Budget Act of 1997 requires that in establishing the ambulance fee schedule, "…the Secretary will consider appropriate regional and operational differences". That part of the law was seemingly disregarded in the subsequent Negotiated Rule Making Committee (NRC) proceedings. In their Agreement, dated February 14, 2000, it was stated: "All types of providers will be paid under the same fee schedule." By failing to examine New Jersey's unique EMS system, HCFA acted in an unfair and deleterious way. Because no regional or operational differences were "on the NRC table", the resulting fee schedule did not take into consideration New Jersey's unique cost-saving EMS system: 80% of all basic life support (BLS) squads in new Jersey are volunteer. Medicare now saves $39 million annually because volunteers do not charge for transport. And, by state regulation, advanced life support (ALS) providers are not allowed to transport. By having medics respond independently, we cut the number of calls requiring paramedic

intervention in half, compared to the national average. Under the proposed Medicare reimbursement to ALS providers, NJ Mobile Intensive Care Units (MICUs) stand to lose, at a minimum, an estimated $200 per Medicare patient. Those patients account for about 50% of MICU revenues annually. At this rate, MICUs, and the hospitals sponsoring them, stand to lose about $20 million a year statewide. Some ALS systems in more rural areas may stop providing service altogether. In other areas, in order to survive, they will be forced to transport ALS patients. This will erode the volunteer BLS transport system in those areas; within a decade, volunteer first aid squads will cease to operate. Medicare will then be billed for services that volunteers in New Jersey have provided its taxpayers free for 74 years. **This will cost Medicare an estimated $39 million annually!**

NRC Representation

The NRC did not contain a member who solely represented volunteer EMS. Legally, our more than 420 volunteer squads are under the purview of the New Jersey State First Aid Council, and not the NJ Department of Health & Senior Services. Most of our volunteer squads do not operate within fire departments. Not being a state or fire-operated EMS organization, the interests of more than 400 volunteer squads in NJ were not represented.

Definition of ALS Level 1

Under the NRC recommendations dated February 14, 2000, the definition of Advanced Life Support, Level 1, is: 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. In section II. A. b. of the proposed rule, the language has modified to reflect that “the patient’s condition requires an ALS level of care.” This is a crucial change, based on retrospective rather than prospective review of the patient’s condition, which does not reflect the recommendations of the NRC, nor does it reflect the reality of the essence of an ALS level 1 service. **The key aspect of the ALS 1 service is in the determination of who requires a higher level of care.** For example, in a patient with chest pain, this symptom could represent an ischemic cardiac event, or merely indigestion. In New Jersey, we traditionally have not billed Medicare for such assessments; these patients were released to transport by BLS. If we were able to bill for such services, it would mitigate, to some extent, the marked decrease in per call reimbursement allowed by the new fee guidelines.

Some of the problems with the proposed Ambulance Fee Schedule apply not only to NJ, but to many other areas of the country as well. You have received letters from the American Ambulance Association, the National Association of EMS Physicians, the National Association of EMS Directors, and the American College of Emergency Physicians, among others. We wish to echo a few of the comments expressed by these organizations as well:

Medical Conditions List

During the course of the fee schedule negotiated rulemaking process, a Medical Issues Workgroup (composed of emergency physicians, carrier medical directors, nurses and billing experts) developed an innovative list of medical conditions that more accurately describes the full range of circumstances in which ambulance transportation is required. The purpose of this effort was to provide a means by which ambulance crews could relate the condition of the individual they transport to the appropriate service level under the new fee schedule. This provides a simple and effective means to accurately code and bill the ambulance service at the appropriate payment level.

HCFA participated in and contributed to the development of this system. It has been widely distributed over the past year, and has been universally acclaimed by Medicare carriers and providers alike, who believe it would be essential component of the new fee schedule. HCFA even included the medical conditions list as an addendum to its publication of the proposed rule in the Federal Register, and solicited public input on the need for such a list. However, HCFA has not indicated that it intends to implement the medical conditions list at the time it implements the fee schedule. This simply makes no sense. There needs to be a coding system on which the new fee schedule can operate, including a means for providers to be able to justify in their claims the level of service the provide. Likewise, carriers

will need a means to determine whether the condition of the transported individual warrants payment at the level claimed. The Negotiated Rulemaking Committee based the service level definitions for the fee schedule on the medical conditions list, and it would not be possible to implement one without the other. The entire Committee, including HCFA, agreed that without a medical condition coding list, the new fee schedule cannot be effectively administered. We ask that HCFA not implement the fee schedule until it can implement the medical conditions list. Otherwise, there will be billing and claims processing chaos when the fee schedule goes into effect.

Phase-In of Changes to Existing Payment Policy for ALS Mandated Jurisdictions

The statute requires HCFA to phase in the new fee schedule rates "in an efficient and fair manner," and the negotiated rulemaking committee agreed on a gradual four year phase-in to transition ambulance providers from their current allowed charge levels to the new fee schedule. However, the proposed rule has announced a steep payment reduction for providers who are currently paid the advanced life support rate in specific cases consistent with long-standing Medicare policy; and HCFA has announced that these providers will have their new, substantially lower rates, implemented immediately. Thus, for us, the ALS providers in NJ, the transition to the new rates will start from a much lower level than at present, and we will have to bear the full effect of this enormous reduction in Medicare payment rates on the first day the fee schedule goes into effect.

HCFA has announced that its unilateral decision to eliminate all-ALS services will result in an immediate budget savings for Medicare of $67.6 million in 2001. We believe these budget savings, if taken at all, should be phased in at the same rate as the other regulatory changes. HCFA originally decided to make this change in an era when deficit reductions were necessary. In this period of budget surpluses, there is simply no justification for taking such drastic reductions in payment rates for a large group of pre-hospital care providers without giving us sufficient time to adjust our operations to the new reimbursement rules. This decision is inconsistent with HCFA's statutory instruction to phase in the fee schedule in a fare and efficient manner.

Budget Neutrality Issues

Another reduction in overall ambulance rates will result from HCFA's refusal realistically to apply budget neutrality principles to its determination of the conversion factor to establish the new rates under the fee schedule. HCFA has announced that it will not take into account the fact that many ambulance services, such as municipal and volunteer services, subsidize the cost of providing ambulance services and will continue to set their charge levels substantially lower than the Medicare fee schedule. These services have decided as a matter of community policy to set a low charge for ambulance services, and there is no reason to believe they will start charging the fee schedule amount (as HCFA fears) as soon as the fee schedule is implemented. Because they must charge Medicare no more than they charge the rest of the community for ambulance transportation, Medicare will pay less for services in those areas.

However, HCFA's calculation of the conversion factor assumes that these entities will bill Medicare the full fee schedule amount. HCFA has announced that this may result in budget savings for Medicare of between $75 and $150 million. HCFA recognizes that its refusal to consider this factor may have the effect of taking money away from the Medicare ambulance budget, but claims that it has no obligation to attempt to ensure budget neutrality in this process. It maintains that its only obligation under the statute is to ensure that "the aggregate amount of payments for ambulance services not exceed the amount that would have been paid absent the fee schedule." (Emphasis added.) We believe HCFA has an obligation to attempt to implement the statute in a truly budget neutral manner and that it should recalculate the conversion factor on the basis of more realistic assumptions of the impact of low-charging providers.

Finally, we simply do not understand the methodology that HCFA used to arrive at the amount to be set aside for air ambulance services. The fact that the fee schedule would reallocate at least $7 million (and potentially as much as $34 million) from ground to air services clearly demonstrates the problems with HCFA's assumptions in this regard. This shifting of funds from ground to air services is totally

unwarranted; especially in light of the fact that air services will be receiving their full costs while ground services will be facing a reduction from their already below-cost payment rates.

All of the above factors combine to cause the conversion factor to be set at a level that will take substantial amounts of funds away from ground ambulance services. HCFA needs to consider this problem seriously and, as discussed below, do a meaningful assessment of its impact on the emergency medical systems in this country and the availability of ambulance services to the Medicare population.

Regulatory Impact Analysis

In the proposed rule, HCFA stated that it was not required to conduct a regulatory impact analysis under Executive Order 12866 because the rule would not have an economically significant effect. HCFA concluded that the total impact on the economy would be only $84.5 million in reduced revenues for ambulance providers and suppliers. However, that assessment fails to take into account the additional reductions in ambulance revenues that are likely to result from HCFA's failure to set budget targets in a neutral manner, as discussed above. Nor does HCFA's impact analysis address the adverse effects the rule might have on public health and safety, given the difficult maintaining operations that will be faced by many New Jersey ALS providers as well as others throughout the country.

In addition, HCFA's analysis fails to take into account the enormous dislocations that will occur as a result of the redistributive features of the new fee schedule. In New Jersey alone, we face Medicare payment reductions of 40% percent or greater for ALS services. Given the fact that total Medicare expenditures for ambulance services currently exceed $2.5 billion, the cumulative effect on the nation's emergency medical systems of the changes resulting just from this redistribution is unquestionably greater than $100 million. For that reason, HCFA should complete a state-by-state assessment of the proposed rule to determine if there are regulatory alternatives that would have a less drastic effect on ambulance providers and Medicare beneficiaries.

High Cost Drugs

The regulation also fails to provide a means by which MICUs may be paid for high cost drugs that are increasingly an important part of pre-hospital emergency medical treatment. For example, Amiodarone has now been recommended by the American Heart Association as a first line drug for cardiac arrest patients in Ventricular Fibrillation. The cost of this drug is about $300, nearly the total allowed reimbursement for ALS! HCFA's position fails to take into account that many such drugs are just coming on the market and their costs will not be included in the base year expenditure from which HCFA determined the conversion factor. In the end, the total cost of these drugs, if they are to be made available, must be borne by ambulance services, which will not be able to afford them on the reimbursement rate established by this rule. As a result, ambulance services may not be able to have the drugs available, thereby severely diminishing the quality of pre-hospital care for heart attack and other victims.

Please allow me to express our strongly held view that it is crucial to the successful implementation of the fee schedule that the above matters are addressed prior to implementation. We appreciate the opportunity to submit these comments and trust their submission will enable HCFA to begin resolution of these vital issues immediately. **We are looking for a delay in implementation of the rule until the above issues can be addressed** and systems can be reorganized to comply with the regulations without jeopardizing the health of our many Medicare patients. Please feel free to contact me at the above address if you have any questions.

Sincerely,

Sol Nevins, MD, FACEP
Chair, NJ MICU Advisory Committee