



Federal Register

**Monday,
November 15, 2004**

**Book 4 of 4 Books
Pages 66917–67040**

Part IV

Department of Health and Human Services

Centers for Medicare & Medicaid Services

**Medicare Program; Coverage and Payment
of Ambulance Services; Recalibration of
Conversion Factor; Inflation Update for
CY 2005; Notice**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-1267-N]

RIN 0938-AN20

Medicare Program; Coverage and Payment of Ambulance Services; Recalibration of Conversion Factor; Inflation Update for CY 2005

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

ACTION: Notice.

SUMMARY: This notice sets forth: (1) A discussion of the annual review of the conversion factor (CF) used to calculate the Medicare program ambulance fee schedule; and (2) the annual ambulance inflation factor for ambulance services for calendar year 2005.

EFFECTIVE DATE: The revised CF is effective for services furnished on or after January 1, 2005.

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

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative and Regulatory History

The Secretary will annually review the conversion factor (CF) and will adjust the CF if actual experience under the fee schedule is significantly different from the assumptions used to determine the initial CF, as stated in § 414.610(g). Additionally, the ambulance inflation factor (AIF) must be adjusted annually, as stated in section 1834(l)(3)(B) of the Social Security Act (the Act) and in § 414.610(f).

Under section 1861(s)(7) of the Act, Medicare Part B (Supplementary Medical Insurance) covers and pays for ambulance services, to the extent prescribed in regulations at 42 CFR parts 410 and 414, 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.

Ambulance services (air and ground) are divided into different levels of services based on the medically necessary treatment provided during transport. These services include the levels of service as follows:

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. Prior to 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 (AFS) through negotiated rulemaking. On February 27, 2002, we published a final rule in the **Federal Register** (Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services, 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: (1) Implemented a statutory requirement that ambulance suppliers accept Medicare assignment; (2) codified the establishment of new HealthCare Common Procedure Coding System (HCPCS) codes to be reported on claims for ambulance services; (3) established increased 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; (4) revised the certification requirements for coverage of non-emergency ambulance services; and (5) 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 over to full payment based solely on the fee schedule amount.

B. Ambulance CF Review

The February 27, 2002 final rule also provided that we would annually review rates and adjust the CF and air ambulance rates if actual experience under the fee schedule is significantly different from the assumptions used to determine the initial CF and air ambulance rates. The CF and air ambulance rates would not be adjusted solely because of changes in the total number of ambulance transports (§ 414.610(g)). This notice describes the claims data for the first 9 months of the AFS (April 1, 2002 through December 31, 2002) and explains the calculations used to determine whether the existing CF has resulted in a significant discrepancy between assumptions and actual experience under the AFS. These 2002 claims data were used because they were the most recent complete period of claims data under the AFS that were available for this analysis.

C. Ambulance Inflation Factor for CY 2005

Section 1834(l)(3)(B) of the Act (implemented by regulation at § 414.610(f)) provides the basis for updating payment amounts for ambulance services. This provision requires that the AFS be updated by the AIF annually, based on the percentage increase in the consumer price index (CPI) for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year (§ 414.610(f)).

II. Data and Methodology for Recalibration

As stated in section I.B. of this notice, we used claims data from the period April 1, 2002 through December 31, 2002 because this was the latest complete period for which we had claims data during which the AFS was in effect. We used a similar methodology to set the original CF as described in the February 27, 2002 final rule. We counted the number of trips at each level and determined the percentage of utilization of each to the total number of trips, then we compared these percentages to the same percentages from the original data used to set the CF. This method provided a means to evaluate the accuracy of the assumptions that were used to set the original CF. We also examined the degree to which ambulance billers' charges were less than the AFS amounts. This gave the actual amount of "low billing." We then determined the conversion factor for ground services based on the actual claims data and compared that amount to the CF that has been in use based on the assumptions. The resulting CF was only eight-tenths of 1 percent (0.8 percent) lower than the CF that was in use. We then performed a similar analysis using the 9-month 2002 claims data to evaluate the payment rates for air ambulance services. This resulted in payment rates that were 2.8 percent lower than the rates currently in use. We have determined that this is not a significant difference. Therefore, in accordance with § 414.610(g), we have determined that no adjustment to the existing payment rate structure is warranted.

The February 27, 2002 final rule also stated that we would review the basis for the bonus amounts paid for ambulance transports that originate in a rural area. Given that the Congress, through enactment of section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, has provided for significant additional spending for these services, we have determined that no further adjustment in the payment amounts for these rural ambulance services is warranted.

III. Provisions of the Notice

A. AFS CF Update

In accordance with § 414.610(g), we have reviewed actual claims data and determined that actual experience under the AFS is not significantly different than the assumptions used to set the CF. Therefore, we are not revising the

existing CF as a consequence of actual experience.

B. AIF for 2005

Section 1834(l)(3)(B) of the Act, as specified in § 414.610(f), provides for an update in payments for CY 2005 that is equal to the percentage increase in the CPI for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year (that is, June 2004). We will use the actual percentage increase and not an estimate or projection. The AIF for 2005 is 3.3 percent.

During the transition period (see § 414.615), the AIF is applied to both the fee schedule portion of the blended payment amount and to the reasonable charge or cost portion of the blended payment amount separately for each ambulance provider or supplier. Then, these two amounts are added together to determine the total payment amount for each provider or supplier.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period of public comment before the provisions of a notice such as this take effect. We can waive this procedure, however, if we find good cause that a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of finding and its reasons in the notice issued.

We find it unnecessary to undertake notice and comment rulemaking because the statute and regulation specify the methods of computation of annual updates, and we have no discretion in this matter. Further, this notice does not change substantive policy, but merely applies the update methods specified in statute and regulation. Therefore, for good cause, we waive notice and comment procedures.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping 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

We have examined the impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of

the Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 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). As stated above, the AIF (equal to the percentage increase in the CPI-U of June 30, 2004 as compared to June 30, 2003) for 2005 is 3.3 percent. We estimate that the application of the AIF will result in this notice being considered a major rule because it will result in an additional total program expenditure of approximately \$100 million in CY 2005.

The 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 to \$29 million in any 1 year. For purposes of the RFA, all ambulance providers or suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

We consider that a substantial number of entities are affected if the rule impacts more than 5 percent of the total number of small entities as it does in this notice. This notice will impact every ambulance provider and supplier in the same way because all ambulance payment rates for all ambulance services furnished by all types of ambulance suppliers and providers are increased by the same ambulance inflation factor. We estimate the impact of this notice will be an approximate 3 percent increase in Medicare revenues for all ambulance suppliers and providers that furnish services to Medicare beneficiaries. This will be a somewhat less than 2 percent increase in total revenues (that is, Medicare plus non-Medicare revenues). This estimated impact does not meet the threshold established by HHS to be considered a significant impact. Nonetheless, we have prepared the analysis below to describe the impact of this notice.

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 notice applies to small rural hospitals that furnish at least one Medicare covered ambulance service to at least one Medicare beneficiary.

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 notice does not result in an expenditure in any 1 year by State, local, or tribal governments of \$110 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes 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 notice will not have a substantial effect on State or local governments.

We estimate that the total program expenditure for CY 2005 for ambulance

services covered by the Medicare program is approximately \$3.7 billion. This estimate of program spending includes application of an AIF assumed to be approximately 3 percent. This assumption results in an additional total program expenditure of approximately \$100 million distributed over 16,000 suppliers and providers that furnish ambulance services to Medicare beneficiaries.

For recalibrating the AFS, there are two alternatives: (1) To make an adjustment to the AFS, if actual experience is significantly different from our initial assumptions; or (2) to make no adjustment to the AFS because actual experience is not significantly different from our initial assumptions. As discussed in section II.A. of this notice, we have decided not to make an adjustment to the AFS because actual experience is not significantly different from our initial assumptions; however, we note that making the adjustment would have lowered payments to suppliers and providers of ambulance services. Therefore, payments to suppliers and providers of ambulance services are slightly higher than would otherwise be made if we were to make these adjustments to the AFS. We estimate the impact of this action will be an approximate 0.8 percent increase

in Medicare revenues for all ambulance suppliers and providers that furnish ground ambulance services to Medicare beneficiaries and an approximate 2.8 percent increase in Medicare revenues for all ambulance suppliers and providers that furnish air ambulance services to Medicare beneficiaries. This will be a 0.5 percent and 1.5 percent increase in total revenues for ground and air ambulance services respectively (that is, Medicare plus non-Medicare revenues). The estimated impact of this action is, therefore, not significant.

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

Authority: Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)). (Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 29, 2004.

Mark B. McClellan,
Administrator, Centers for Medicare & Medicaid Services.

Approved: September 21, 2004.

Tommy G. Thompson,
Secretary.

[FR Doc. 04-24757 Filed 11-2-04; 4:45 pm]

BILLING CODE 4120-01-P