AMERICAN AMBULANCE ASSOCIATION

December 6, 2019

The Honorable Richard Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Re: Rural and Underserved Communities Health Task Force Request for Information

Dear Chairman Neal and Ranking Member Brady:

On behalf of the American Ambulance Association (AAA), I thank you for extending to us the opportunity to provide comments to the Rural and Underserved Communities Health Task Force as it works to develop bipartisan legislation to improve health care outcomes within underserved communities. Ground ambulance service organizations play a unique and critical role in rural communities. Often, rural ambulance services are the only lifeline left to residents when other health care providers reduce their services or leave the area altogether. Thus, as the Task Force considers legislation to improve health care outcomes in rural and underserved communities, we ask that you include policies to address barriers so that ground ambulance service organizations can continue to serve as the health care safety net that allows rural communities to continue and thrive.

The AAA is the primary trade association for ground ambulance service providers and suppliers 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.

Ambulance services are the essential front line for providing life-saving care and entry point into our nation's health care system. Often, ambulance services with their highly trained paramedics and EMT's are the only providers of emergency medical services for their communities. They are also a vital link, especially in rural areas, for patients whose conditions require them to receive critical medical services while being transported to more specialized or higher acuity facilities located in other cities, towns, or even States. Ambulance services are overwhelmingly small businesses or agencies; more than 85 percent of ambulance services throughout the United States provide 2,500 or fewer transports. These ambulance services are

dedicated to serving their local communities providing care, transport, and disaster preparedness. Particularly in rural areas of the country, ambulances are the medical safety net.

As discussed below, we ask that the Task Force support rural ambulance organizations by including provisions in the legislation to stabilize the payment system (*e.g.,* building the ambulance add-ons into the base rate) and providing a pathway to ensure that changes in the census collection methodology no longer result in rural and super-rural areas being designated as urban.

The "Medicare Ambulance Access, Fraud Prevention and Reform Act of 2019" (H.R. 4938) introduced by Representatives Terri Sewell, Devin Nunes, Peter Welch, Markwayne Mullin and Earl Blumenauer, already includes language to address these issues. This critical legislation would make permanent the Medicare ambulance add-ons including the current increases for ambulance service organizations serving rural and super rural areas. H.R. 4938 would also ensure that those rural and super rural areas with populations of 1,000 people per square mile or less in large urban counties remain designated as rural. Simply put, the legislation would help ensure that patients continue to have access to vital ambulance services in rural and extremely rural areas of the country.

In addition, the we would also like to work with the Congress to promote innovative payment models in which rural ambulance service organizations will be able to participate and incentivize innovations in care to address the rural health care crisis.

I. Response to Questions

In this section, we respond to the specific questions outlined in the RFI for which we can provide meaningful information to the Task Force. We have skipped those questions that are not as relevant to ground ambulance services. As requested, we have limited our answers to 250 words or less for each question.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional systems or factors outside of the health care industry that influence health outcomes within these communities?

In terms of the services that ground ambulances provide, the major factor that impacts quality of care is the chronic underfunding of the ground ambulance payment rates under the Medicare program, as two GAO reports have indicated. In addition, the limitation on reimbursement to transportation makes it difficult for ambulance service organizations that serve as the safety net and respond to many situations where treatment is necessary but not transport to a hospital. The other major factor is the difficulty of attracting and maintaining staff, which we discuss in the question below.

It is also important to note that many federal grant programs are defined too narrowly and exclude ground ambulance organizations, even though these organizations are the designated 911 or equivalent responder. It would be very helpful if all grants, including those directed toward rural "providers" would define eligible organizations to include ground ambulance "suppliers" as well.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

It is important to remove barriers to adopting innovative technologies for ground ambulance services. We applaud the Congress and HHS for establishing policies to promote telehealth services in the Medicare program. However, more needs to be done to assist rural ambulance organizations. Given the lack of stability in the Medicare reimbursement system and chronic underfunding of these services, along with the inability to obtain reimbursement for services provided if there is not a transport involved, rural ambulance services are struggling to keep their doors open. As they struggle to purchase equipment and supplies and maintain highly specialized, qualified employees, it can be nearly impossible for them to find the resources to purchase innovative equipment and supplies, such as telemetry/remote video systems. As suppliers, instead of providers, under Medicare they have been excluded from many of the grants or other assistance programs to help offset the cost of innovative technologies. Similarly, EMS funding is often directed at police or fire departments only. These policies leave privately owned and operated ambulance service organizations with few to no options for finding ways to cover the cost of adopting innovative products and technologies that would improve the care they are delivering on the front lines in their communities.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Under the current system, Medicare's payment rates do not cover the cost of providing ambulance services. This problem is acute in rural areas because there are fewer patients to spread the fix costs and cost of readiness across. Economies of scale are rarely, if ever, achievable in rural areas. In reports in 2007 and 2012, the Government Accountability Office (GAO) in both instances determined Medicare on average reimburses ambulance service providers below cost when the temporary payment adjustments are not taken into account. Since that time, the ambulance fee schedule rates have been further eroded by cuts related to the productivity factor and sequestration. While other providers had positive margins that were reduced by these payment reductions, ambulance service suppliers and providers had to bear

the cuts at a time when they have been experiencing negative margins. These across-the-board cuts have further destabilized ambulance service organizations and placed beneficiaries' access to care, especially in rural areas, at risk.

**4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers? b. there is broader investment in primary care or public health?
c. the cause is related to a lack of flexibility in health care delivery or payment?**

Unlike other Medicare providers, ambulance service organizations are not reimbursed when they provide care, if the patient is not also transported to a hospital. For rural services, this breakdown in the system has become more pronounced. In many communities, for example, hospital emergency departments are no longer open 24-7. In other locations, there are no longer emergency departments or primary care providers at all. In these instances, local ambulance services have stepped in and provided the care that would have otherwise been provided in these settings. Many times, they provide these health care services without reimbursement, because the transportation is not required.

MedPAC has recognized this change in roles and offered in its 2016 *Report to the Congress* the clinic and ambulance model as one way to address the challenge.

> … communities that cannot support a 24/7 emergency department could opt to convert their existing inpatient facilities into a primary care clinic with an affiliated ambulance service. Similar to the federally qualified health center model, Medicare would pay prospective rates for primary care visits and ambulance transports. It would also provide an annual grant or fixed payment to support the capital costs of having a primary care practice, the standby costs of the ambulance service, and uncompensated care costs.[1]

This is only one idea of how the problem could be addressed.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

[1]MedPAC Report to the Congress: Medicare and the Health Delivery System (June 2016)

Unfortunately, because ground ambulance services are defined as suppliers by Medicare, they have not been allowed to participate in a meaningful way in the vast majority of networks or demonstration projects.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

While we do not know of any model or demonstration project focused on ground ambulance services, we do know from talking with our members throughout the country that having a stable Medicare payment system that will allow ambulance organizations to attract more qualified individuals.

With Medicare rates comprising a substantial part of ambulance service organizations' budgets and the chronic underfunding of these rates, ambulance service organizations face serious work force challenges. As you know all too well, it is difficult to attract individuals to remain in rural areas. For ambulance services, the problem is even more acute. Part of the reason is that the stress and hardships of the jobs of EMTs and paramedics. In addition, ambulance service organizations are competing with other businesses, including hospitals, for employees. Often these organizations can provide higher salaries, as a result of the chronic underfunding of the Medicare ambulance rates. The AAA would like to work with you to try to address these problems as well.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

One step toward addressing behavior and substance issues in rural communities is to allow ambulance services to transport patients, when medically necessary and appropriate, to locations other than an emergency department. Current Medicare regulations limit the locations to which beneficiaries may be transported. Allowing alternative destinations would permit ambulance services under medically-approve protocols to take patients to the right type of facility at the right time to meet their health care needs. It would also produce important downstream savings to Medicare by reducing the number of emergency department visits. For those communities that may have mental health facilities or substance abuse clinics, but limited emergency department hours, allowing alternative destinations would help address the rural health care crisis as well. We appreciate that the Innovation Center has developed a pilot program to allow such transports. Unfortunately, the parameters of this model make it difficult for many rural ambulance service organizations to be able to participate. Thus, we continue to work with CMS to find ways to allow for innovative models to be tested in rural areas. These models should be designed to address the specific challenges that rural communities face and

the enhanced role taken on by ambulance service organizations. A one-size-fits all solution or one based on urban experiences alone is unlikely to work.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

Ground ambulance service organizations providing care in rural communities have been able to partner with hospitals and other insurers to identify ways to improve outcomes as patients transition from inpatient stays to their homes. The AAA would like to work with the Task Force to support payment in the Medicare program for such services, which have been shown to reduce hospital readmissions and improve health outcomes.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

The AAA appreciates that the Congress has established the ground ambulance cost data collection system. As CMS launches the system, it will be important for the Congress to monitor it to ensure that the sampling collects sufficiently representative data from rural ground ambulance organizations about their costs and utilization. It will be important to analyze the information collected to assess the true cost of providing ambulance services and modify the ambulance fee schedule to ensure adequate reimbursement rates going forward.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

It is important that the Congress protect access to rural and super-rural ambulance services by ensuring that areas that are clearly rural or super-rural are not inadvertently redefined as urban because of methodological changes in the U.S. Census. Many ambulance service organizations in rural and super-rural areas experienced serious problems when the 2010 Census results led CMS to reclassify clearly rural or super-rural areas as urban. For example, locations in Sequoia National Park, clearly a rural area, lost its status and is now considered urban, because of the reliance upon commuting data that distorts the actual population of many of these areas. During the last review, 132 rural census areas were shifted from rural to urban as well. If nothing else, ambulance services in rural and super-rural areas need an appeals process so that when unbelievable results occur, they can be addressed. The Medicare Ambulance Access,

Fraud Prevention and Reform Act of 2019 (H.R. 4938) ensure that those rural and super rural areas with populations of 1,000 people per square mile or less in large urban counties remain designated as rural. Simply put, the legislation would help ensure that patients continue to have access to vital ambulance services in rural and extremely rural areas of the country.

II. Conclusion

In conclusion, the AAA appreciates the efforts the Task Force has made to recognize and protect ambulance services serving Americans living in rural and super-rural areas. We look forward to working with you on stabilizing the Medicare ambulance fee schedule, reforming the ambulance fee schedule to recognize the expanded role of ambulance services, especially in rural areas, treating ambulance service organizations more like providers of health care services and providing regulatory relief. Please do not hesitate to contact AAA Senior Vice President of Government Affairs Tristan North at (202) 802-9025 or tnorth@ambulance.org or Kathy Lester at (202)-534-1773 or klester@lesterhealthlaw.com if you would like to discuss our comments in more detail or have any questions.

Sincerely,

Aarron Reinert
President

cc: The Honorable Jodey Arrington
The Honorable Danny Davis
The Honorable Terri Sewell
The Honorable Brad Wenstrup