Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

State Ambulance Policies and Services

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E X E C U T I V E S U M M A R Y

PURPOSE

To provide baseline data about the ambulance industry and determine how State and local ordinances affect the delivery of ambulance services.

BACKGROUND

According to Section 1861(s)(7) of ***The Social Security*** Act, Medicare pays for medically necessary ambulance services when other forms of transportation would endanger the beneficiary's health. Ambulance suppliers provide two distinct levels of service--advanced life support and basic life support. The major distinctions between the levels are the types of vehicles and the skills of the personnel and the services they render.

The Health Care Financing Administration (HCFA) is considering proposed Medicare regulations that would base reimbursement for ambulance services on the patient's condition rather than the type of vehicle and personnel used. The final rule may include a special waiver for suppliers in non-Metropolitan Statistical Areas who would be hurt financially if they use only advanced life support ambulances. The HCFA may consider several options and may include a special waiver only if HCFA is convinced through overwhelming information of the need for the waiver.

We decided to examine the effect and need for a special waiver based on Metropolitan Statistical Areas and non-Metropolitan Statistical Areas. In addition, we developed baseline information on the number of ambulance suppliers, vehicles, and personnel nationwide. We conducted in-person and telephone interviews with 53 State Emergency Medical Services Directors for the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands. Using a structured discussion guide, we (1) identified State, county, and municipal mandates that require specific levels of ambulance services and (2) obtained baseline data on the number of suppliers, licensed vehicles, and certified personnel operating within the States in 1995 and 1996. We analyzed the 1995 universe of Medicare ambulance claims to determine the distribution of allowed claims by Metropolitan Statistical Areas and non-Metropolitan Statistical Areas for the 53 States. We also reviewed financial analyst reports on the ambulance industry.

FINDINGS

Medicare ambulance costs and services are skyrocketing

Between 1987 and 1995, Medicare allowances increased 229.1 percent from $602 million to almost $2.0 billion. More than four out of five Medicare ambulance services are provided in Metropolitan Statistical Areas. In 1995, this translated to about 6 million of the 7.5 million services rendered in Metropolitan Statistical Areas.

Ambulance service is a growth industry controlled by a few major corporations

The Emergency Medical Services Directors in 41 of the 53 States noted that three large corporations are buying out small private ambulance companies in their States. The three major corporations--Laidlaw, American Medical Response, and Rural/Metro--are located in all 41 primary and shared State markets. By the end of 1996, these three corporations owned at least 20 percent of the national private ambulance market.

All States regulate ambulance services; however, less than half mandate levels of service and only one requires advanced life support

All States have administrative codes and regulations that set standards for ambulance services. The codes and regulations set requirements for licensure, certification, and recertification of ambulance suppliers, vehicles, and personnel to operate within the States. Nationally, 21 of the 53 States legislatively mandate a minimum level of ambulance services. Of these, Hawaii is the only State that requires advanced life support services. Approximately 11 percent of localities also mandate ambulance services, and another 11 percent of localities contract for ambulance services using general tax revenues.

Only two States use Metropolitan Statistical Areas to designate ambulance service areas

Of the 53 States, 5 1 (or 96.2 percent) do not define their ambulance service areas as Metropolitan Statistical Area and non-Metropolitan Statistical Area. The significance is that HCFA may consider a waiver exception in the proposed ambulance regulations based on a Metropolitan Statistical Area/non-Metropolitan Statistical Area designation. If the waiver exception is based on this designation and all non-Metropolitan Statistical Area suppliers qualified for waivers, HCFA would continue to allow at least $185.7 million annually in advanced life support reimbursement. Furthermore, a portion of the current $134.0 million in basic life support allowed services may be billed and allowed at the higher advanced life support level assuming suppliers with waivers converted their programs to provide advanced life support services only.

RECOMMENDATION

Previous Office of Inspector General studies have recommended that HCFA base reimbursement on the patient's condition rather than the type of vehicle and personnel used. We continue to support this recommendation. In addition, HCFA should:

- re-evaluate its proposal to use the Metropolitan Statistical Area/non-Metropolitan Statistical Area designation as the basis for granting waivers when determining a waiver policy in its final rule on ambulance coverage.

AGENCY COMMENTS

We received comments on the draft report from the Assistant Secretary for Management and Budget (ASMB) and HCFA. The HCFA concurred with the general findings and recommendation of our draft report. Since we released the draft report, HCFA published the Notice of Proposed Rulemaking for Medicare ambulance services on June 18, 1997. The proposal includes two options for a waiver provision for suppliers in non-Metropolitan Statistical Area designations.

Both HCFA and ASMB stated that HCFA had not yet decided which option, if any, it would use to grant waivers. Based on these agency comments, we modified the recommendation on the Metropolitan Statistical Area/non-Metropolitan Statistical Area by making an explicit reference to HCFA's proposed rule. We also made changes based on HCFA's technical comments.

The full text of each agency's comments appears in appendix D.

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INTRODUCTION

PURPOSE

To provide baseline data about the ambulance industry and determine how State and local ordinances affect the delivery of ambulance services.

BACKGROUND

Coverage and payment for ambulance services under Medicare depend on a variety of factors including the patient's medical condition, the equipment used to transport the patient, and the types of personnel rendering services. To help explain these factors, we have included the following scenario.

> John Blue, age 72, gets up early one Saturday morning to mow the lawn. He has not been feeling well the last few days and dreads the yard work. He starts the mower, however, and begins to mow. After making the first pass over the lawn, he feels a terrible pressure in his chest, as if someone kicked him. He leaves the mower running and sits down on the lawn. By now, he is pale and is sweating profusely. He then clutches his chest, his vision goes black, and he falls to the ground.
>
> Across the street, Jane Smith is returning from her morning jog and sees Mr. Blue collapse. Jane runs across the street and quickly senses that her neighbor may be in cardiac arrest. She calls 911 for help from her cellular telephone, gives the information to the dispatcher, and starts cardiopulmonary resuscitation (CPR) .
>
> The dispatcher sends emergency medical services teams. Within 2 minutes, the first responders, who are volunteer fire fighters, arrive. They begin two-person CPR. Within another 2 minutes, paramedics arrive by ambulance. They quickly evaluate Mr. Blue's condition and apply an automatic defibrillator to electrically stimulate the heart. Mr. Blue now has a pulse and is being ventilated with supplemental oxygen. The paramedics administer medication and start an intravenous drip. The paramedics then transport Mr. Blue to Central Hospital. Within minutes of his collapse, Mr. Blue is on his way to the hospital. [1]

We will use this scenario to illustrate Medicare coverage and reimbursement for emergency ambulance services in this report.

'Scenario adapted from Bryan Bledsoe, Robert Porter, and Bruce Shade, Paramedic Emergency ***Care,*** 3rd edition, 1997, p. 18.

Medicare Coverage of Ambulance Services

Medicare pays for medically necessary ambulance services, according to Section 1861(s)(7) of *The Social Security Act,* when "the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations." Health Care Financing Administration (HCFA) regulations state that ambulance services are covered only if other forms of transportation would endanger the beneficiary's health. Medicare does not cover other forms of transportation, such as a wheelchair or stretcher van, that could transport patients who do not require ambulance services. In the scenario, other forms of transportation may have endangered Mr. Blue's condition.

Ambulance suppliers* must satisfy State and local requirements to operate within a State and must comply with HCFA's regulations to qualify for Medicare reimbursement. To meet HCFA's definition of an ambulance, each vehicle must (1) be designed specifically for transporting the sick or injured; (2) contain a stretcher, linens, first aid supplies, oxygen equipment, and other lifesaving equipment required by State or local ordinances (usually adapted from the General Services Administration KKK-A-1822 standards); and (3) be staffed with personnel trained to provide first aid treatment. The paramedics in the scenario provided emergency medical treatment and then transported the patient to the hospital in an ambulance.

Levels of Ambulance Service

Ambulance suppliers provide two distinct levels of service, advanced life support (ALS) and basic life support (BLS). In order to be considered ALS, the ambulance must be equipped with specialized equipment and medications such as defibrillators and pulmonary/cardiac monitors. The specialized equipment may be permanently mounted or portable in nature. The ALS vehicles also maintain radio-telephone contact with physicians or hospitals.

A more important distinction between ALS and BLS is the personnel who staff the ambulance. In most States, BLS services are rendered by basic and intermediate emergency medical technicians (EMTs), and the more intensive ALS services are rendered by paramedic EMTs. The ALS services may include:

- administering intravenous medications,
- defibrillating the patient, and
- performing other advanced life support services, such as electrocardiogram monitoring and airway monitoring.

[2]We will refer to ambulance companies, services, and providers as "ambulance suppliers."

Currently, ambulance reimbursement is based on the type of ambulance and personnel used (ALS or BLS) and the service status (emergency or non-emergency). In the scenario, the ambulance supplier would bill Medicare for emergency ALS services.

Growth of State Emergency Medical Services Systems

The emergency medical services (EMS) system emerged only in the past 30 years. Prior to the late 1960s, local fire departments provided most EMS. Fire fighters often had minimal training in emergency procedures, airway management, or other lifesaving techniques. The emphasis was on rapid transportation; the prevailing belief was that care began in the hospital emergency room. Rescue techniques, personnel training, and equipment were rudimentary.

The federal government allocated funds for EMS after publication of a major study on prehospital emergency medical care. In 1966, the National Academy of Science/National Research Council published *Accidental Death and Disability: The Neglected Disease of Modern Society*. The report suggested developing EMS systems, training prehospital emergency care providers, and upgrading ambulances and their equipment. This led to the enactment of the *National Highway Safety Act* of *1966* that compelled States to develop EMS systems or lose highway funding. The *Emergency Medical Services Act of 1973* funded the development of regional EMS systems. Since 1981, the *Consolidated Omnibus Budget Reconciliation Act* eliminated all federal funding for EMS except block grants. The Departments of Transportation and Health and Human Services administer these grants.

The EMS system is marked by increased technology and upgraded professional standards for regulating and licensing ambulance vehicles and for training and certifying ambulance personnel.[3] However, regional differences may exist in the frequency and sophistication of prehospital care.

Licensing Vehicles and Certifying Personnel in States

The State EMS Directors oversee (1) inspecting and licensing vehicles[4] and (2) testing and certifying emergency medical personnel[5] within the States. The organizational structure of these offices varies considerably throughout the country. Some offices are located in the State's Public Health Department or Department of Health and Human Services, while others are in the Department of Public Safety. A few States have an independent board that proposes regulations and reports directly to the Governor's office. All State EMS Directors set administrative policies and procedures for vehicle and

[3]Bledsoe, pp. 5 and 20.

[4]We will refer to registering or permitting ambulance vehicles as "licensing vehicles."

[5]We will refer to credentialing, registering, or licensing EMS personnel as "certifying personnel. "

personnel standards. The chart below describes the major EMS personnel who provide prehospital medical care to patients. [6]

KEY PLAYERS IN PREHOSPITAL EMERGENCY MEDICAL CARE

A ***first responder*** is a police officer, fire fighter, or lay person who has received basic emergency medical training such as CPR and basic airway management in an approved first responder program. This person's role is to stabilize the patient until the EMT or paramedic arrives. First responders usually do not transport patients.

The following personnel do transport patients:

A ***basic EMT*** is currently certified through the U.S. Department of Transportation National Standard Curriculum for basic EMTs. The person is competent in CPR, airway management, hemorrhage control, fracture stabilization, emergency childbirth, basic extrication (disentanglement), communications, and use of a pneumatic anti-shock garment.

An ***intermediate EMT*** is a person who has all the basic EMT skills and is competent in limited advanced life support care (typically intravenous therapy and advanced airway management).

A ***paramedic EMT*** is a person with the highest level of training for prehospital providers. The person has all the basic and intermediate EMT skills and is trained in advanced patient assessment, trauma management, pharmacology, cardiology, and other medical emergencies. Paramedics should successfully complete Advanced Cardiac Life Support and Pediatric Advanced Life Support courses as offered by the American Heart Association.

Several States certify various combinations of EMT levels with airway and/or cardiac management, defibrillation, and intravenous therapy.

The HCFA requires at least two trained personnel in the ambulance, one of whom must have first aid training. As shown in the scenario, prehospital emergency care services are rendered by various levels of personnel, from first responders to paramedics. The U.S. Department of Transportation has developed standardized curricula for initial training and recertification of first responders and all three levels of EMTs. The initial training includes classroom lectures, practical skills laboratory work, and hospital clinical experience. At the advanced levels, training may include a supervised field internship. Continuing education includes refresher courses and periodic in-service skills training. Most States use U.S Department of Transportation curricula to train and certify their

[6] Bledsoe, pp. 28-29.

ambulance personnel. The other States enhance these basic curricula with more requirements. (The requirements for initial training, continuing education, and recertification for EMT personnel are described in appendix A.)

Ambulance Industry Consolidation

Until recently, the $7 billion ambulance industry was very fragmented.[7] Most ambulance suppliers were fire department rescue squads and other public agencies, many operating with only one ambulance.[8] The remaining suppliers were private companies, primarily small "Mom and Pop" firms.' Several years ago, several large suppliers started acquiring competitors. After years of "consolidation, " these suppliers have emerged with a substantial share of the national ambulance market.

Proposed Changes for Medicare Coverage of Ambulance Services

The HCFA is considering proposed regulations to revise Medicare guidelines for ambulance services. Under current HCFA regulations, the type of vehicle and EMS personnel who render medically necessary services determine whether the supplier receives BLS or ALS reimbursement. In the scenario, paramedics treated the patient, transported him to the hospital in an ALS vehicle, and subsequently the ambulance supplier submitted a Medicare claim for ALS reimbursement. Under proposed regulations, HCFA may consider reimbursing suppliers based on the *patient's condition* rather than the type of vehicle and personnel used. The final rule may include a waiver for suppliers outside Metropolitan Statistical Areas (MSAs) who might be hurt financially if they use only ALS ambulances. The HCFA may consider several options and may include a special waiver only if HCFA is convinced through overwhelming information of the need for the waiver.

METHODOLOGY

We decided to examine the effect and need for a special waiver based on Metropolitan Statistical Areas and non-Metropolitan Statistical Areas. In addition, we developed baseline information on the number of ambulance suppliers, vehicles, and personnel nationwide. We conducted in-person or telephone interviews in November and December 1996 with 53 State EMS Directors including the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands. (We will refer to the 53 States and territories collectively as States.) We excluded the Pacific

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"'Ambulance Chasing," ***Time Magazine,*** December 9, 1996, p. 58.

[8]"Ambulance Companies Adapt to Market, " ***Modern Healthcare,*** May 27, 1996, p. 40.

[9]*Time* ***Magazine,*** op. cit.

Island Trust Territories because of the small number of services rendered during 1995. Using a structured discussion guide, we:

- identified State, county, and municipal legislative mandates that require specific levels of ambulance services;
- identified the responsibilities of the EMS office for inspecting and licensing ambulance vehicles and training and certifying ambulance personnel;
- obtained data on the number of ambulance suppliers currently operating within each State;
- obtained data on the number of ambulance vehicles licensed in 1995 and 1996 by type of vehicle; and
- obtained data on the number of personnel certified in 1995 and 1996.

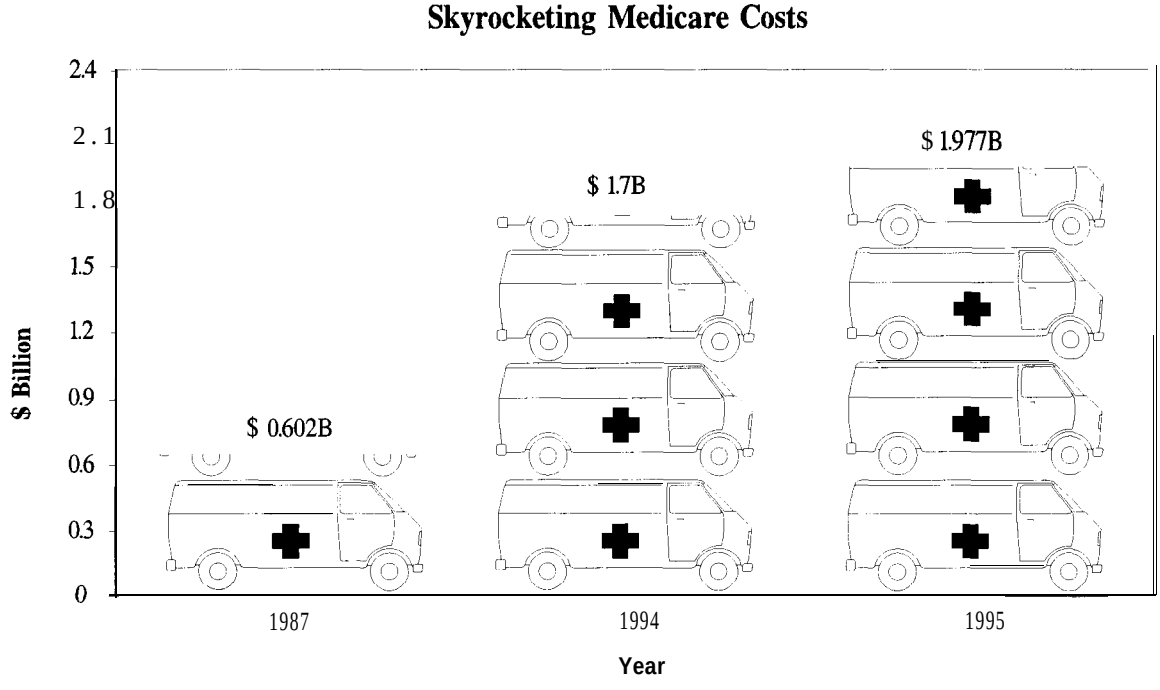
We analyzed the 1995 universe of ambulance claims to determine the distribution of allowed claims by MSAs and non-MSAs for the 53 EMS States. We also reviewed financial analyst reports and articles on the ambulance industry.

This report is the first in a series on Medicare ambulance services prepared by the Office of Inspector General.

FINDINGS

MEDICARE AMBULANCE COSTS AND SERVICES ARE SKYROCKETING

The cost of Medicare ambulance services has skyrocketed over an 8-year period. Between 1987 and 1995, Medicare allowances increased from $602 million to almost $2.0 billion. The graphic below shows the 229.1 percent increase.



The number of ambulance personnel, vehicles, and services provided also is increasing dramatically. According to the States, between 1995 and 1996, licensed vehicles increased from approximately 28,000 to more than 45,000 (60.7 percent increase) and certified ambulance personnel increased from approximately 427,000 to nearly 7 15,000 (67.4 percent increase). (See appendix B for further detail.) According to HCFA, the number of services increased from 7.2 million in 1994 to 7.4 million in 1995. [10]

More than four out of five Medicare ambulance services are provided in MSAs. In 1995, this translated to about 6 million of the 7.5 million services rendered in MSAs. These services represented about $1.6 billion of Medicare payments. Almost half of the services

[10]We define an ambulance "service" as a one-way or round-trip ambulance service provided on a single date by a supplier.

in MSAs are BLS services. The table below shows the breakdown of national expenditures by type of service for MSAs and non-MSAs.[11]

1995 National Expenditures for Ambulance Services

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	2,148,657	28.9	$682,731,389	34.5
	BLS	3,665,397	49.3	$876,749,616	44.3
	Cannot determine ALS or BLS	189,487	2.6	$72,850,592	3.7
	SUBTOTAL	6,003,541	80.8	$1,632,331,597	82.6
non-MSA	ALS	616,746	8.3	$185,671,938	9.4
	BLS	743,386	10.0	$133,975,863	6.8
	Cannot determine ALS or BLS	56,051	0.8	$23,165,570	1.2
	SUBTOTAL	1,416,183	19.1	$342,813,371	17.3
Virgin Islands (not categorized into MSA/non-MSA)		230	0.0	$66,423	0.0
Zip code outside United States, Puerto Rico, and Virgin Islands		101	0.0	$33,604	0.0
Cannot determine location of zip code		7,883	0.1	$1,971,517	0.1
TOTALS		7,427,938	100.0	$1,977,216,513	100.0

AMBULANCE SERVICE IS A GROWTH INDUSTRY CONTROLLED BY A FEW MAJOR CORPORATIONS

Beginning in 1991, several large ambulance suppliers started consolidating the industry by acquiring competitors, large and small. By the end of 1996, three major suppliers had emerged with at least 20 percent of the national private ambulance market. American Medical Response (AMR), after absorbing 75 competitors in 4 years, now operates in

"The total amounts and percents may not exactly equal the sums of individual amounts and percents because of rounding.

28 States with annual revenues of more than $500 million. MedTrans, a subsidiary of the Toronto-based Laidlaw, Inc., grew ten-fold into at least a $500 million operation in 23 States. Rural/Metro, operating in 14 States, increased its revenues 46 percent to $250 million.[12] In January 1997, Laidlaw announced that it will purchase AMR and merge it with MedTrans. Laidlaw estimates that it then will have about 14 percent of the U. S . ambulance market.[13]

The EMS Directors in 41 of the 53 States (or 77.4 percent) noted that three large corporations are buying out small private ambulance companies in their States. The three major corporations--Laidlaw, AMR, and Rural/Metro--are located in all 41 primary and shared State markets. Many factors are combining to favor consolidation and to insure the growth of the ambulance industry and the costs of ambulance services:

- The aging of the U.S. population is likely to increase the total number of ambulance services per year, both emergency and non-emergency.

- Rapidly advancing technology and skills are expanding the range of procedures that can be performed by ambulance personnel, thereby increasing the average revenue per service.

- Privatization of municipal emergency response and fire protection services may increase as cities and towns contract with ambulance suppliers. Financial analysts expect this to overcome a counter "reverse privatization" trend where municipal fire departments take over emergency services in addition to providing first response.

- Increasingly, volunteer municipal rescue squads, which have been providing essentially free ambulance services, will bill Medicare and other third party insurers for their costs.

- Growing economies of scale for regionally dominant ambulance suppliers will take market share from smaller firms. These economies are a result of the minimum staffing and response time requirements for EMS services and the cost of purchasing and maintaining a fleet of ambulances and dispatching operations. By combining contiguous operations, a larger player is able to consolidate dispatching and eliminate duplicate ambulance units.

- Increasing the need for non-emergency interfacility ambulance services will result from managed care plans discharging their members from hospitals sooner into less expensive alternative care sites.

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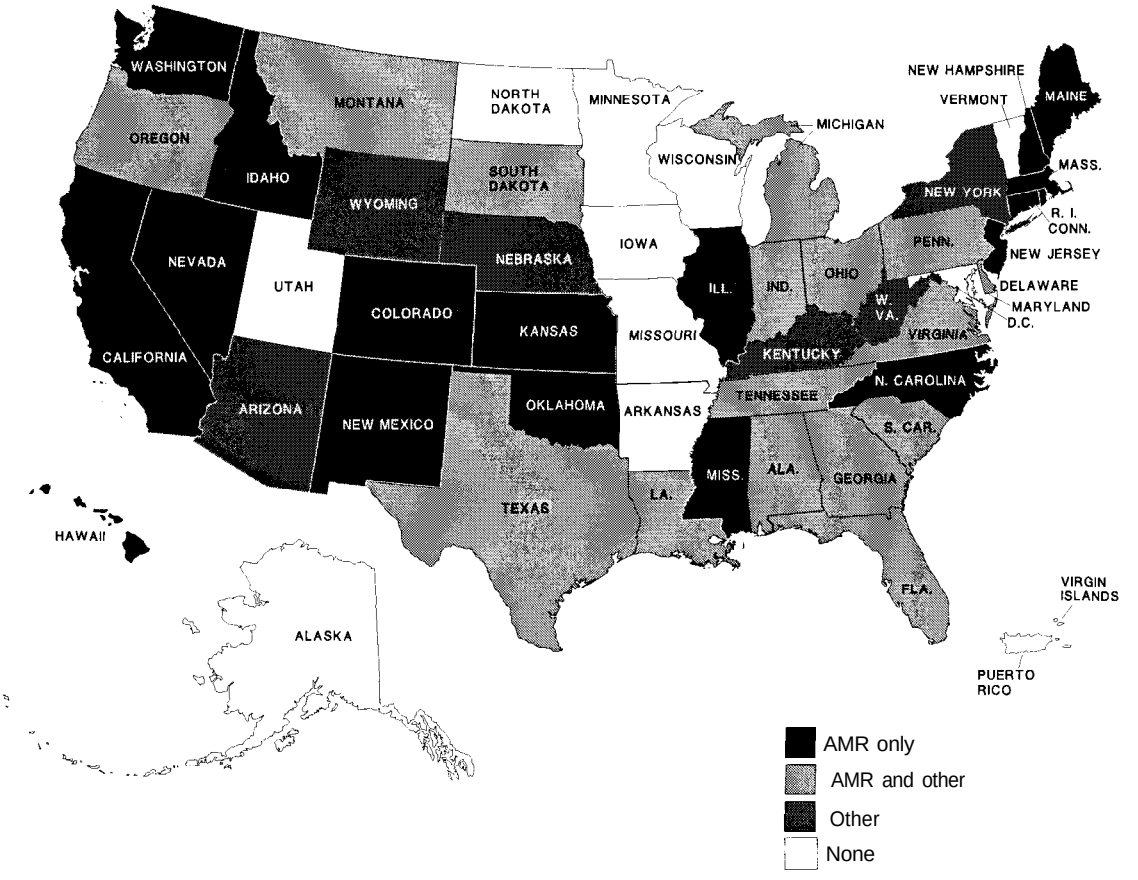
[12]Estimates on market share are based on financial analyst reports about the ambulance industry copyrighted by The Investext Group 1996; State EMS Directors reported State coverage by consolidators.

[13]*The New York Times,* January 7, 1997, p. C-2.

- Increasing use of non-emergency or scheduled ambulance service, especially among large ambulance corporations, will continue. Only 11 States license other health care vehicles, such as wheelchair vans. In other States, these vehicles are licensed by the same agencies that inspect and license taxicabs. Although these 11 States licensed 4,158 wheelchair vans and other vehicles in 1996, these vehicles represent only about 9.2 percent of all licensed patient transportation vehicles.

The map and chart on the next page show the State EMS Directors' responses about the extent of ambulance corporations nationwide.

National Ambulance Transportation Corporations
and their 41 Primary and Shared State Markets



AMR MedTrans Laidlaw (AMR)	AMR and Rural/ Metro	AMR & Others	Rural/ Metro	Rural/ Metro & Others	Others Alone
ME,NH,MA,RI	TN,SC	PA,DE	KY,NE	NY,AZ	WV,WY
CT,NJ,DC,NC	AL,GA	VA,MI			
MS,IL,KS,OK	FL,OH	LA,MT			
CO,NM,WA,ID	IN,SD				
NV,CA,HI	TX,OR				
TOTALS: 19	10	6	2	2	2

With the merger of AMR and LAIDLAW, the new AMR (AMR, MEDTRANS, and LAIDLAW) will have a major presence in 19 STATES and operate in **16 other STATES.** RURAL/METRO will maintain a presence in **2 STATES** and operate in **12 other STATES,** including **10 with AMR.**
2 STATES have corporations other than AMR and RURAL/METRO, and **12 STATES** have no known corporations.

ALL STATES REGULATE AMBULANCE SERVICES; HOWEVER, LESS THAN HALF MANDATE LEVELS OF SERVICE AND ONLY ONE REQUIRES ADVANCED LIFE SUPPORT

All States have administrative codes and regulations that set standards for ambulance services. The codes and regulations set requirements for licensure, certification, and recertification of ambulance suppliers, vehicles, and personnel to operate within the States. Four States require ambulance suppliers to apply for a certificate of need and appear at a hearing to justify the need for their services. Suppliers can operate within these States only after receiving the certificate of need.

Nationally, 21 of the 53 States legislatively mandate a minimum level of ambulance services. Of these, Hawaii is the only State that requires ALS services. The other 20 States require "at least" BLS services. Often the mandates are described as minimum levels of trained personnel who attend patients. For example, to provide BLS services, most States require at least two personnel in the vehicle, with one EMT (basic or intermediate) in the back with the patient. The remaining 32 of the 53 States do not legislatively mandate a minimum level of ambulance services.

Approximately 11 percent of localities mandate minimum standards for ambulance services. Throughout our interviews, respondents emphasized that almost all localities voluntarily exceed the minimum State standards by providing BLS and ALS services. As an example, an EMS Director mentioned, "Though we do not have a State law mandating any level of ambulance services, ALS services are available to 98 percent of our population. "

Another 11 percent of localities contract for ambulance services using general tax revenues. State EMS Directors noted that a locality may solicit bids for BLS and ALS services and use tax revenues to finance the contracts. Of the localities with contracts, about 44 percent contract for BLS services and 40 percent contract for ALS services.

ONLY TWO STATES USE METROPOLITAN STATISTICAL AREAS TO DESIGNATE AMBULANCE SERVICE AREAS

Of the 53 States, 5 1 (or 96.2 percent) do not define their ambulance service areas as MSA and non-MSA. The State EMS Directors define the service areas by (1) counties, (2) naturally-occurring population densities, or (3) suppliers' areas of coverage when they initially apply to provide services.

The significance is that HCFA may consider a waiver exception in the proposed ambulance regulations based on an MSA/non-MSA designation. A waiver may allow non-MSA suppliers to demonstrate financial hardships resulting from lower BLS reimbursement because they operate with ALS vehicles and personnel only. Some State EMS Directors believe that most non-MSA suppliers in their States would apply for a waiver. For example, one Director believes that most of his 275 suppliers would apply for waivers.

If HCFA considers and includes a waiver exception in any proposed ambulance regulations, this exception may have a financial impact on Medicare reimbursement. The table on page 8 shows that HCFA allowed about $342.8 million (or 17.3 percent) in non-MSAs for ambulance services nationally in 1995. The breakdown was about $185.7 million for ALS services and $134.0 million for BLS services (we cannot determine the exact level for about $23.1 million of ALS/BLS services). If the waiver exception is based on an MSA or non-MSA designation and all non-MSA suppliers qualified for waivers, HCFA would continue to allow at least $185.7 million annually in ALS reimbursement. Furthermore, a portion of the current BLS allowed services may be billed and allowed at the higher ALS level assuming suppliers with waivers converted their programs to provide ALS services only.

RECOMMENDATION

Previous Office of Inspector General studies have recommended that HCFA base reimbursement on the patient's condition rather than the type of vehicle and personnel used. We continue to support this recommendation. In addition, HCFA should:

- re-evaluate its proposal to use the Metropolitan Statistical Area/non-Metropolitan Statistical Area designation as the basis for granting waivers when determining a waiver policy in its final rule on ambulance coverage.

We have included national and State baseline ambulance data in appendices B and C for HCFA's information and analysis.

AGENCY COMMENTS

We received comments on the draft report from the Assistant Secretary for Management and Budget (ASMB) and HCFA. The HCFA concurred with the general findings and recommendation of our draft report. Since we released the draft report, HCFA published the Notice of Proposed Rulemaking for Medicare ambulance services on June 18, 1997. The proposal includes two options for a waiver provision for suppliers in non-Metropolitan Statistical Area designations.

Both HCFA and ASMB stated that HCFA had not yet decided which option, if any, it would use to grant waivers. Based on these agency comments, we modified the recommendation on the Metropolitan Statistical Area/non-Metropolitan Statistical Area by making an explicit reference to HCFA's proposed rule. We also made changes based on HCFA's technical comments.

The full text of each agency's comments appears in appendix D.

APPENDIX A

EMERGENCY MEDICAL SERVICES TRAINING REQUIREMENTS FOR AMBULANCE PERSONNEL

Since the 1960s, the National Highway Traffic Safety Administration of the U.S. Department of Transportation (DOT) has provided National Standardized Curricula for prehospital EMS personnel. Most States have incorporated these DOT standards into their certification requirements for emergency medical technicians (EMTs). All curricula allow students to gain the knowledge, skills, and attitude necessary to be a competent, productive, and valuable member of the EMS team. Courses are designed to instruct students to serve as a vital link in the chain of the health care team. Training includes all skills necessary for EMTs to provide emergency medical care at the BLS or ALS level with an ambulance or other specialized service. All States require continuing education and recertification for EMS personnel at all levels. Specific courses and refresher skills vary among States.

In addition to requirements summarized below, DOT also has curricula for EMS dispatchers and emergency vehicle operators.

FIRST RESPONDERS

The first responder is the first individual who arrives at the scene regardless of the individual's certification. It is the goal of the DOT *First Responder: National Standard Curriculum* to provide students with the core knowledge, skills, and attitudes to "…use a limited amount of equipment to perform initial assessment and intervention, and assist other EMS providers." The DOT course provides an introduction to these concepts and an orientation to the specific systems and services with which the first responder will be affiliated. This level of provider is not intended to be utilized as the minimum staffing for an ambulance. Enrichment programs and continuing education help fulfill other specific needs for first responder training.

Twenty-two States report that they currently certify first responders or have plans to do so shortly.

BASIC EMT

The core curriculum is presented within a 1 lo-hour training program. The basic EMT works with other health care professionals to deliver professional prehospital emergency medical care. After successfully completing the program, the student is capable of performing the following functions at the minimum entry level:

- Recognize the nature and seriousness of the patient's condition or extent of injuries to assess requirements for emergency medical care;

- Administer appropriate emergency medical care based on assessment findings of the patient's condition;

- Lift, move, position, and otherwise handle the patient to minimize discomfort and prevent further injury; and,

- Perform safely and effectively the expectations of the job description.

Twenty-four States require the basic 110-hour DOT course, 12 States require 120 hours, and the remaining 17 States require more than 120 hours of training.

INTERMEDIATE EMT

The intermediate EMT course includes basic EMT skills and training in specific medical management skills. These skills include the use of 12-lead electrocardiogram machines, airway management by endotracheal intubation and defibrillating life-threatening arrhythmias, plus the provision of certain intravenous medications.

The intermediate EMT training requirements vary widely. Ten States do not certify this EMT level. For the other 43 States, additional training ranges from 27 to 300 hours.

PARAMEDIC EMT

As the highest-trained prehospital emergency care person in the EMS system, the paramedic concentrates on the care and well-being of the patient. Paramedics must complete from 500 to more than 1,800 hours of training beyond the other EMT levels. Paramedics must complete training in advanced medical techniques, such as transcutaneous cardiac pacing, drug therapy, chest decompression, gastric tube placement, and the administration of a large range of medications.

Minimum training requirements for paramedics vary substantially from State to State. Thirty-two States require less than 900 hours, 16 States require between 900 and 1,400 hours, and 5 States do not specify the minimum hours.

APPENDIX B

NUMBER OF AMBULANCE SUPPLIERS, VEHICLES, AND PERSONNEL FOR 1995 AND 1996

During the interviews with EMS Directors, we obtained data on the number of services, licensed ambulance vehicles by type, and the number of ambulance personnel by type of certification. While most States had some data available, many do not have computerized databases and keep cumulative counts of services, vehicles, and personnel only.

PLEASE NOTE:

For States with available data, EMS Directors stated that 18,523 ambulance suppliers operate in the 53 States as of December 1996.

For the number of licensed ambulance vehicles:

- 10 of the 53 States (18.9 percent) did not have statistics available for 1995.
- 4 of the 53 States (7.5 percent) did not have statistics available for 1996.
- 5 of the 53 States (9.4 percent) did not have statistics available for both years.

For the number of certified ambulance personnel, many States could not provide separate statistics for both years. They did, however, provide cumulative statistics for 1996.

The percents of vehicles and personnel may not total 100.0 percent due to rounding.

LICENSED AMBULANCE VEHICLES

VEHICLE TYPE	1995		1996	
	Vehicles	Percent	Vehicles	Percent
ALS-only vehicle	9,284	33.4	14,773	32.6
BLS-only vehicle	7,337	26.4	10,580	23.4
ALS/BLS vehicle	7,266	26.1	12,363	27.3
Rescue vehicle	548	2.0	918	2.0
Fire trucks	974	3.5	1,925	4.3
Air ambulances (fixed wing and rotor)	286	1.0	570	1.3
Water/Marine ambulances	6	0.02	6	0.01
Wheelchair vans	807	2.9	954	2.1
Other health care vehicles	1,305	4.7	3,204	7.1
TOTALS	**27,813**	**100.0**	45,293	**100.0**

CERTIFIED AMBULANCE PERSONNEL

PERSONNEL TYPE	1995		1996	
	Number	Percent	Number	Percent
Ambulance driver	5,636	1.3	5,981	0.8
First responder	72,045	16.9	115,371	16.1
Basic EMT	221,315	51.9	376,113	52.6
Intermediate EMT*	90,146	21.1	120,506	16.9
Paramedic EMT	36,240	8.5	87,693	12.3
Other (e.g., nurses, physician assistants)	1,142	0.3	9,261	1.3
TOTAL	**426,524**	**100.0**	**714,925**	**100.0**

*NOTE: These statistics include the cardiac technician and other advanced level personnel between the basic and paramedic levels.

APPENDIX C

BREAKDOWN OF 1995 AMBULANCE SERVICES AND ALLOWED AMOUNTS BY **MSAs** AND **NON-MSAs**

The following tables display the number of services and allowed amounts for 1995 Medicare ambulance services, broken out by Metropolitan Statistical Area (MSA) and type of service, for each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands. In these tables, the total amounts and percents may not exactly equal the sums of individual amounts and percents because of rounding. We defined a "service" as a one-way or round-trip ambulance service provided on a single date by a single supplier.

ALABAMA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	58,385	36.2	$14,668,352	40.7
	BLS	50,145	31.1	$8,243,558	22.9
	Cannot determine ALS or BLS	4,645	2.9	$1,664,383	4.6
	SUBTOTAL	113,175	70.3	$24,576,294	68.2
non-MSA	ALS	32,772	20.3	$8,539,037	23.7
	BLS	13,689	8.5	$2,402,169	6.7
	Cannot determine ALS or BLS	1,433	0.9	$536,788	1.5
	SUBTOTAL	47,894	29.7	$11,477,994	31.8
TOTALS		161,069	100.0	$36,054,288	100.0

ALASKA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	1,097	26.8	$316,913	27.9
	BLS	782	19.1	$183,250	16.1
	Cannot determine ALS or BLS	19	0.5	$9,037	0.8
	SUBTOTAL	1,898	46.4	$509,200	44.8
non-MSA	ALS	1,193	29.2	$381,338	33.5
	BLS	957	23.4	$219,307	19.3
	Cannot determine ALS or BLS	40	1.0	$27,485	2.4
	SUBTOTAL	2,190	53.6	$628,130	55.2
TOTALS		4,088	100.0	$1,137,330	100.0

ARIZONA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	34,155	54.9	$11,475,961	51.0
	BLS	17,329	27.9	$4,754,138	21.1
	Cannot determine ALS or BLS	1,768	2.8	$1,664,320	7.4
	SUBTOTAL	53,252	85.6	$17,894,418	79.5
non-MSA	ALS	5,469	8.8	$2,634,197	11.7
	BLS	2,755	4.4	$1,010,084	4.5
	Cannot determine ALS or BLS	702	1.1	$973,540	4.3
	SUBTOTAL	8,926	14.4	$4,617,821	20.5
TOTALS		62,178	100.0	$22,512,239	100.0

ARKANSAS

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	33,388	40.8	$12,138,205	40.6
	BLS	3,532	4.3	$707,472	2.4
	Cannot determine ALS or BLS	657	0.8	$229,112	0.8
	SUBTOTAL	37,577	45.9	$13,074,789	43.7
non-MSA	ALS	36,159	44.1	$14,812,736	49.5
	BLS	7,444	9.1	$1,717,669	5.7
	Cannot determine ALS or BLS	739	0.9	$327,781	1.1
	SUBTOTAL	44,342	54.1	$16,858,186	56.3
TOTALS		81,919	100.0	$29,932,975	100.0

CALIFORNIA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	203,703	35.4	$101,144,322	45.8
	BLS	324,033	56.3	$94,223,333	42.7
	Cannot determine ALS or BLS	26,127	4.5	$13,871,311	6.3
	SUBTOTAL	553,863	96.2	$209,238,967	94.7
non-MSA	ALS	14,045	2.4	$7,628,657	3.5
	BLS	6,255	1.1	$2,227,065	1.0
	Cannot determine ALS or BLS	1,872	0.3	$1,817,930	0.8
	SUBTOTAL	22,172	3.8	$11,673,652	5.3
TOTALS		576,035	100.0	$220,912,619	100.0

COLORADO

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	22,162	44.3	$7,289,992	48.6
	BLS	17,058	34.1	$4,220,867	28.2
	Cannot determine ALS or BLS	2,438	4.9	$1,013,177	6.8
	SUBTOTAL	41,658	83.3	$12,524,036	83.6
non-MSA	ALS	4,234	8.5	$1,454,301	9.7
	BLS	3,694	7.4	$835,641	5.6
	Cannot determine ALS or BLS	414	0.8	$173,425	1.2
	SUBTOTAL	8,342	16.7	$2,463,367	16.4
TOTALS		50,000	100.0	$14,987,403	100.0

CONNECTICUT

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	36,381	23.9	$14,571,394	27.0
	BLS	110,418	72.5	$36,569,773	67.9
	Cannot determine ALS or BLS	5,493	3.6	$2,750,981	5.1
	SUBTOTAL	152,292	100.0	$53,892,148	100.0
non-MSA	ALS	0	0.0	$0	0.0
	BLS	0	0.0	$0	0.0
	Cannot determine ALS or BLS	0	0.0	$0	0.0
	SUBTOTAL	0	0.0	$0	0.0
TOTALS		152,292	100.0	$53,892,148	100.0

DELAWARE

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	327	1.2	$112,297	1.8
	BLS	20,038	76.2	$4,785,904	78.4
	Cannot determine ALS or BLS	93	0.4	$44,958	0.7
	SUBTOTAL	20,458	77.8	$4,943,159	81.0
non-MSA	ALS	230	0.9	$125,383	2.1
	BLS	5,594	21.3	$1,004,607	16.5
	Cannot determine ALS or BLS	18	0.1	$30,128	0.5
	SUBTOTAL	5,842	22.2	$1,160,118	19.0
TOTALS		26,300	100.0	$6,103,277	100.0

DISTRICT OF COLUMBIA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	2,542	13.7	$455,810	18.3
	BLS	15,990	86.1	$2,015,634	81.1
	Cannot determine ALS or BLS	36	0.2	$13,920	0.6
	SUBTOTAL	18,568	100.0	$2,485,363	100.0
non-MSA	ALS	0	0.0	$0	0.0
	BLS	0	0.0	$0	0.0
	Cannot determine ALS or BLS	0	0.0	$0	0.0
	SUBTOTAL	0	0.0	$0	0.0
TOTALS		18,568	100.0	$2,485,363	100.0

FLORIDA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	248,325	60.6	$68,921,704	67.0
	BLS	128,693	31.4	$25,427,559	24.7
	Cannot determine ALS or BLS	6,812	1.7	$2,096,035	2.0
	SUBTOTAL	383,830	93.6	$96,445,298	93.7
non-MSA	ALS	17,280	4.2	$4,784,798	4.7
	BLS	8,208	2.0	$1,447,335	1.4
	Cannot determine ALS or BLS	611	0.1	$206,932	0.2
	SUBTOTAL	26,099	6.4	$6,439,065	6.3
TOTALS		409,929	100.0	$102,884,364	100.0

GEORGIA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	70,685	32.6	$18,863,125	33.5
	BLS	71,750	33.1	$16,904,396	30.0
	Cannot determine ALS or BLS	6,910	3.2	$2,613,323	4.6
	SUBTOTAL	149,345	69.0	$38,380,844	68.2
non-MSA	ALS	36,594	16.9	$10,653,153	18.9
	BLS	27,973	12.9	$6,219,993	11.1
	Cannot determine ALS or BLS	2,627	1.2	$1,026,304	1.8
	SUBTOTAL	67,194	31.0	$17,899,450	31.8
TOTALS		216,539	100.0	$56,280,294	100.0

HAWAII

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	6,357	58.3	$1,078,090	41.0
	BLS	834	7.6	$228,011	8.7
	Cannot determine ALS or BLS	80	0.7	$50,582	1.9
	SUBTOTAL	7,271	66.7	$1,356,683	51.6
non-MSA	ALS	2,875	26.4	$484,911	18.4
	BLS	340	3.1	$94,474	3.6
	Cannot determine ALS or BLS	418	3.8	$693,336	26.4
	SUBTOTAL	3.633	33.3	$1,272,720	48.4
TOTALS		10,904	100.0	$2,629,403	100.0

IDAHO

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	2,310	15.5	$542,271	19.2
	BLS	3.091	20.7	$416,200	14.7
	Cannot determine ALS or BLS	0 130	9	$41,682	1.5
	SUBTOTAL	5,531	37.1	$1,000,154	35.3
non-MSA	ALS	2,627	17.6	$646,104	22.8
	BLS	6,306	42.3	$1,061,400	37.5
	Cannot determine ALS or BLS	460	3.1	$122,636	4.3
	SUBTOTAL	9,393	62.9	$1,830,140	64.7
TOTALS		14,924	100.0	$2,830,294	100.0

ILLINOIS

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	84,748	21.6	$19,316,409	24.7
	BLS	212,042	54.0	$40,634,439	51.9
	Cannot determine ALS or BLS	22,207	5.7	$5,417,452	6.9
	SUBTOTAL	318,997	81.3	$65,368,299	83.5
non-MSA	ALS	15,715	4.0	$3,477,002	4.4
	BLS	53,848	13.7	$8,440,103	10.8
	Cannot determine ALS or BLS	3,887	1.0	$1,007,895	1.3
	SUBTOTAL	73,450	18.7	$12,925,000	16.5
TOTALS		392,447	100.0	$78,293,300	100.0

INDIANA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	30,769	23.8	$7,509,669	32.3
	BLS	62,054	48.0	$9,175,257	39.5
	Cannot determine ALS or BLS	1,488	1.2	$484,387	2.1
	SUBTOTAL	94,311	73.0	$17,169,313	73.8
non-MSA	ALS	11,520	8.9	$2,652,673	11.4
	BLS	22,678	17.6	$3,218,071	13.8
	Cannot determine ALS or BLS	638	0.5	$215,941	0.9
	SUBTOTAL	34,836	27.0	$6,086,686	26.2
TOTALS		129,147	100.0	$23,255,999	100.0

IOWA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	13,742	25.9	$3,126,695	28.8
	BLS	6,859	12.9	$1,089,084	10.0
	Cannot determine ALS or BLS	2,692	5.1	$594,336	5.5
	SUBTOTAL	23,293	43.9	$4,810,115	44.4
non-MSA	ALS	13,934	26.3	$3,343,506	30.8
	BLS	14,139	26.7	$2,154,510	19.9
	Cannot determine ALS or BLS	1,673	3.2	$531,489	4.9
	SUBTOTAL	29,746	56.1	$6,029,505	55.6
TOTALS		53,039	100.0	$10,839,620	100.0

KANSAS

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	25,548	42.9	$6,831,723	46.9
	BLS	4,078	6.8	$792,463	5.4
	Cannot determine ALS or BLS	409	0.7	$149,745	1.0
	SUBTOTAL	30,035	50.4	$7,773,931	53.3
non-MSA	ALS	10,030	16.8	$3,054,438	21.0
	BLS	17,875	30.0	$3,100,912	21.3
	Cannot determine ALS or BLS	1,668	2.8	$644,920	4.4
	SUBTOTAL	29,573	49.6	$6,800,270	46.7
TOTALS		59,608	100.0	$14,574,201	100.0

KENTUCKY

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	24,124	14.2	$5,423,655	17.8
	BLS	59,233	34.8	$8,503,519	28.0
	Cannot determine ALS or BLS	1,308	0.8	$401,197	1.3
	SUBTOTAL	84,665	49.7	$14,328,371	47.1
non-MSA	ALS	18,749	11.0	$4,823,221	15.9
	BLS	64,304	37.8	$10,279,310	33.8
	Cannot determine ALS or BLS	2,480	1.5	$992,073	3.3
	SUBTOTAL	85,533	50.3	$16,094,604	52.9
TOTALS		170,198	100.0	$30,422,975	100.0

LOUISIANA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	49,309	35.2	$18,632,925	39.5
	BLS	48,418	34.6	$12,492,822	26.5
	Cannot determine ALS or BLS	5,703	4.1	$2,683,550	5.7
	SUBTOTAL	103,430	73.9	$33,809,296	71.7
non-MSA	ALS	20,593	14.7	$8,623,377	18.3
	BLS	14,327	10.2	$3,841,519	8.1
	Cannot determine ALS or BLS	1,554	1.1	$884,974	1.9
	SUBTOTAL	36,474	26.1	$13,349,870	28.3
TOTALS		139,904	100.0	$47,159,166	100.0

MAINE

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	9,700	21.1	$2,742,965	22.6
	BLS	15,398	33.5	$3,221,002	26.5
	Cannot determine ALS or BLS	1,193	2.6	$396,832	3.3
	SUBTOTAL	26,291	57.1	$6,360,799	52.3
non-MSA	ALS	6,905	15.0	$2,449,367	20.2
	BLS	11,245	24.4	$2,768,419	22.8
	Cannot determine ALS or BLS	1,584	3.4	$576,818	4.7
	SUBTOTAL	19,734	42.9	$5,794,605	47.7
TOTALS		46,025	100.0	$12,155,403	100.0

MARYLAND

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	16,255	10.3	$5,433,078	15.2
	BLS	128,852	81.8	$27,561,504	76.9
	Cannot determine ALS or BLS	625	0.4	$301,901	0.8
	SUBTOTAL	145,732	92.5	$33,296,483	92.9
non-MSA	ALS	3,646	2.3	$1,134,085	3.2
	BLS	7,824	5.0	$1,366,153	3.8
	Cannot determine ALS or BLS	262	0.2	$50,464	0.1
	SUBTOTAL	11,732	7.5	$2,550,702	7.1
TOTALS		157,464	100.0	$35,847,184	100.0

MASSACHUSETTS

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	45,605	12.7	$23,832,309	17.8
	BLS	307,840	85.6	$106,115,908	79.4
	Cannot determine ALS or BLS	5,393	1.5	$3,457,849	2.6
	SUBTOTAL	358,838	99.8	$133,406,066	99.8
non-MSA	ALS	55	0.0	$36,584	0.0
	BLS	532	0.1	$196,227	0.1
	Cannot determine ALS or BLS	24	0.0	$79,913	0.1
	SUBTOTAL	611	0.2	$312,724	0.2
TOTALS		359,449	100.0	$133,718,790	100.0

MICHIGAN

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	99,386	34.5	$32,589,082	45.0
	BLS	145,739	50.6	$26,611,988	36.8
	Cannot determine ALS or BLS	5,045	1.8	$2,306,174	3.2
	SUBTOTAL	250,170	86.9	$61,507,243	84.9
non-MSA	ALS	18,950	6.6	$7,146,620	9.9
	BLS	17,554	6.1	$3,137,464	4.3
	Cannot determine ALS or BLS	1,274	0.4	$617,463	0.9
	SUBTOTAL	37,778	13.1	$10,901,548	15.1
TOTALS		287,948	100.0	$72,408,791	100.0

MINNESOTA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	18,197	34.6	$7,109,934	46.0
	BLS	13,440	25.6	$2,089,654	13.5
	Cannot determine ALS or BLS	2,167	4.1	$850,768	5.5
	SUBTOTAL	33,804	64.3	$10,050,356	65.0
non-MSA	ALS	5,669	10.8	$2,665,488	17.2
	BLS	11,984	22.8	$2,157,717	14.0
	Cannot determine ALS or BLS	1,080	2.1	$590,803	3.8
	SUBTOTAL	18,733	35.7	$5,414,009	35.0
TOTALS		52,537	100.0	$15,464,365	100.0 II

MISSISSIPPI

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	32,609	44.0	$13.513.552	56.6
	BLS	3,195	4.3	$430,770	1.8
	Cannot determine ALS or BLS	354	0.5	$71,855	0.3
	SUBTOTAL	36,158	48.8	$14,016,178	58.7
non-MSA	ALS	18,177	24.5	$6,648,291	27.9
	BLS	18,544	25.0	$2,745,733	11.5
	Cannot determine ALS or BLS	1,271	1.7	1.9 $459,441	
	SUBTOTAL	37,992	51.2	$9,853,465	41.3
TOTALS		74,150	100.0	$23,869,642	100.0

MISSOURI

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	58,306	42.8	$18,409,012	49.8
	BLS	34,106	25.1	$7,270,087	19.7
	Cannot determine ALS or BLS	2,089	1.5	$899,727	2.4
	SUBTOTAL	94,501	69.4	$26,578,826	71.9
non-MSA	ALS	30,755	22.6	$8,192,186	22.2
	BLS	9,408	6.9	$1,698,560	4.6
	Cannot determine ALS or BLS	1,445	1.1	$495,693	1.3
	SUBTOTAL	41,608	30.6	$10,386,439	28.1
TOTALS		136,109	100.0	$36,965,265	100.0

MONTANA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	1,153	9.6	$343,029	11.5
	BLS	1,342	11.1	$291,447	9.8
	Cannot determine ALS or BLS	720	6.0	$240,251	8.1
	SUBTOTAL	3,215	26.7	$874,727	29.4
non-MSA	ALS	1,549	12.9	$481,248	16.2
	BLS	6,365	52.8	$1,287,482	43.2
	Cannot determine ALS or BLS	918	7.6	$334,007	11.2
	SUBTOTAL	8,832	73.3	$2,102,737	70.6
TOTALS		12,047	100.0	$2,977,465	100.0

NEBRASKA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	7,212	25.2	$1,820,628	30.6
	BLS	5,320	18.6	$823,120	13.8
	Cannot determine ALS or BLS	711	2.5	$212,450	3.6
	SUBTOTAL	13,243	46.2	$2,856,198	48.0
non-MSA	ALS	3,943	13.8	$1,342,326	22.6
	BLS	10,933	38.1	$1,502,543	25.2
	Cannot determine ALS or BLS	550	1.9	$251,523	4.2
	SUBTOTAL	15,426	53.8	$3,096,393	52.0
TOTALS		28,669	100.0	$5,952,591	100.0

NEVADA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	15,192	75.0	$5,781,365	77.1
	BLS	1,874	9.3	$461,481	6.2
	Cannot determine ALS or BLS	525	2.6	$256,553	3.4
	SUBTOTAL	17,591	86.8	$6,499,399	86.7
non-MSA	ALS	1,681	8.3	$666,431	8.9
	BLS	873	4.3	$193,571	2.6
	Cannot determine ALS or BLS	112	0.6	$138,071	1.8
	SUBTOTAL	2,666	13.2	$998,073	13.3
TOTALS		20,257	100.0	$7,497,472	100.0

NEW HAMPSHIRE

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	5,714	18.3	$1,912,891	23.3
	BLS	14,860	47.5	$3,390,317	41.2
	Cannot determine ALS or BLS	933	3.0	$325,645	4.0
	SUBTOTAL	21,507	68.7	$5,628,852	68.5
non-MSA	ALS	2,916	9.3	$909,306	11.1
	BLS	6,531	20.9	$1,565,909	19.0
	Cannot determine ALS or BLS	351	1.1	$119,091	1.4
	SUBTOTAL	9,798	31.3	$2,594,306	31.5
TOTALS		31,305	100.0	$8,223,159	100.0

NEW JERSEY

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	4,476	1.9	$1,458,482	2.7
	BLS	232,109	98.0	$52,157,797	97.0
	Cannot determine ALS or BLS	311	0.1	$163,987	0.3
	SUBTOTAL	236,896	100.0	$53,780,267	100.0
non-MSA	ALS	0	0.0	$0	0.0
	BLS	0	0.0	$0	0.0
	Cannot determine ALS or BLS	0	0.0	$0	0.0
	SUBTOTAL	0	0.0	$0	0.0
TOTALS		236,896	100.0	$53,780,267	100.0

NEW MEXICO

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	8,664	39.0	$2,151,390	41.1
	BLS	2,145	9.6	$318,254	6.1
	Cannot determine ALS or BLS	1,157	5.2	$383,158	7.3
	SUBTOTAL	11,966	53.8	$2,852,801	54.5
non-MSA	ALS	4,345	19.5	$1,301,275	24.9
	BLS	5,164	23.2	$745,435	14.2
	Cannot determine ALS or BLS	753	3.4	$336,472	6.4
	SUBTOTAL	10,262	46.2	$2,383,182	45.5
TOTALS		22,228	100.0	$5,235,983	100.0

NEW YORK

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	98,318	18.8	$29,768,282	20.0
	BLS	383,404	73.3	$105,789,968	71.2
	Cannot determine ALS or BLS	10,001	1.9	$3,505,831	2.4
	SUBTOTAL	491,723	94.0	$139,064,081	93.5
non-MSA	ALS	13,994	2.7	$4,667,902	3.1
	BLS	16,031	3.1	$4,414,184	3.0
	Cannot determine ALS or BLS	1,176	0.2	$529,448	0.4
	SUBTOTAL	31,201	6.0	$9,611,535	6.5
TOTALS		522,924	100.0	$148,675,616	100.0

NORTH CAROLINA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	72,496	37.5	$9,652,655	38.3
	BLS	55,250	28.6	$7,198,917	28.6
	Cannot determine ALS or BLS	3,745	1.9	$577,593	2.3
	SUBTOTAL	131,491	68.1	$17,429,166	69.2
non-MSA	ALS	30,323	15.7	$3,727,988	14.8
	BLS	29,777	15.4	$3,782,414	15.0
	Cannot determine ALS or BLS	1,604	0.8	$240,282	1.0
	SUBTOTAL	61,704	31.9	$7,750,684	30.8
TOTALS		193,195	100.0	$25,179,850	100.0

NORTHDAKOTA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	2,981	25.1	$930,212	31.3
	BLS	697	5.9	$125,897	4.2
	Cannot determine ALS or BLS	117	1.0	$44,874	1.5
	SUBTOTAL	3,795	31.9	$1,100,983	37.1
non-MSA	ALS	2,336	19.7	$807,062	27.2
	BLS	5,223	44.0	$908,001	30.6
	Cannot determine ALS or BLS	525	4.4	$155,442	5.2
	SUBTOTAL	8,084	68.1	$1,870,505	62.9
TOTALS		11,879	100.0	$2,971,489	100.0

OHIO

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	95,812	24.7	$35,870,093	37.2
	BLS	218,217	56.3	$44,110,888	45.7
	Cannot determine ALS or BLS	7,732	2.0	$4,032,328	4.2
	SUBTOTAL	321,761	83.0	$84,013,309	87.1
non-MSA	ALS	19,761	5.1	$5,055,498	5.2
	BLS	44,326	11.4	$6,838,443	7.1
	Cannot determine ALS or BLS	1,612	0.4	$568,164	0.6
	SUBTOTAL	65,699	17.0	$12,462,106	12.9
TOTALS		387,460	100.0	$96,475,415	100.0

OKLAHOMA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	30,114	36.8	$12,115,833	45.5
	BLS	9,060	11.1	$1,764,797	6.6
	Cannot determine ALS or BLS	4,679	5.7	$1,915,688	7.2
	SUBTOTAL	43,853	53.6	$15,796,318	59.3
non-MSA	ALS	19,667	24.0	$7,814,542	29.3
	BLS	16,745	20.5	$2,365,319	8.9
	Cannot determine ALS or BLS	1,587	1.9	$655,936	2.5
	SUBTOTAL	37,999	46.4	$10,835,797	40.7
TOTALS		81,852	100.0	$26,632,115	100.0

OREGON

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	22,072	53.4	$11,146,689	60.2
	BLS	5,211	12.6	$1,259,724	6.8
	Cannot determine ALS or BLS	295	0.7	$173,276	0.9
	SUBTOTAL	27,578	66.7	$12,579,689	67.9
non-MSA	ALS	9,454	22.9	$4,834,347	26.1
	BLS	4,008	9.7	$955,188	5.2
	Cannot determine ALS or BLS	280	0.7	$148,001	0.8
	SUBTOTAL	13,742	33.3	$5,937,536	32.1
TOTALS		41,320	100.0	$18,517,225	100.0

PENNSYLVANIA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	156,903	23.6	$51,282,540	27.2
	BLS	417,727	62.9	$111,605,918	59.2
	Cannot determine ALS or BLS	8,363	1.3	$3,697,613	2.0
	SUBTOTAL	582,993	87.7	$166,586,072	88.4
non-MSA	ALS	21,912	3.3	$7,718,960	4.1
	BLS	58,501	8.8	$13,696,989	7.3
	Cannot determine ALS or BLS	1,101	0.2	0.3 $537,124	
	SUBTOTAL	81,514	12.3	$21,953,073	11.6
TOTALS		664,507	100.0	$188,539,145	100.0

PUERTO RICO

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	203	0.4	$64,483	0.7
	BLS	45,929	90.8	$8,869,682	89.6
	Cannot determine ALS or BLS	22	0.0	$43,348	0.4
	SUBTOTAL	46,154	91.3	$8,977,513	90.6
non-MSA	ALS	50	0.1	$16,943	0.2
	BLS	4,346	8.6	$897,107	9.1
	Cannot determine ALS or BLS	5	0.0	$12,077	0.1
	SUBTOTAL	4,401	8.7	$926,127	9.4
TOTALS		50,555	100.0	$9,903,640	100.0

RHODE ISLAND

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	10,238	22.9	$2,715,568	23.4
	BLS	33,975	76.0	$8,683,575	74.9
	Cannot determine ALS or BLS	462	1.0	$187,016	1.6
	SUBTOTAL	44,675	100.0	$11,586,159	100.0
non-MSA	ALS	0	0.0	$0	0.0
	BLS	0	0.0	$0	0.0
	Cannot determine ALS or BLS	0	0.0	$0	0.0
	SUBTOTAL	0	0.0	$0	0.0
TOTALS		44,675	100.0	$11,586,159	100.0

SOUTH CAROLINA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	38,833	34.7	$6,904,506	32.5
	BLS	35,826	32.1	$7,113,473	33.5
	Cannot determine ALS or BLS	5,104	4.6	$1,220,494	5.7
	SUBTOTAL	79,763	71.4	$15,238,473	71.8
non-MSA	ALS	15,023	13.4	$2,765,457	13.0
	BLS	15,738	14.1	$2,908,339	13.7
	Cannot determine ALS or BLS	1,230	1.1	$316,242	1.5
	SUBTOTAL	31,991	28.6	$5,990,039	28.2
TOTALS		111,754	100.0	$21,228,512	100.0

SOUTH DAKOTA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	2,164	15.0	$328,158	13.6
	BLS	676	4.7	$91,205	3.8
	Cannot determine ALS or BLS	196	1.4	$37,229	1.5
	SUBTOTAL	3,036	21.0	$456,592	19.0
non-MSA	ALS	5,331	36.8	$1,173,325	48.7
	BLS	5,886	40.7	$723,441	30.0
	Cannot determine ALS or BLS	215	1.5	$55,517	2.3
	SUBTOTAL	11,432	79.0	$1,952,284	81.0
TOTALS		14,468	100.0	$2,408,876	100.0

TENNESSEE

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	63,144	30.0	$11,061,363	32.1
	BLS	65,545	31.1	$10,024,454	29.1
	Cannot determine ALS or BLS	9,245	4.4	$1,872,519	5.4
	SUBTOTAL	137,934	65.5	$22,958,337	66.6
non-MSA	ALS	38,795	18.4	$6,608,975	19.2
	BLS	30,090	14.3	$4,084,049	11.9
	Cannot determine ALS or BLS	3,845	1.8	$811,399	2.4
	SUBTOTAL	72,730	34.5	$11,504,423	33.4
TOTALS		210,664	100.0	$34,462,760	100.0

TEXAS

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	198,230	45.5	$56,101,236	48.5
	BLS	134,250	30.8	$30,470,137	26.3
	Cannot determine ALS or BLS	16,262	3.7	$5,431,930	4.7
	SUBTOTAL	348,742	80.0	$92,003,303	79.6
non-MSA	ALS	52,431	12.0	$15,793,111	13.7
	BLS	28,785	6.6	$5,188,871	4.5
	Cannot determine ALS or BLS	5,935	1.4	$2,655,405	2.3
	SUBTOTAL	87,151	20.0	$23,637,388	20.4
TOTALS		435,893	100.0	$115,640,690	100.0

UTAH

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	5,976	32.0	$2,330,668	40.8
	BLS	8,213	44.0	$1,913,676	33.5
	Cannot determine ALS or BLS	931	5.0	$298,290	5.2
	SUBTOTAL	15,120	80.9	$4,542,634	79.6
non-MSA	ALS	710	3.8	$325,521	5.7
	BLS	2,761	14.8	$782,756	13.7
	Cannot determine ALS or BLS	90	0.5	$55,021	1.0
	SUBTOTAL	3,561	19.1	$1,163,298	20.4
TOTALS		18,681	100.0	$5,705,932	100.0

VERMONT

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	999	6.5	$285,415	7.3
	BLS	2,833	18.4	$633,643	16.3
	Cannot determine ALS or BLS	102	0.7	$37,101	1.0
	SUBTOTAL	3,934	25.5	$956,159	24.6
non-MSA	ALS	3,055	19.8	$911,236	23.4
	BLS	8,074	52.3	$1,895,749	48.7
	Cannot determine ALS or BLS	366	2.4	$131,073	3.4
	SUBTOTAL	11,495	74.5	$2,938,058	75.4
TOTALS		15,429	100.0	$3,894,217	100.0

VIRGIN ISLANDS

Type of service	Services		Medicare Allowed Amount	
	Number	Percent	Amount	Percent
ALS	30	13.0	$8,329	12.5
BLS	198	86.1	$53,034	79.8
Cannot determine ALS or BLS	2	0.9	$5,060	7.6
TOTALS	230	100.0	$66,423	100.0

This table combines the MSA and non-MSA data, because the Virgin Islands have not been categorized into MSA and non-MSA areas.

VIRGINIA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	21,868	19.4	$5,161,184	24.2
	BLS	56,988	50.5	$8,758,276	41.0
	Cannot determine ALS or BLS	3,182	2.8	$1,048,512	4.9
	SUBTOTAL	82,038	72.7	$14,967,973	70.1
non-MSA	ALS	7,066	6.3	$2,226,454	10.4
	BLS	22,908	20.3	$3,876,677	18.2
	Cannot determine ALS or BLS	798	0.7	$279,413	1.3
	SUBTOTAL	30,772	27.3	$6,382,544	29.9
TOTALS		112,810	100.0	$21,350,517	100.0

WASHINGTON

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	23,140	27.5	$8,789,827	34.1
	BLS	40,826	48.5	$10,137,758	39.3
	Cannot determine ALS or BLS	1,431	1.7	$644,412	2.5
	SUBTOTAL	65,397	77.8	$19,571,997	75.9
non-MSA	ALS	9,329	11.1	$3,747,401	14.5
	BLS	8,692	10.3	$2,178,189	8.4
	Cannot determine ALS or BLS	684	0.8	$305,385	1.2
	SUBTOTAL	18,705	22.2	$6,230,975	24.1
TOTALS		84,102	100.0	$25,802,972	100.0

WEST VIRGINIA

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	16,123	15.5	$3,028,476	17.1
	BLS	25,046	24.1	$3,328,849	18.8
	Cannot determine ALS or BLS	867	0.8	$249,986	1.4
	SUBTOTAL	42,036	40.5	$6,607,311	37.3
non-MSA	ALS	17.213	16.6	$3,836,367	21.6
	BLS	42,544	41.0	$6,579,830	37.1
	Cannot determine ALS or BLS	2,041	2.0	$700,983	4.0
	SUBTOTAL	61,798	59.5	$11,117,181	62.7
TOTALS		103,834	100.0	$17,724,492	100.0

WISCONSIN

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	17,969	15.8	$5,513,531	21.4
	BLS	62,308	54.7	$12,604,319	48.9
	Cannot determine ALS or BLS	6,363	5.6	$2,125,220	8.3
	SUBTOTAL	86,640	76.0	$20,243,070	78.6
non-MSA	ALS	5,538	4.9	$1,889,976	7.3
	BLS	19,770	17.4	$2,920,997	11.3
	Cannot determine ALS or BLS	1,983	1.7	$703,751	2.7
	SUBTOTAL	27,291	24.0	$5,514,725	21.4
TOTALS		113,931	100.0	$25,757,795	100.0

WYOMING

Category/Type of Service		Services		Medicare Allowed Amount	
		Number	Percent	Amount	Percent
MSA	ALS	548	9.8	$163,440	11.6
	BLS	819	14.6	$153,452	10.9
	Cannot determine ALS or BLS	150	2.7	$46,695	3.3
	SUBTOTAL	1,517	27.0	$363,587	25.9
non-MSA	ALS	2,148	38.2	$658,828	46.9
	BLS	1,838	32.7	$339,937	24.2
	Cannot determine ALS or BLS	116	2.1	$41,568	3.0
	SUBTOTAL	4,102	73.0	$1,040,333	74.1
TOTALS		5,619	100.0	$1,403,920	100.0

APPENDIX D

AGENCY COMMENTS

The full text of comments received from the Health Care Financing Administration and the Office of the Assistant Secretary for Management and Budget follows.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D C . 20201

DATE: JAN 22 1998

To: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "State Ambulance Policies and Services," (OEI-09-95-00410)

We have reviewed the above-referenced report, which discusses Medicare coverage of ambulance services and proposes changes to Medicare's payment policies. The report is one of a series of OIG reports concerning Medicare coverage and payment for ambulance services. Previous studies conducted by OIG recommended that reimbursement be based on the patient's medical condition rather than the type of vehicle and personnel used in providing an ambulance service. As the report indicates, the Health Care Financing Administration (HCFA) proposed this reimbursement change, along with a proposal to consider waivers in certain non-Metropolitan Statistical Areas (MSAs), in a Notice of Proposed Rulemaking issued in June of 1997.

As the report suggests, coverage and payment for ambulance services under Medicare depend on a variety of factors, including the patient's medical condition, the equipment used to transport the patient, and the type of personnel rendering services. Medicare pays for medically necessary ambulance services, under section 186 1(s)(7) of the Social Security Act, when "the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations."

The OIG report explains that Medicare ambulance costs and services (defined as a one-way or round-trip ambulance service provided on a single date) have increased significantly over the past eight years. Between 1987 and 1995, Medicare allowances increased from $602 million to almost $2 billion. The number of ambulance personnel, vehicles, and services provided also increased. The report determined that more than four out of five Medicare ambulance services are provided in MSAs. These services alone represent about $ 1.6 billion in Medicare payments.

OIG continues to support its prior recommendation that HCFA base reimbursement for ambulance services on the patient's medical condition rather than the type of vehicle and personnel used. OIG also recommends that HCFA rc-evaluate the use of the MSA/non-MSA designation as a possible basis for granting waivers to this payment policy.

HCFA concurs with all OIG recommendations. Our detailed comments are as follows:

OIG Recommendation

HCFA should base reimbursement on the patient's medical condition rather than the type of vehicle and personnel used.

HCFA Response

We concur. HCFA agrees with the general findings and recommendations suggested in this OIG report and is considering how best to finalize and implement them.

On June 17, 1997. HCFA published in the Federal Register a Notice of Proposed Rulemaking (NPRM) addressing several of the issues raised by the OIG report about Medicare coverage and payment for ambulance services. The NPRM was based on the work of an interdepartmental workgroup convened by HCFA, which worked closely with representatives from the ambulance industry in developing the proposed rule. In addition to proposing that payment for ambulance services be based on the medical condition of the patient, the NPRM included several other proposals to update and clarify Medicare's ambulance policies, and solicited comments in all of these areas.

In August 1997, after publication of the NPRM, the President signed into law the Balanced Budget Act of 1997 (BBA), which included a mandate to develop a fee schedule for ambulance services through negotiated rulemaking, to take effect by January 1, 2000. A number of members of Congress subsequently raised concerns about whether the proposal in the NPRM to base payment on the patient's medical condition would overlap with payment issues to be addressed in the fee schedule regulation and urged HCFA to incorporate this proposal into the negotiated rulemaking mandated by the BBA.

In addition, HCFA received approximately 2,270 public comments in response to the NPRM, and is reviewing those comments. HCFA plans to proceed with further development of the NPRM proposals, including the change in payment policy recommended by OIG. However, in view of the BBA mandate and Congressional

concerns, we are considering how best to finalize the proposed policy to base reimbursement on the patient's medical condition.

OIG Recommendation

HCFA should reevaluate the use of the MSA/non-MSA designation as the basis for granting waivers.

HCFA Response

We concur. The main issue addressed by the OIG report is HCFA's consideration of a possible waiver procedure for the proposed new ambulance rule included in the NPRM, which would base ambulance reimbursement levels on the medical condition of the patient rather than on the type of vehicle and personnel used.

In discussions about this NPRM proposal, some representatives of the ambulance industry voiced concerns that this policy could have a negative impact on a supplier's ability to serve communities with small populations. Some representatives argued that, in areas where it is not economical to operate both basic life support (BLS) ambulances and advanced life support (ALS) ambulances, the policy could cause some suppliers to go out of business. Further discussions led HCFA to solicit comments in the NPRM from interested parties on the need for an exception to the proposed policy, and the areas and type of suppliers to which such an exception might apply. The NPRM specifically described two options being considered if an exception were determined to be warranted. one of which (identified as the preferred option) would have been available only in non-MSA areas. However, it is important to note that HCFA has not decided whether to adopt an exception at all, aud if so, whether waivers should be based on a non-MSA designation. HCFA specifically invited comments (which were due on August 18.1997) on other waiver options not included iu the NPRM, and is reviewing those comments.

Technical Comments

Page 5, 2nd paragraph: This short paragraph entitled "Ambulance Industry Consolidation" seems incomplete. While it tells us what the industry looked like "until recently," it does not say how the industry has consolidated, as the title implies *(e.g.,* what it looks like now).

Page 12 of the report concludes that, if a waiver were to be based on a non-MSA designation, "HCFA would continue to allow at least $185.7 million annually in ALS reimbursement" (in non-MSAs). According to OIG's data, this is the amount Medicare allowed in 1995 for ALS services in non-MSAs. The conclusion appears to assume that every non-MSA would qualify for a waiver. In fact, HCFA's proposed waiver option includes other conditions that must be met in addition to location in a non-MSA (e.g., the supplier must be the sole supplier in the area and must provide only ALS vehicles and staff). OIG's data also suggest that many non-MSAs provide both ALS and BLS services. Perhaps OIG assumes that if a waiver based on non-MSAs were to be adopted, all non-MSAs would convert their programs to conform to the waiver criteria If so, this assumption should be made clear.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington. D.C 20201

MAY - 7 1997

MEMORANDUM TO: June Gibbs Brown
Inspector General

FROM: John J. Callahan
Assistant Secretary for Management and Budget

SUBJECT: Concur with Comment: OIG Draft Report, "State Ambulance Policies and Services

The wording of OIG's recommendation in this report implies that HCFA has finalized a decision to use MSA/non-MSA designations as the basis for granting waivers to its proposed ambulance coverage policy.

In fact, HCFA is only proposing this waiver option in regulation. The regulation will also propose an alternative waiver option and will seek public comment on both options, as well as any other options commenters might suggest.

OIG should change the language in its report to clarify that: 1) HCFA has not finalized a decision on granting waivers, 2) using MSA and non-MSA designations in granting waivers is only one of two options being considered in its ambulance regulations, and 3) commenters will be asked to react to the two alternatives and suggest additional options.

OIG may also want to consider changing the wording of its recommendation to say:

. "When determining a waiver policy in its final rule on ambulance coverage, HCFA should re-evaluate its proposal to use Metropolitan Statistical Area/non-Metropolitan Statistical Area designations as the basis for granting waivers."