Federal Register

Thursday,
July 1, 2004

Part IX

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 414

Medicare Program; Medicare Ambulance MMA Temporary Rate Increases Beginning July 1, 2004; Interim Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 414

[CMS–1492–IFC]

RIN 0938–AN24

Medicare Program; Medicare Ambulance MMA Temporary Rate Increases Beginning July 1, 2004

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule codifies the four payment provisions for Medicare covered ambulance services contained in section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

DATES: *Effective date:* These provisions are effective on July 1, 2004.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 30, 2004.

ADDRESSES: In commenting, please refer to file code CMS–1492–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (fax) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments to *http://www.cms.hhs.gov/regulations/ecomments* or to *www.regulations.gov* (attachments must be in Microsoft Word, WordPerfect, or Excel; we prefer Microsoft Word).

2. *By mail.* You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1492–IFC, P.O. Box 8011, Baltimore, MD 21244–8011.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT: Anne E. Tayloe, (410) 786–4546.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1492–IFC and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call telephone number: (410) 786–7197.

I. Background

[If you choose to comment on issues in this section, please include the caption ''Background'' at the beginning of your comments.]

A. Legislative and Regulatory History

Under section 1861(s)(7) of the Social Security Act (the Act), Medicare Part B (Supplementary Medical Insurance) covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated for the beneficiary. The House Ways and Means Committee and Senate Finance Committee Reports that accompanied the 1965 legislation creating the Act suggest that the Congress intended that: (1) The ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and (2) only ambulance service to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered (H.R. Rep. No. 213, 89th Cong., 1st Sess. 37 and S. Rep. No. 404, 89th Cong., 1st Sess., Pt. I, 43 (1965)). The reports indicate that transportation may also be provided from one hospital to another, to the beneficiary's home, or to an extended care facility.

Our regulations relating to ambulance services are located at 42 CFR Part 410, subpart B and 42 CFR Part 414, subpart H. Section 410.10(i) lists ambulance services as one of the covered medical and other health services under Medicare Part B. Ambulance services are subject to basic conditions and limitations set forth at § 410.12 and to specific conditions and limitations included at § 410.40. Part 414, subpart H describes how payment is made for ambulance services covered by Medicare.

The Medicare program pays for ambulance services for Medicare beneficiaries when other means of transportation are contraindicated. Ambulance services (air and ground) are divided into different levels of service based on the medically necessary treatment provided during transport. These services include the levels of service listed below.

For Ground:

- Basic Life Support (BLS)
- Advanced Life Support, Level 1 (ALS1)
- Advanced Life Support, Level 2 (ALS2)
- Specialty Care Transport (SCT)
- Paramedic ALS Intercept (PI)

For Air:

- Fixed Wing Air Ambulance (FW)
- Rotary Wing Air Ambulance (RW)

Historically, payment levels for ambulance services depended, in part, upon the entity that furnished the services. Before the implementation of the ambulance fee schedule on April 1, 2002, providers (hospitals, including critical access hospitals, skilled nursing facilities, and home health agencies) were paid on a retrospective reasonable cost basis. Suppliers, which are entities that are independent of any provider, were paid on a reasonable charge basis.

The Balanced Budget Act of 1997 (BBA) (establishing section 1834(l) of the Act) mandated the development of an ambulance fee schedule through negotiated rulemaking. On February 27, 2002, we published a final rule in the **Federal Register** (67 FR 9100) that established a fee schedule for the

payment of ambulance services under the Medicare program, effective for services furnished on or after April 1, 2002. The fee schedule replaced the retrospective reasonable cost payment system for providers and the reasonable charge system for suppliers of ambulance services. Additionally, the final rule—implemented a statutory requirement that ambulance suppliers accept Medicare assignment; codified the establishment of new Health Care Common Procedure Coding System (HCPCS) codes to be reported on claims for ambulance services; established increased mileage payment under the fee schedule for ambulance services furnished in rural areas based on the location of the beneficiary at the time the beneficiary is placed on board the ambulance; revised the certification requirements for coverage of nonemergency ambulance services; and provided for a 5-year transition period during which program payment for Medicare covered ambulance services would be based upon a blended rate comprised of a fee schedule portion and a reasonable cost (providers) or reasonable charge (suppliers) portion. We are now in the third year of that transition to full payment based solely on the fee schedule amount.

B. Transitional Assistance for Rural Mileage 18 Through 50—Section 221 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

Section 221 of the Benefits Improvement and Protection Act of 2000 (BIPA) provided a temporary bonus mileage payment through December 31, 2003 for miles 18 through 50 for ambulance transports originating in a rural area. This bonus amount could not be less than one-half of the rural bonus paid under the ambulance fee schedule for miles 1 through 17. This provision was implemented by § 414.610(c) of the ambulance fee schedule final rule.

C. Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)

Section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) contains four provisions affecting payment for Medicare-covered ambulance services. All four affect only the fee schedule (FS) portion of the program's payment, and they affect only ground ambulance services. They are all cumulative; that is, they are percentage increases applied in concert with one another. They are all effective July 1, 2004, but with different sunset dates. The four provisions are as follows:

1. A percentage increase in the FS payment rates for ambulance services—1 percent for urban and 2 percent for rural ambulance services. This increase sunsets on December 31, 2006.

2. A 25 percent increase for the mileage rate for miles 51 and greater (both urban and rural). This increase sunsets on December 31, 2008.

3. A Regional FS that provides a floor amount for the ground ambulance base rate. The floor amount is determined by establishing nine FSs based on each of the nine census divisions using the same methodology as was used to establish the national FS. This increase sunsets on December 31, 2009.

4. An increase in the payment for the base rate where the ambulance transport originates in a rural area determined by the Secretary to be in the lowest 25th percentile of all rural populations arrayed by population density. Rural areas include Goldsmith areas (a type of rural census tract). To determine these rural areas, first, all areas (rural counties plus Goldsmith areas) are arrayed in ascending order by population density. Then, all of these rural areas are divided into quartiles by population. The rural areas that comprise the lowest quartile of population (that is, the lowest 25 percent of rural population) comprise the areas eligible for this bonus payment. Approximately half of all rural areas (rural counties plus Goldsmith areas) are required to include 25 percent of the rural population when rural areas are arrayed by population density. The bonus amount is based on the Secretary's estimate of the ratio of the average cost per trip for the rural areas in the lowest quartile compared to the average cost per trip for the rural areas in the highest quartile. In making this estimate, the Secretary may use data provided by the General Accounting Office (GAO). This provision sunsets on December 31, 2009.

II. Provisions of the Interim Final Rule

[If you choose to comment on issues in this section, please include the caption ''Provisions of the Interim Final Rule'' at the beginning of your comments.]

A. Percentage Increase in the Payments for Rural and Urban Ambulance Services

Section 414.610 is amended by revising paragraph (c)(1) to specify that, for services furnished during the period July 1, 2004 through December 31, 2006, ambulance services originating in urban areas are paid based on a rate that is one percent higher than otherwise would be applicable under the ambulance FS, and ambulance services originating in rural areas are paid based on a rate that is two percent higher than otherwise would be applicable under the ambulance FS.

B. Payment Rate for Mileage Greater Than 50 Miles

Section 414.610 is amended by adding a new paragraph (c)(7) to specify that, for services furnished during the period July 1, 2004 through December 31, 2008, each loaded ambulance mile greater than 50 (that is, miles 51 and greater) for ambulance transports originating in either urban areas or in rural areas are paid based on a rate that is 25 percent higher than otherwise would be applicable under the ambulance FS.

C. Regional Ambulance Fee Schedule

A new section 414.617 is added to specify that for services furnished during the period July 1, 2004 through December 31, 2009, the ground ambulance base rate is subject to a floor amount, which is determined by establishing nine fee schedules based on each of the nine census divisions, and using the same methodology as was used to establish the national FS. If the regional FS methodology for a given census division results in an amount that is lower than the national ground base rate, then it is not used, and the national FS amount applies for all providers and suppliers in the census division. If the regional fee schedule methodology for a given census division results in an amount that is greater than the national ground base rate, then the FS portion of the base rate for that census division is equal to a blend of the national rate and the regional rate in accordance with the following schedule:

Time period	Regional percent	National percent
7/1/04–12/31/04	80	20
CY 2005	60	40
CY 2006	40	60
CY 2007–CY 2009	20	80
CY 2010 and thereafter	0	100

D. Super-Rural Bonus

Section 414.610(c)(5) is amended to specify that, for services furnished during the period July 1, 2004 through December 31, 2009, the payment amount for the ground ambulance base rate is increased where the ambulance transport originates in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. Rural areas include Goldsmith

areas (a type of rural census tract). Approximately half of all rural areas (rural counties plus Goldsmith areas) are required to include 25 percent of the rural population arrayed in order of population density. The amount of this increase is based on the Secretary's estimate of the ratio of the average cost per trip for the rural areas comprised of the lowest quartile of population arrayed by density compared to the average cost per trip for the rural areas comprised of the highest quartile arrayed by density. In making this estimate, the Secretary may use data provided by the GAO. We have determined that the amount of this increase is equal to 22.6 percent.

III. Methodology

[If you choose to comment on issues in this section, please include the caption ''Methodology'' at the beginning of your comments.]

A. Percentage Increase in the Payments for Rural and Urban Ambulance Services

This provision is self-implementing. A plain reading of the statute requires a merely ministerial application of the mandated increase in rates, and there is no authority for any discretionary action by the Secretary.

B. Payment Rate for Mileage Greater Than 50 Miles

This provision is self-implementing. A plain reading of the statute requires a merely ministerial application of the mandated increase in rates, and there is no authority for any discretionary action by the Secretary.

C. Regional Fee Schedule

The statute requires that the same methodology be used to determine each of the regional fee schedules as was used to determine the national FS. We applied this methodology to Medicare claims data from calendar year 2001. We used 2001 data because they were the most recent complete data for a year in which Medicare payments were based solely on the reasonable charge/reasonable cost payment methodologies and not blended with portions of the national ambulance fee schedule implemented on April 1, 2002. We needed to use these former payment amounts (that is, payments exclusive of the national FS amounts) to apply the methodology used for determining the national FS, which had originally used claims data from 1998. For a full description of this methodology, see the **Federal Register** (''Medicare Program; Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services'')—Final Rule with Comment Period, published February 27, 2002 (67 FR 9100). We then determined a regional conversion factor (CF) by using the 2001 claims data from the states in each Census Division. Then we divided the regional CF by the national CF for 2001 claims data. Where this result was less than 1.0, the value of 1.0 was used. Then we multiplied this number by 80 percent, which is the statutory phase-in percentage of the regional FS for 2004, and added 0.2 (20 percent of 1.0) to that amount. In this way we created an index that reflects a blended FS amount of 80 percent regional FS and 20 percent national FS. This index was then applied to the FS portion of the blended payment rate for the period July 1, 2004 through December 31, 2004. In subsequent years, the blending percentage between the national FS amount and the regional FS amount will change as described in the chart, shown in section II.C., above.

D. Super-Rural Bonus

The statute states that in establishing the super-rural bonus, CMS will estimate the average cost per trip in the lowest quartile (25 percentile) of rural population arrayed by population density as compared to the estimate of the average cost per trip in the highest quartile of rural population arrayed by population density. In order to implement this provision promptly, data may be used from the Comptroller General (GAO) of the U.S. We obtained the same data as the data that were used in the GAO's September 2003 Report titled ''Ambulance Services: Medicare Payments Can Be Better Targeted to Trips in Less Densely Populated Rural Areas'' (GAO report number GAO–03–986) and used the same general methodology in a regression analysis as that used in that report. We considered only the full cost providers that were included in the data set, just as the GAO had done. The regression analysis correlated the providers' ambulance costs to the number of trips, the square of the number of trips, and the percentage of trips that were advanced life support (ALS) as opposed to those that were at the basic life support (BLS) level of care. The result of this regression was a formula that predicted the average cost per trip based on the variables just described. We then used the Medicare claims data from calendar year 2002 from every ambulance supplier and provider that furnished ambulance services in any rural area. These claims data showed the number of each level of ground ambulance services needed to satisfy the regression formula. The proxy that the GAO used for the total number of ambulance trips was the number of Medicare ambulance trips doubled. We then took the predicted average cost per trip in those rural areas in the lowest quartile of rural population arrayed by population density and compared that cost to the predicted average cost per trip in the rural areas in the highest quartile of rural population arrayed by population density. The result was that the average cost per trip in the lowest quartile was 22.6 percent higher than the average cost per trip in the highest quartile.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a proposed rule in the **Federal Register** and provide a period for public comment before we publish a final rule. We can waive this procedure, however, if we find good cause that notice and comment procedure is impracticable, unnecessary, or contrary to the public interest, and we incorporate a statement of this finding and its reasons in the rule issued. We find it unnecessary to undertake notice and comment rulemaking in this instance because the statute specifies that these provisions may be implemented on the basis of an interim final rule or program instruction, in recognition of the fact that the statutorily required implementation date could not be met otherwise. Pursuant to this authority, we have issued program instructions to our contractors implementing these provisions with an effective date of July 1, 2004, as specified by the statute. The purpose of this IFC is to provide a vehicle for public comment and to conform the Code of Federal Regulations (CFR) to the statutory language. Chapter 8 of the Contract with America Advancement Act of 1996 (CWAAA) generally requires an agency to submit a rule to Congress 60 days before it is to be effective. The CWAAA, however, contains an exception where the rule includes a waiver based on good cause, as here. For this reason, and because we have already implemented these provisions of the MMA under the authority cited, we have concluded that the requirement for a 60-day delay in effective date for congressional review of major rules does not apply in this case.

V. Collection of Information Requirements

This document does not impose information collection and record keeping requirements. Consequently, it need not be reviewed by the Office of

Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VI. Regulatory Impact Analysis

[If you choose to comment on issues in this section, please include the caption ''Regulatory Impact Analysis'' at the beginning of your comments.]

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We have determined that this is a major rule.

The following impacts reflect the fact that the effective date of the MMA provisions is July 1, 2004 for all provisions. The figures are Medicare's expenditures (that is, exclusive of the Part B coinsurance and deductible requirements). These impacts also reflect the fact that the MMA provisions affect only the FS portion of the blended payment during the transition period, and, in 2004, the FS portion is only 60 percent of the total blended payment (40 percent of the payment is from the former reasonable charge/reasonable cost methodology).

Program Impact:

Fiscal year	Cost ($millions)
2004	20
2005	200
2006	220
2007	160
2008	120
2009	120

BREAKOUT OF 2004 REGIONAL FS IMPACT ON GROUND BASE RATES BY CENSUS DIVISION

Census division	Regional factor percentage increases
1. New England (CT, ME, MA, NH, RI, VT)	23.3
2. Middle Atlantic (NJ, NY, PA)	4.7
3. East North Central (IN, IL, MI, OH, WI)	0
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	0
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	0
6. East South Central (AL, KY, MS, TN)	0
7. West South Central (AR, LA, OK, TX)	10.2
8. Mountain (AZ, CO, ID, NM, MT, UT, NV, WY)	9.9
9. Pacific (AK, CA, HI, OR, WA)	38.6

The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million or less in any 1 year. For purposes of the RFA, most ambulance providers and most ambulance suppliers are considered small businesses. Individuals and States are not included in the definition of a small entity. This rule will have a significant impact on all ambulance providers and suppliers to the extent that this rule authorizes higher payments to anyone furnishing Medicare-covered ambulance services to Medicare beneficiaries. There is a one percent increase in payments for all urban transports and a two percent increase in payments for all rural transports, as well as a 22.6 percent increase in payments for the base rate in the least populated rural areas in the country. Also, there is a 25 percent increase in the payments for mileage in excess of 50 miles, which we anticipate will occur primarily in rural areas. Finally, the ambulance entities furnishing services in 26 States will receive increased payments to their base rate because of the FS rate floor established by census division.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This rule will impact small rural hospitals to the extent that they furnish Medicare covered ambulance services. As noted above, ambulance FS payments are increased by 2 percent for all rural trips, and there is a 22.6 percent increase in the base rate payments for ambulance transports in the least populated rural areas in the country.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This rule does not have any unfunded mandates.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This rule does not impose any compliance costs on the governments mentioned.

B. Anticipated Effects

This rule results in increased spending for all Medicare-covered ambulance services furnished to Medicare beneficiaries. Therefore, all entities that furnish these services will benefit from increased program revenues. Entities that furnish these services in rural areas will particularly benefit from increased revenue and especially those rural entities that furnish these services in the least populated areas in the country. Entities that furnish these services in 26 States will benefit from increased revenue resulting from the payment floor established based on the regional FS. There will be a commensurate cost to the Medicare program of approximately $840 million over the total 5-year period during which these provisions will be in effect.

C. Alternatives Considered

This rule conforms the Medicare program regulations to the statutory provisions contained in section 414 of the MMA. These provisions are essentially prescriptive in the statute and do not allow for discretionary alternatives on the part of the Secretary. In determining the super-rural bonus amount, we followed the statutory guidance of using the data from the

GAO report cited above and followed the same regression analysis that was used in that report.

D. Conclusion

Because this rule results in higher payments to all entities that furnish Medicare-covered ambulance services to Medicare beneficiaries, we anticipate that the primary effect of this rule will be to increase revenues for these entities. This rule will not adversely affect any of these entities. Those entities that furnish ambulance services in rural areas will particularly benefit, especially for those services furnished in the least populated rural areas.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and record keeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

Subpart H—Fee Schedule for Ambulance Services

■ 1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

■ 2. Section § 414.610 is amended by—
■ A. Revising paragraph (c)(1).
■ B. Revising paragraph (c)(5).
■ C. Adding paragraph (c)(7).

The revisions and addition read as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

* * * * *

(1) *Ground ambulance service levels.* The CF is multiplied by the applicable RVUs for each level of service to produce a service-level base rate. For services furnished during the period July 1, 2004 through December 31, 2006, ambulance services originating in urban areas (both base rate and mileage) are paid based on a rate that is one percent higher than otherwise is applicable under this section, and ambulance services originating in rural areas (both base rate and mileage) are paid based on a rate that is two percent higher than otherwise is applicable under this section. The service-level base rate is then adjusted by the GAF. Compare this amount to the actual charge. The lesser of the actual charge or the GAF adjusted base rate amount is added to the lesser of the actual mileage charges or the payment rate per mile, multiplied by the number of miles that the beneficiary was transported. When applicable, the appropriate RAF is applied to the ground mileage rate to determine the appropriate payment rates. The RVU scale for the ambulance fee schedule is as follows:

* * * * *

(5) *Rural adjustment factor (RAF).* (i) For ground ambulance services where the point of pickup is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles and by 25 percent for miles 18 through 50. The standard mileage rate applies to every mile over 50 miles. For air ambulance services where the point of pickup is in a rural area, the total payment is increased by 50 percent; that is, the rural adjustment factor applies to the sum of the base rate and the mileage rate.

(ii) For services furnished during the period July 1, 2004 through December 31, 2009, the payment amount for the ground ambulance base rate is increased by 22.6 percent where the point of pickup is in a rural area determined to be in the lowest 25 percent of rural population arrayed by population density. The amount of this increase is based on CMS's estimate of the ratio of the average cost per trip for the rural areas in the lowest quartile of population compared to the average cost per trip for the rural areas in the highest quartile of population. In making this estimate, CMS may use data provided by the GAO.

* * * * *

(7) *Payment rate for mileage greater than 50 miles.* For services furnished during the period July 1, 2004 through December 31, 2008, each loaded ambulance mile greater than 50 (that is, miles 51 and greater) for ambulance transports originating in either urban areas or in rural areas are paid based on a rate that is 25 percent higher than otherwise is applicable under this section.

■ (3) A new § 414.617 is added to read as follows:

§ 414.617 Transition from regional to national ambulance fee schedule.

For services furnished during the period July 1, 2004 through December 31, 2009, the amount for the ground ambulance base rate is subject to a floor amount determined by establishing nine fee schedules based on each of the nine census divisions using the same methodology as used to establish the national fee schedule. If the regional fee schedule methodology for a given census division results in an amount that is less than or equal to the national ground base rate, then it is not used, and the national FS amount applies. If the regional fee schedule methodology for a given census division results in an amount that is greater than the national ground base rate, then the FS portion of the base rate for that census division is equal to a blend of the national rate and the regional rate in accordance with the following schedule:

Time period	Regional percent	National percent
7/1/04–12/31/04	80	20
CY 2005	60	40
CY 2006	40	60
CY 2007–CY 2009	20	80
CY 2010 and thereafter	0	100

(Catalog of Federal Domestic assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 27, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: June 17, 2004.

Tommy G. Thompson,

Secretary.

[FR Doc. 04–15090 Filed 6–30–04; 8:45 am]

BILLING CODE 4120–01–P