AMERICAN AMBULANCE ASSOCIATION

Talking Points on CMS' Release of Medicare Payment Data

On April 9, 2014, the Centers for Medicare and Medicaid Services (CMS) publicly released payment data for Medicare fee-for-service payments in 2012. The data release shows that Medicare Part B made approximately $77 billion in payments to more than 880,000 distinct Medicare providers. This data release contains information on the utilization, payment and submitted charges of each physician, ambulance service provider and other health care professional that received a Medicare payment in 2012.

The release of this information has generated a number of stories by news organizations focused on the top recipients of Medicare payments in various states and cities, which in some instances has included ambulance services. The data does not tell the full story and it is important that ambulance service providers furnish more information specific to their operation if asked about the data released by CMS about their organization.

The American Ambulance Association (AAA) is providing the following guidance to its members, who may receive inquiries from the media and patients:

Commitment to transparency and accurate Medicare payments

The AAA supports increased transparency in the way Medicare pays providers for the care provided to beneficiaries, but is important that the context of provider costs is also available to help beneficiaries and policymakers make more informed decisions about health care services.

The AAA remains committed to working with CMS to advance our common goals of ensuring transparency and ensuring that payment rates cover the cost of providing care to beneficiaries. Ambulance services are a vital and integral component of our nation's health care infrastructure; thus, it is important to understand the full scope of data – costs as well as payments – when evaluating these life-saving and life-sustaining services.

Release of payment data was limited to fee-for-service suppliers

The CMS Part B fee-for-service payment data included physicians and other health care professionals paid on a fee-for-service basis paid under the Medicare Part B program. The data set did not include payments to hospitals and other institutional providers paid under the Medicare Part A program. This distinction is important because ambulance services are unique and the costs of providing ambulance services are substantially different than the costs borne by other providers, making comparisons among these groups inappropriate. It is also important because the number of beneficiaries for whom ambulance services provide care is in general significantly higher than most non-institutionalize health care professionals in their area.

Medicare payments to ambulance service providers are an extremely small portion of total fee-for-service payments

In 2012, approximately 1% of the $574 billion spent by Medicare was spent on ambulance services. In 2012, Medicare made approximately $77 billion in fee-for-service payments. Of this, approximately $4.95 billion was paid to ambulance providers nationwide. Even when compared to just payments to fee-for-service providers under Medicare Part B, ambulance services represent less than 6.5% of total fee-for-service Medicare spending.

The payment data do not differentiate between individual practitioners and organizations

Most of the news reports on the payment data have focused on the ambulance services that received the highest total payments from Medicare. However, the data do not distinguish between individual practitioners, such as a physician, and organizational suppliers, such as an ambulance service.

Ambulance service providers are complex organizations that serve entire communities, employing dedicated professionals who serve communities on a 24-hour a day, seven days a week basis. These services provide life-saving emergency medical care to beneficiaries, as well as life-sustaining care for beneficiaries transitioning between different health care facilities on a non-emergency basis.

Even small rural ambulance services can provide thousands of a patient encounters in a typical year. For the largest ambulance services, the number of patient encounters can run into the hundreds of thousands a year. Thus, it is not surprising that these larger organizations would place at or near the top of Medicare payments.

Medicare's payments for ambulance services do not cover the cost of providing care

Medicare reimburses ambulance services on a fee-for-service basis, with the payment rate for each level of service based on a national fee scheduled established by the Centers for Medicare and Medicaid Services (CMS). Medicare's payment is supposed to cover the cost of providing all necessary medical supplies used during the ambulance transport, the transport, the EMS team, and the administrative support (*e.g.*, dispatch centers).

However, the GAO has consistent concluded that the current reimbursement rates **do not** cover the cost of providing these services and care to beneficiaries. In 2010, the Government Accountability Office (GAO) determined that without direct intervention from the Congress, the Medicare reimbursement rate was below the cost of providing care. With the congressional add-on payments, the average margin was approximately 2 percent. However, these numbers overstate the margins, because the GAO acknowledged it did not take into account recent changes to Medicare's payment methodologies that further reduced Medicare's payment for ambulance services. The GAO's report also did not take into account the current 2 percent reduction under sequestration, mandated by the Budget Control Act of 2011. These findings echo those presented in 2007 by the GAO, which also found that on average, the Medicare rates did not cover the cost of caring for beneficiaries.

Payment data is not indicative of the quality of health care provided

CMS recognizes that the payment dataset has a number of limitations. Most importantly, CMS notes on its website that "the data are not intended to indicate the quality of care provided and are not risk-adjusted to account for difference sin underlying severity of disease of patient populations."