



Ground Ambulance & Patient Billing Advisory Committee

Findings from MedPAC and GAO Analyses



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Introduction



Zach Gaumer, Principal – Health Management Associates

Washington DC-based health care policy analyst for over 20 years, including 16 years of federal service. Career focus on improving the efficiency of Medicare and Medicaid reimbursement systems and expanding access to care.

Health Management Associates (4 years)

- Clients: Foundations, payers, providers, manufacturers, trade associations, beneficiary groups
- Policy areas: Medicare and Medicaid reimbursement systems, Medicare Trust Fund solvency, hospitals, ambulance, virtual care, coverage of innovative devices, value-based payment, gun control
- Disclosure: Data analysis for the American Ambulance Association

Medicare Payment Advisory Commission (11 years)

- Hospital policy and reimbursement
- Ambulance (2013 Report to Congress)
- Telehealth
- Ambulatory Surgical Centers

Government Accountability Office (6 years)

- Hospital reimbursement policy
- Medicare Advantage
- End-stage renal disease

Research Questions

1. To what extent do the costs for providing ambulance transports vary by ambulance organizational type?
2. Did the MedPAC or GAO studies suggest that patients were treated differently when it came to balance billing dependent on the organizational model that responded?
3. What were the solutions did MedPAC and GAO recommend for better aligning Medicare reimbursement with costs?

Government Accountability Office (GAO): 2002 and 2007 reports to Congress (1 of 3)



Reminder: GAO is a non-partisan Congressional support agency which evaluates federal programs and spending

GAO Findings (2002)

- Trip volume is the key factor affecting differences in ambulance providers' cost per trip.
- Ambulance costs reflect readiness—need to have a vehicle and crew available in an emergency—these are fixed costs.
- Entities that make fewer trips tend to have a higher cost per trip than those that make more trips.
- The length the transport had little effect on their cost per trip.
- In 2001, the least densely populated quarter of rural counties averaged far fewer trips than the most densely populated quarter.
- Trip volume is a strong indicator of costs, and Medicare payment differences across rural counties likely do not fully reflect differences in providers' cost per trip.

Government Accountability Office (GAO): 2002 and 2007 reports to Congress (2 of 3)



Reminder: GAO is a non-partisan Congressional support agency which evaluates federal programs and spending

GAO Findings (2007)

- Costs of ground ambulance services were highly variable across providers in 2004, reflecting differences in certain provider and community characteristics.
- Providers that had higher costs per transport typically had:
 - Fewer transports per year,
 - A greater percentage of transports in which more than a basic medical intervention occurred,
 - More transports in super-rural areas (rural counties with lowest population density),
 - Lower productivity—measured as number of transports furnished per staffed hour, and
 - A greater percentage of revenues from local tax support.

Government Accountability Office (GAO): 2002 and 2007 reports to Congress (3 of 3)

Conclusions:

- Costs of transports are variable across the industry
- A significant portion of the costs are fixed, and associated with readiness.
- Low volume ambulance entities have higher costs, super rural entities had higher costs
- Caution about data representativeness
 - 2003 analysis: Small survey sample with 215 respondents, data from 1997
 - 2007 analysis: Small survey sample with 421 respondents, data from 2003

Government Accountability Office (GAO): 2012 report to Congress (1 of 2)



GAO Findings (2012)

- Ground ambulance providers' costs per transport for 2010 varied widely. The median cost per transport was \$429: Urban: \$374 to \$410, Rural: \$404 to \$550, Super Rural: \$445 to \$639
- Providers with higher costs had:
 - Lower volume (Medicare and non-Medicare)
 - Higher transport intensity (emergency vs. nonemergency)
 - Higher government subsidies
- Labor costs the largest component of cost (61 percent), other costs include: overhead (11%), vehicle (7%), supplies (7%), fuel (4%)
- Industry margins = 2.0 percent margin, with substantial variation (-2.3 percent to 9.3 percent)
- Economies of scale: Average cost per transport is higher for suppliers and providers with 600 or fewer transports per year, due to the certain fixed costs of ambulance entities
- The smallest ambulance entities have the highest costs per transport
- The characteristics of suppliers that did not contribute to differences in costs per transport: service area (urban/rural), the service mix of Medicare transports (ALS v BLS), the use of volunteer staff, and type of ownership (non-profit v. for-profit)

Government Accountability Office (GAO): 2012 report to Congress (2 of 2)



Conclusions:

- The volume of transports has a significant impact on ambulance entity costs per transport
- High-cost providers: low volumes, higher transport intensity (higher share of emergency transports), higher government subsidies
- Characteristics not associated with higher costs: service area (urban/rural), service mix (ALS-BLS), use of volunteer staff, ownership
- The inflection point of 600 transports per year (or fewer than 2 transports per day) suggests the smallest ambulance entities have higher costs per transport. This is a useful marker
- Caution about data representativeness: Small survey sample of 154 ambulance entities, data from 2012.

Medicare Payment Advisory Commissioner (MedPAC): 2013 Report to Congress (1 of 2)



- MedPAC: Non-partisan Congressional agency, advises Congress on Medicare payment policy issues
- 2013 Report mandated by the Middle Class Tax Relief and Job Creation Act of 2012: Need to reform existing system?

Recommendation #1

The Congress should:

- allow the three temporary ambulance add-on policies to expire;
- **direct the Secretary to rebalance the relative values for ambulance services** by lowering the relative value of basic life support nonemergency services and increasing the relative values of other ground transports. Rebalancing should be budget neutral relative to current law and maintain payments for other ground transports at their level prior to expiration of the temporary ground ambulance add-on; and
- direct the Secretary to replace the permanent rural short-mileage add-on for ground ambulance transports with a new budget-neutral adjustment directing **increased payments to ground transports originating in geographically isolated, low-volume areas to protect access in those areas.**

Recommendation #2

The Congress should direct the Secretary to:

- promulgate national guidelines to more precisely define medical necessity requirements for both emergency and nonemergency (recurring and nonrecurring) ground ambulance transport services;
- develop a set of national edits based on those guidelines to be used by all claims processors; and
- identify geographic areas and/or ambulance suppliers and providers that display aberrant patterns of use, and use statutory authority to address clinically **inappropriate use of basic life support nonemergency ground ambulance transports.**

Medicare Payment Advisory Commissioner (MedPAC): 2013 Report to Congress (2 of 2)



Conclusions:

- The 7 ambulance Relative Value Units should be rebalanced using more current data, BLS non-emergency may be over valued
- Fraud concern with BLS non-emergency dialysis transports
- Costs centers of ambulance entities difficult to isolate, ambulance entity cost structures of ambulance entities varies widely
- Ambulance cost reports are needed from suppliers/providers, cost data representing all types of entities are not currently available
- Medicare's existing policies intended to help cover costs where they are higher are not efficiently targeted
- Low-volume providers have substantially higher costs per transport, geographically isolated providers in particular
- Zip code population density could be used to better target payments to higher cost providers

Other recent analysis that may inform this Committee's work (1 of 3)

- FairHealth commercial claims analysis
 - Methods: Analysis of 2019, 2020, and 2021 ambulance charges and allowed payment amounts from commercial claims, compared to Medicare claims of the same year, type, and geography
 - Median charges per transport vary widely by: State, Urban/rural area, Transport type
 - Median commercial allowed amounts higher than Medicare allowed amounts, but vary widely by state and transport type

Other recent analysis that may inform this Committee's work (2 of 3)

Median commercial allowed amounts relative to Medicare median allowed amounts							
Ground ambulance code	States with less than 100%	States with 100%-149%	States with 150%-199%	States with 200%-249%	States with 250%-299%	States with 300%-349%	States with 350%-399%
ALS-Emergency (A0427)	MD, ME, PR, VA, VI, VT	AK, AL, AR, CT, DE, FL, MI, NC, NH, NM, NY, OH, PA, SC, TN, WV, WY	AZ, DC, ID, IL, IN, KY, MA, MT, NE, NV, OR, SD, WA, WI	CO, GA, IA, LA, MS, NJ, OK, RI	TX, CA, HI, ND, UT	MN	
BLS non-Emergency (A0428)	DC, PR, RI, VI	CT, FL, MD, ME, NC, NJ, NM, NY, PA, VT, WY	AL, ID, MI, OH, SC, SD	AR, DE, GA, IN, KY, MA, MN, MS, NH, TN, VA, WV	AZ, CO, LA, MT, NE, NV, OK, UT, WI	HI	AK, CA, IA, IL, ND, OR, TX, WA

- Within individual states variation by urban/rural and transport type even wider
- Between 2019 and 2021, commercial payments have declined relative to Medicare

Other recent analysis that may inform this Committee's work (3 of 3)

- Ambulance cost center categories: Dynamic
 - Labor remains the biggest component, but has increased as a share in the last year
 - Fuel - highly variable within a given year
 - Supplies - increases may be consistent with emergency department supplies
- Supplier and provider types are more complex than 10 years ago
- Volume analyses: The pandemic has accelerated change in the industry
 - Non-emergency transports have declined
 - Interfacility transports have declined
 - Volume of smaller entities (<800 transports per year) remain 75% of the industry, super rural entities 20%

1. To what extent do the costs for providing ambulance transports vary by ambulance organizational type?

- Higher costs per transport for:
 - Low-volume ambulance entities (less than 600 transports per year)
 - Entities with higher shares of emergency transports
 - Entities in geographically isolated areas
 - Entities with higher shares of government subsidies
- Characteristics not associated with higher costs: service area (urban/rural), service mix (ALS v. BLS), use of volunteer staff, ownership (for-profit, non-profit, govt.)
- More current and more comprehensive cost data are needed to better answer this question.

2. Did the MedPAC or GAO studies suggest that patients were treated differently when it came to balance billing dependent on the organizational model that responded?

- MedPAC and GAO did not speak to balance billing.
- The survey data used to assess costs and payments were not sufficient to assess balance billing, bad debt, and uncompensated care.

3. What were the solutions MedPAC and GAO recommend for better aligning Medicare payment with costs?

- Investigate the rapid growth of BLS non-emergency dialysis transports
- Rebase ambulance RVU weights using more current data than 1997
- Better target add-on policies to support low-volume entities in isolated areas with low population density
- Require ambulance entities to submit cost reports to CMS

4. Other considerations?

- Commercial payment rates are higher than Medicare payment rates and vary substantially across states, by urban/rural area, and by transport type
- Existing commercial claims data sources are useful for assessing variation and aggregate payment levels, but no single source is comprehensive enough to assess the full range of payments by all commercial payers in all geographies