

## **CMS Issues Final Ambulance Rule**

Today, December 1, 2006, CMS issued a final rule for physician payments. Buried in the contents are changes to the ambulance fee schedule. In my opinion, overall, CMS has made some good changes. However, there are some issues that will cause pain for some rural ambulance services while creating joy for some formally urban ones.

In addition to the changes listed below, the CPI+1% urban and CPI+2% rural annual payment updates expire on December 31, 2006. The 2007 ambulance fee schedule update is 4.3% for urban and rural, which is the straight CPI value (CPI+0) used in the ambulance update. Also, the bonus for rural miles 1-17 expires on December 31, but the bonus for miles 51+ remains in effect.

### **The good changes:**

1. CMS is NOT changing the definition of Specialty Care ambulance transport. In the proposed rule CMS had proposed limiting payments for SCT to only claims with hospital origins and hospital destinations, virtually eliminating the higher payment rate for transports of beneficiaries on ventilators from a hospital to a specialized nursing home (among other examples). The fee schedule was originally adopted using the term "interfacility" which permitted those kinds of payments. CMS wanted to change the definition to use the term "interhospital". They have abandoned that proposal.
2. CMS is discontinuing the annual review of conversion factor assumptions. CMS included a provision in the ambulance fee schedule that required them to annually assess whether the assumptions they used to compute the rates had resulted in budget neutrality. After 5 years of the fee schedule and no changes, they decided this was no longer necessary.
3. CMS has withdrawn their proposal to alter the emergency response definition.

### **Urban-Rural Definition Change:**

In the proposed rule CMS announced that it would adopt OMB's current CBSA classification system of urban-rural counties and abandon the 1990s MSA system. This change would bring the ambulance fee schedule into conformity with other parts of the federal government and with other Medicare payment systems. Unfortunately for some, and great for others, it reclassifies a number of counties in the country from rural to urban or from urban to rural. On balance, from a bureaucratic view, not much is changing because 89% of the current zip codes are staying with the same designation, and of the 11% changing, roughly half are making the change either way. For those areas that used to be urban and will now be rural, this means slightly increased payments. For those areas that used to be rural that will now be urban, it means slightly decreased rates - these folks will be most unhappy. Here is the basic methodology to figure out if a county is urban or rural under the ambulance fee schedule.

1. If the county is neither metropolitan or micropolitan, it is rural. STOP HERE. (These have always been considered rural, but there are less of them now.)
2. If the county is micropolitan, it is rural, STOP HERE. (These were previously urban or rural, depending on the county, because "micropolitan" didn't exist under the old MSA system.)
3. If the county is urban and the zip code is RUCA level 4 or higher, the zip code within the urban county is rural. STOP HERE. (These were previously urban.)
4. The urban county zip codes that are RUCA levels 1-3.xx are urban. (These were previously urban.)

Each zip code and its RUCA level are contained in an appendix to the final rule (see link below).

But, they aren't the big losers...

### **The Big Losers:**

*Air Ambulance* -- The most significant impact of the urban-rural definition change will occur to air ambulance providers. Air ambulance base rates are 50% higher in rural areas than urban ones. As with ground ambulance providers, while there will be shifts both directions, they won't typically impact the same provider. The provider in a county that is shifting rural to urban is not likely to be the same provider for a county shifting the other direction. So while the net change in zip codes may not be statistically significant, losing 50% of reimbursement is a very big deal to the air ambulance company serving the area shifting rural to urban.

*Super Rural Areas* -- In the proposed rule issued in May, CMS stated that the Super Rural areas would not be affected by the change they proposed, and they included a zip code list to prove it. In the final rule they made a similar statement...

"Comment: Several commenters were concerned about the impact of the proposed CBSA-based geographic changes on the provisions of the Medicare Modernization Act (MMA) for rural service areas, specifically concerning the "Super Rural Bonus" areas.

Response: The "Super Rural Bonus" areas are areas that we determine to be in the lowest 25th percentile of all rural populations arrayed by population density in accordance with section 1834(l)(12) of the Act. Ambulance pickups in these areas currently receive a 22.6 percent add-on to their Medicare payments. **None of the Super Rural Bonus areas should be adversely affected by the proposed CBSA-based changes**, as our use of RUCA levels will preserve the rural status of an area whether or not it is located in a county which is designated as urban under the OMB definitions. Areas that do lose their rural status to become urban have become urban because of a significant increase in the surrounding population."

However, recently CMS posted the final zip code list for 2007, and a **number of Super Rural zip codes are losing their designation**. While the urban-rural payments only differ by a few dollars, the Super Rural areas receive a base rate that is 22.6% higher than the urban rate. The Super Rural areas that will no longer be so are going to see a 22.6% immediate reduction in payments on January 1<sup>st</sup>.

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