AMERICAN AMBULANCE ASSOCIATION

August 29, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Room 445–G
Hubert H. Humphrey Building,
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS–1612–P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule

Dear Administrator Tavenner:

On behalf of the American Ambulance Association (AAA), I want to thank you for the opportunity to provide comments on the proposed rule "Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015" (Proposed Rule). We appreciate the opportunity to support the implementation of the extension of the ambulance payment add-ons, which we agree is self-implementing. However, as described in more detail below, we are concerned about the proposal to modify the geographic area designations.

The AAA is the primary trade association for 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.

I. The Proposal to Adjust Geographic Area Designations Does Not Account for the Most Currently Modified RUCA Codes and Does Not Describe the Actual Impact on Ambulance Services.

The AAA agrees with CMS that it is appropriate to adjust the geographic area designations periodically so that the ambulance fee schedule reflects population shifts. We are concerned, however, that the proposed modification does not describe the actual impact of the proposed change because it does not take into account the most recent

modifications to the RUCA codes. When the updated codes are applied, many more ZIP codes will change than CMS has identified in the Proposed Rule.

As CMS recognizes, changes to the geographic area designations can have significant negative financial implications on ambulance service providers which serve areas changing from rural to urban. Payments to ambulance services are tied to the point of pick up. The preamble describes how the "geographic designation of urban, rural, or super rural is assigned to each claim for an ambulance transport based on the point of pick-up ZIP code that is indicated on the claim." In addition, when the point of pick up is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles. Changes in the designation of ZIP codes can dramatically change the payment amounts ambulance services receive.

Working with an independent analyst, the AAA tried to replicate the modifications to the current geographic area designations. The use of the county/CBSA file looks correct. It appears, however, that the ZIP-code-based RUCAs were not updated, despite the fact that the preamble indicates CMS intended to do so.

> The updated RUCA code definitions were introduced in late 2013 and are based on data from the 2010 decennial census and the 2006–10 American Community Survey. We are proposing to adopt the most recent modifications of the RUCA codes beginning in CY 2015, to recognize levels of rurality in census tracts located in every county across the nation, for purposes of payment under the ambulance fee schedule.[1]

We understand from conversations with CMS officials that the Proposed Rule does not include the most recent RUCA codes from the Health Resources and Services Administration. When these codes are applied, we believe substantially more ZIP codes would shift. By our estimates, it appears that about three times the number of ZIP codes identified in the Proposed Rule would go from being urban to rural if the modified RUCAs were applied. Perhaps more importantly, we estimate that more than 1,500 ZIP codes would shift from rural to urban. While we cannot precisely replicate the Proposed Rule, the data sources are sufficient to provide a close approximation.

For example, we looked at the rural to urban transitions in Virginia. Of the ZIP codes that our analysis showed shifted designations, only five appear on the list in the Proposed Rule. It appears that each of the "missing" ZIP codes had a previous RUCA value that indicated rural status. For example, 22939 (Augusta, VA) would appear to shift from rural to urban under the new MSAs. The old RUCA would result in it remaining rural, which is what we believe CMS may have concluded. However, under the new RUCAs, it would be designated as urban.

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[1] 97 Fed. Reg. 40318, 40383 (July 2014).

We also believe that some ZIP codes would no longer have super rural status. Contrary to this analysis, the preamble states that there will be no impact on ambulance services designated as super-rural.

> Adoption of the revised OMB delineations and the updated RUCA codes would have no negative impact on ambulance transports in super rural areas, as none of the current super rural areas would lose their status due to the revised OMB delineations and the updated RUCA codes.[2]

Similarly, the preamble indicates that the impact on rural services will be minimal.

> The geographic designations for approximately 99.48 percent of ZIP codes would be unchanged by OMB's revised delineations and the updated RUCA codes. There are a similar number of ZIP codes that would change from rural to urban (122, or 0.28 percent) and from urban to rural (100, or 0.23 percent).[3]

Based upon our understanding of the updated RUCA codes, the changes will significantly impact many more ambulance services than the Proposed Rule anticipates. As noted above, more than 1,500 ZIP codes would no longer be designated as rural.

III. Recommendation: CMS Should Delay Implementation of the Modifications and Provide For a Transition Period To Provide Sufficient Time for Ambulance Services To Prepare for the Changes

If our analysis is correct and there are substantially more ZIP codes shifting from rural to urban status, the modifications will change the reimbursement rates for many ambulance services. Given that these changes can dramatically impact an ambulance provider or supplier's reimbursement rates, it is also important that the industry have sufficient notice of the changes and adequate time to adjust to them.

As an initial matter, we suggest that CMS delay the implementation of the adjustment until Calendar Year (CY) 2016. Delaying the modifications until CY 2016 would allow CMS to have sufficient time to publish the changes in rural and urban status and allow all interested parties to provide comments on the proposal. This approach is particularly important given that the Proposed Rule indicates that the modifications to the geographic area designations result in few changes from rural to urban status and none with regard to super-rural status. Implementing the changes in CY 2016 would also be consistent with when CMS didn't implement changes from the 2000 census until CY 2007.

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[2] *Id.* at 40374.
[3] *Id.*

If there are changes to super rural ZIP codes, the AAA recommends that CMS grandfather in the super-rural ZIP codes that would otherwise lose their designations.

In addition to delaying implementation to CY 2016, we recommend a phase-in for points of pick up in rural areas, we suggest implementing a transition that would phase-in the payment reduction over a specified period. For example, with regard to the 3.0 percent rural add-on, the adjustment could be phased-in over four years.

Year	Add-on Amount
2016	2.75%
2017	2.5%
2018	2.25%
2019	2.0%

A similar approach could be applied to the rural mileage add-on with the 50 percent increase phased out for those ZIP codes that change over a specific period.

Year	Percent Increase
2016	37.5%
2017	25%
2018	12.5%
2019	0.0%

This approach would be similar to the way CMS has proposed to help other providers adjust to the reduction in payment amounts due to the changes in the geographic area designations.[4] For example, in the case of dialysis facilities, CMS identified 105 counties and 113 facilities that would move from rural to urban status under the new designations. "While we believe that the new CBSA delineations would result in wage index values that are more representative of the actual costs of labor in a given area, we also recognize that use of the new CBSA delineations would result in reduced payments to some facilities."[5] To address this concern, CMS proposes a transition blended wage index for all facilities over a period of two years. We propose a four-year transition blended amount for ambulance providers and suppliers because of the significant role the super rural and rural add-ons, as well as the rural mileage adjustment, play in maintaining the economic stability of many providers and suppliers.

We would welcome the opportunity to work with CMS to find an option that dampens the immediate impact on ambulance providers and suppliers while also allowing the modifications to take effect.

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[4] 79 Fed. Reg. 40208, 40231 (July 11, 2014).
[5] *Id.*

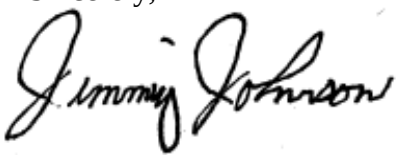
III. Conclusion

Again, we recommend an implementation date of CY 2016 for changes in designation of urban and rural ZIP codes and then a four-year phase-in of the lower reimbursement rates for those ZIP codes losing rural status. We also recommend any ZIP codes that would otherwise lose their super rural status be grandfathered as super rural.

We appreciate the opportunity to provide you with our comments. Please do not hesitate to contact Tristan North at (202) 486-4888 or Kathy Lester at (202) 534-1773 if you have any questions.

Thank you.

Sincerely,



Jimmy Johnson
President