January 20, 2015

Yvette Roubideaux, M.D., M.P.H.
Acting Director
Indian Health Service
The Reyes Building
801 Thompson Avenue
Rockville, MD 20852

Re: Payment for Physician and Other Health Care Professional Services purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care; Proposed Rule

Dear Director Roubideaux:

On behalf of the American Ambulance Association (AAA), I want to thank you for the opportunity to provide comments on the proposed rule "Payment for Physician and Other Health Care Professional Services purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care" (Proposed Rule). The Proposed Rule appeared in the Federal Register on December 5, 2014.

The AAA is the primary trade association for ground ambulance service providers in the United States. We promote health care policies that ensure excellence in the ambulance services industry and provide research, education, and communications programs to enable our members to effectively address the needs of the diverse communities they serve. AAA members provide coverage to more than 75 percent of the U.S. population with emergency and non-emergency ambulance services.

I. Summary of the Proposed Rule

The Proposed Rule would amend the regulations governing the Indian Health Service (HIS) Purchased and Referred Care program (PRC), formerly known as the Contract Health Services, to apply Medicare payment methodologies to all physician and other health care professional services and non-hospital-based services that are either authorized under such regulations or purchased by urban Indian organizations. As proposed, payments under health programs operated by IHS, a Tribe, a Tribal organization, or an urban Indian organization (collectively referred to herein as I/T/U programs) would hereinafter be based on the lowest of: (1) the amount provided for such service under the applicable Medicare fee schedule or Medicare waiver, (2) the amount

negotiated with a specific provider or its agent, or the amount negotiated by a repricing agent, if applicable, or (3) the health care provider's or supplier's "usual and customary" rate for the same service. A stated goal of the proposed rule is to expand HIS beneficiary access to medical care.

It is our understanding that this proposed change would apply to the reimbursement of ground and air ambulance services under the PRC program.

II. Comments of the American Ambulance Association

The AAA recognizes the current funding shortfalls faced by the PRC program, and understands IHS' desire to better align its payment policies with that of other federal health programs. The AAA further recognizes that the current policy of reimbursing health care providers at their usual and customary rate may not be reasonable in all instances. However, the AAA cannot support the proposal to apply a Medicare-like methodology to the payment of ambulance services provided under the PRC program. Our reasons for opposing the proposal are set out below.

The Medicare Ambulance Fee Schedule does not adequately reimburse ambulance providers or suppliers for the cost of providing ground and air ambulance services to I/T/U programs

On October 1, 2012, the Government Accountability Office (GAO) released a report[1] on the adequacy of Medicare's payment for ground ambulance services. That report determined that, on average, ambulance providers were reimbursed by Medicare at 1% below their cost when the current add-ons for ambulance service were not taken into account[2]. An earlier GAO report in 2007 determined that, on average, Medicare reimbursed ambulance providers at 6% below their costs. Although the two reports utilized different methodologies, both reports demonstrate consistent underfunding of the ambulance system over a period of many years. Moreover, the most recent GAO report almost certainly underestimates the financial challenges faced by ambulance providers, as the report does not take into account recent changes in Medicare reimbursement for ambulance services, including the expiration of a temporary GPCI add-on, the implementation of a new productivity adjustment, the adoption of fractional mileage, or ongoing sequestration of Medicare payments.

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[1] *Ambulance Providers: Costs and Medicare Margins Varied Widely; Transport of Beneficiaries Have Increased* (GAO-13-6, October 1, 2012).

[2] The current add-ons for ambulance include a 2% increase for ambulance transports provided in urban areas, a 3% increase for ambulance transports provided in rural areas, and an additional bonus for transports that originate in so-called "super-rural" areas. **Under current law, these add-ons are scheduled to expire on March 31, 2015.**

The AAA cannot support the current proposal because it would magnify the existing disparity between the average ambulance provider's total costs and their total reimbursement.

The total savings achieved by switching reimbursement for ambulance services to a Medicare-like methodology is likely to be small, while the impact of this payment reduction will fall disproportionately on a small number of ambulance suppliers

In April 2013, the Government Accountability Office (GAO) estimated that implementing a Medicare-like methodology for PRC programs could save as much as $32 million on physician services, with additional savings from other non-hospital services. However, the AAA believes that the aggregate savings that could be attained by shifting ambulance services to a Medicare-like methodology would be quite small.

According to a June 2013 report by the Medicare Payment Advisory Commission (MEDPAC), Medicare paid approximately $5.3 billion on ambulance services in calendar year 2011. In that same year, Medicare spent approximately $68 billion on services reimbursed under the Medicare Physician Fee Schedule in 2011. If that same ratio were applied to the projected $32 million in savings for physician services, it would indicate that the HIS would save approximately $2.5 million by switching reimbursement for ambulance services to a Medicare-like rate. This represents less than 0.2% of the $914 million Congress allocated for PRC programs in Fiscal Year 2015.

While the total savings to be achieved are quite small, these savings would come at the expense of a small fraction of the total number of ambulance providers. The AAA currently estimates that there are more than 15,000 ambulance providers currently operating in the United States. Only a small fraction of that number will provide ambulance services to I/T/U programs in any given year. Moreover, the ambulance providers that provide services to I/T/U programs are disproportionately likely to be small and/or rural providers. The 2007 GAO Report indicated that Medicare pays super rural providers 17% below their costs before giving effect to the existing add-ons[3]. Shifting payments under the I/T/U programs to the existing flawed Medicare methodology would magnify the financial difficulties these small and rural services encounter, and, therefore, would threaten their ability to continue to provide necessary services to both IHS beneficiaries, and their communities as a whole.

The AAA believes that the arms-length negotiations should be the primary rate-setting mechanism for the reimbursement of ambulance services provided to I/T/U programs

Under current PRC payment rules, the primary rate-setting mechanism for health care services is a negotiated transaction between the I/T/U program and the health care

[3] *Ambulance Providers: Costs and Expected Margins Varied Greatly* (GAO-07-383, May 2007).

provider community. The AAA believes that arms-length negotiations between I/T/U programs and ambulance providers should remain the primary rate-setting mechanism for the reimbursement of ambulance services under the PRC program.

I/T/U programs are currently empowered to set payments rates for ambulance services as part of negotiated transactions with ambulance providers and suppliers. In fact, several of our members have indicated that they have recently been approached by Tribal Leaders requesting Medicare-like rates. In some instances, the ambulance provider has agreed to these proposed rates. In other instances, the ambulance provider has declined to contract on these terms, citing a belief that the applicable Medicare fee schedule amounts do not adequately reimburse them for their costs of providing services to IHS beneficiaries.

The AAA has no issue with individual ambulance providers agreeing to contract with an I/T/U program at the applicable Medicare rates. However, the current proposal would force ambulance providers to accept the Medicare rates, even if doing so would require them to provide services at a loss. AAA believes that ambulance providers should be free to reject such an offer if they reasonable believe that they cannot operate profitably at such rates. To the extent the local ambulance provider rejects an offer to contract at the Medicare rates, the I/T/U program would have the option of either: (1) revising its offer to better reflect local economic conditions or (2) finding another ambulance provider willing to contract at the Medicare rates.

In competitive markets that support multiple ambulance providers, the AAA would expect that the I/T/U program will be able to find an ambulance provider that is willing to accept Medicare-like rates. In rural areas where ambulance providers face substantially higher operating costs, the I/T/U programs may find that they must pay higher rates in order to find ambulance providers willing to contract for such services.

While the AAA believes that a market-based approach should be the primary rate-setting mechanism, the AAA recognizes that the current policy of reimbursing ambulance providers—in the absence of a contract—at their usual and customary charge may, in some instances, reduce the incentives for ambulance providers to enter into good faith negotiations with I/T/U programs over ambulance rates. Therefore, the AAA would support a proposal to revise the existing payment rules to provide that non-contracted ambulance services be reimbursed at something less than the provider's usual and customary rate. However, the AAA does not support setting that payment rate at the Medicare rate, as GAO reports have consistently demonstrated that Medicare rates do not cover the costs of providing services in many parts of the country.

Instead, the AAA would recommend that IHS set the payment rate for non-contracted ambulance services at 150% of the corresponding Medicare allowable. The AAA believes that this payment level would provide sufficient incentives for both the I/T/U

program and the ambulance providers to negotiate in good faith towards a contracted rate. In the event that the parties are unable to agree upon a mutually agreeable rate, the 150% of Medicare threshold would permit the I/T/U program to realize substantial savings compared with the current policy of reimbursing ambulance providers at their usual and customary rate, while ensuring that ambulance providers in particularly high-cost areas are still able to recoup their costs of providing necessary ambulance services.

III. Conclusion

For the reasons set forth above, the AAA cannot support the proposal to apply Medicare payment methodologies to ambulance services provided to I/T/U programs. Instead, the AAA believes that reimbursement should continue to be based on: (1) an arms-length negotiation between the I/T/U program and the ambulance provider or (2) where no prior agreement on the rates exists, at 150% of the corresponding Medicare allowable.

Please do not hesitate to contact Tristan North at (202) 486-4888 or tnorth@the-aaa.org or Kathy Lester at (202) 534-1773 or klester@lesterhealthlaw.com if you have any questions.

Thank you.

Sincerely,

/Mike Hall/

Mike Hall
President