August 7, 2012

Mr. Mark Miller, PhD
Executive Director
MedPAC
601 New Jersey Ave NW - Suite 9000
Washington, DC 20001

Dear Dr. Miller:

We appreciate the opportunity to provide additional input from our meeting on 30 March 2012 with your team conducting the ambulance fee schedule study. The Association of Critical Care Transport (ACCT) is a non-profit grassroots patient advocacy organization committed to ensuring that critically ill and injured patients have access to the safest and highest quality critical care transport system possible. ACCT is comprised of air and ground critical care transport providers, FAA part 135 air operators, business organizations, associations, physicians and individuals dedicated to the best interests of patients in critical care transport, including by ensuring that critical care transport providers have sufficient resources to meet their patient care missions. Our regular member organizations provide the entire spectrum of out of hospital services from 911 emergency ambulance response and specialized care transport services, to the most complex intra and interstate critical care medical transport. In total ACCT member organizations operate 454 medical helicopters, 38 fixed wing air ambulances and 79 ground critical care ambulances throughout the United States.

During our meeting with your team, we highlighted a number of issues related to the wide variation in capability and care in critical care medical transport and the subsequent relationship between variability and current incentives and disincentives in CMS ambulance reimbursement policy. Our comments in this submittal cover the current study and our recommendation for developing a better definition and reimbursement methodology for critical care transport.

**Ambulance Reimbursement Study:**

As required by the Congress, the current study underway by MedPAC includes the following areas of focus:

- The appropriateness of the current temporary ambulance add-on payments;
  - Urban (2%) and Rural (3%) ground ambulance add-ons
- “Super Rural” ground ambulance add-on (22.6%)
- Grandfathering of certain areas for air ambulance rural add-on
  - The effect of add-on payments on provider’s Medicare margins; and
  - The potential need to reform the ambulance fee schedule, including whether the current add-ons should be built into base rate.

From a historical perspective, in the negotiations creating the 2002 fee schedule, there was strong agreement that it was not possible to create a RVU for each type of transport that was applicable to both urban and rural environments due to volume differentials. The development of the 50% rural modifier to both base and mileage in the original fee schedule was based on the premise that this was a reasonable methodology to adjust for the low volume and subsequently higher ratio of fixed to variable costs experienced by rural ground and air ambulance suppliers.

Despite the rural add on CMS identified in the final fee schedule (67FR 9110), the application of the fee schedule did not fully address the challenges of rural suppliers. In addition to the fixed/variable cost ratio, total completion times for very rural ambulance transports are much longer resulting in higher actual transport costs and continuing coverage when a team is engaged in sometimes entire shift long single transports resulting in significantly higher cost per transport. The need for additional payment recognition of rural and super rural ambulance transport was recognized in the 2003 GAO study “Ambulance Services: Medicare payments can be better targeted to trips in less densely populated rural areas” (GAO 03 986), which found:

“Although Medicare’s payments generally are higher for trips originating in the least densely populated rural counties than in other counties, the payment differential is probably not large enough to account for the higher costs incurred by low-volume providers likely to serve these areas. Far fewer Medicare-covered ambulance trips are typically provided in rural counties than in urban counties. Trip volume also varies widely across rural counties, with the least densely populated generally having substantially fewer trips than the most densely populated. This suggests that the cost per trip is likely higher for providers serving the least densely populated rural counties. Ambulance providers on average are paid more for trips originating in the least densely populated rural counties than for those in the most densely populated rural counties, but the payment differences are modest and unlikely to reflect the higher cost per trip of low-volume providers.”

In part based on the GAO study, the Ambulance Fee Schedule has been amended by the Congress with temporary urban, rural and super-rural add-ons for ground ambulance transport which have been renewed by Congress annually. In addition, in 2007 CMS proposed changing the methodology of urban rural pick up locations from Metropolitan Statistical Area (MSA of

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non MSA with Goldsmith modifier for some mixed urban rural counties) to defining rural areas to Rural Urban Commuting Areas (RUCA), which resulted in approximately 1,800 pick-up location zip codes changing from rural to urban. Based on input from air medical suppliers, Congress created a temporary hold harmless exemption of the affected zip codes, which has also been subsequently renewed through December 31, 2012.

Pursuant to ACCT’s mission to ensure access for critically ill and injured patients to high quality and safe transport, we believe that Medicare policy should be designed to ensure such access based not on the vehicle modality, but rather based on the patient's medical condition and needs, including time sensitive conditions. Further, ACCT believes that Medicare policy, in both ground and air ambulance reimbursement, will promote such access by better reflecting the costs of providing services at varying levels of clinical capability and quality, including at the level of critical care, and in varying geographic locations, including rural and super rural areas. The ability to initiate or maintain high acuity and complex interventions during transport reduces morbidity and subsequent in-patient hospitalization costs; conversely, failure to initiate on an urgent basis or maintain during transport acute medical interventions, pharmacological interventions or technologies would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition.¹

ACCT recommends that MedPAC take into consideration the higher costs of providing care to critical care patients, and the higher costs associated with providing care and transport to patients from rural and super rural geographic areas. Accordingly, ACCT believes that the global level of payment for both air and ground ambulance payments must be maintained or, to the extent empirically justified, increased. Improvement of Medicare reimbursement policy to better recognize the cost of providing care at varying levels of clinical capability and improve access, particularly in rural areas, is not feasible if the global level of reimbursement for ground and air ambulance payment is reduced.

More specifically, ACCT recommends strongly that the current add-ons for ground ambulances be made permanent. In addition, ACCT believes that ground ambulance reimbursement should recognize a new RVU for critical care transport (described in more detail below).

Further, ACCT believes that air ambulance reimbursement should be realigned to reflect the higher costs of providing critical care transport to those critically ill and injured patients for whom air ambulance transport is medically necessary and appropriate. Air ambulance agency viability to provide access for patients to life-saving care and transport is highly dependent on patient volume, which remains challenging in oversaturated and rural areas, and which is often outside of the provider's control. ACCT believes that the monetary value of the hold harmless exemption of the reclassified zip codes should be maintained within the air ambulance portion

¹ Follows CPT code for critical care service 99291 and 99292 relevant to the transport environment.
of the fee schedule. We believe that that value could be utilized to create a new category of reimbursement for air ambulance providers that function as "sole community providers", such as those that serve a geographic region of 100 statute miles from another base, to maintain and improve access to air ambulance services for rural patients. Alternatively, the hold harmless exemption of the reclassified zip codes could be updated such that any changes to the urban / rural classification would be conducted on a scheduled update basis to not only account for rural areas becoming urban, but urban areas becoming rural.

As noted in the Rural and Wilderness EMS Agenda for the Future:

“Federal programs that are geared toward ensuring a stable and vibrant EMS system need a better method of defining rural and access that is structured toward this unique combination of access issues. A rural appropriate EMS definition must account for a combination of service availability, population coverage, and a time based geographic delivery of emergency services. To insure the existence of a stable and vibrant EMS system, Federal programs should define and serve rural communities with policies that encourage service availability with optimal response times to emergent events.” (2004 National Rural Health Association).

**Critical Care Transport**

Under current reimbursement policy there is no definition of “critical care transport.” For ground ambulances, the “Specialty Care Transport” RVU covers care beyond the standard national scope of a paramedic. ACCT believes that this RVU is appropriate for a substantial segment of ground ambulance transports. However, the Specialty Care Transport RVU does not distinguish between the transport of a stable patient with a single paramedic maintaining hospital started infusion medications versus the transport of an unstable critically ill or injured patient, such as one on extra corporeal membrane oxygenation (ECMO) requiring an entire critical care team, adapted vehicle patient care environment and quite literally hundreds of thousands of dollars of equipment specifically designed to maintain life for critical care patients. This investment results in significant downstream savings as the ability to maintain hospital level care and immediately respond to life threatening clinical deterioration is tied to reduced ALOS and costs of intensive care.

This lack of distinction is further exacerbated by lack of differentiated reimbursement. While the current SCT rate is designed to reimburse paramedic interfacility transport, it is not designed to recognize the cost of ground or air based critical care transport. The failure of Medicare policy and reimbursement to recognize the higher costs of ground critical care transport results in a very limited number of providers willing to offer this level of service; those that do provide ground critical care services undertake substantial losses. Further, the lack of
provider capability to provide true critical care during transport results in higher downstream hospitalization costs.

For air ambulances, there is a single base rate for helicopters or fixed wing air ambulances regardless of clinical team capability, scope of practice, medical equipment and technology, physician medical oversight and patient acuity. The effect of these reimbursement policies allows provider defined care and wide variability in what constitutes “critical care.” Medicare reimbursement policy does not reflect that wide variation in clinical capability and quality provided to patients transported by air ambulance, and the costs associated with the higher levels of critical care. Air ambulance transport is necessary and medically appropriate for many critically ill and injured patients, including those for whom time is clearly the difference between life and death, such as patients with time sensitive neurological or cardiac conditions. Medicare payment policy, should revolve around medical appropriateness, and incentivize the transport by air of those patients for whom air transport is medically necessary and appropriate and not inadvertently disincentivize the medically appropriate transport of critically ill and injured patients who could be adequately transported by a ground critical care ambulance.

To the extent that MedPAC is providing a recommendation to the Congress with regard to whether the Ambulance Fee Schedule should be amended, it is ACCT’s recommendation that MedPAC provide an RVU for ground critical care transport and develop a realigned reimbursement system for air ambulance transport that reflects the clinical capability of the transport provider and the level of clinical resources required to provide care to the individual patient.

This of course requires a definition of "critical care transport." Defining "critical care transport" for the purposes of payment policy or licensure whether for ground or air is very difficult and has proven challenging for the industry and policy makers. We have attempted to provide such a definition for your consideration to inform your thinking and recommendations with regard to Medicare policy. With regard to licensure, we believe that purview remains with the States. Our proposed recommendation for Medicare purposes is designed to be applicable to the level of care provided to a critical care patient regardless of the vehicle transporting the patient:

The provision of medical care by a **critical care transport team** to a **patient requiring critical care transport** by a **critical care transport agency** such that failure to initiate or maintain acute medical interventions, pharmacological interventions, or technologies on an immediate basis may result in clinical instability or sudden, clinically significant or life threatening deterioration of the patient’s condition (subject to the corresponding definitions in Attachment A).

The terms included in the definition themselves require further explanation, all of which you will find in Attachment A.
We thank you for your consideration of ACCT’s recommendations and appreciate your interest in ensuring that Medicare reimbursement policy improves access to high quality and safe critical care transport for vulnerable patients. Should you have any questions, please do not hesitate to contact Lisa Tofil at 202-828-5003 or lisa.tofil@hklaw.com.

Sincerely,

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Executive Director and General Counsel, ACCT

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Attachment A

ACCT Recommended Definition of Critical Care Transport
For Consideration by MedPAC for Medicare Reimbursement Purposes

**Purpose:**
To provide a recommendation to MedPAC to inform the current ambulance reimbursement study on the need to create a new relative value unit (RVU) and reimbursement level for critical care transport.

Critical care transport is distinct from the currently defined “Specialty Care Transport (SCT)” and thus should be separately recognized under the Ambulance Fee Schedule. The SCT RVU in the Ambulance Fee Schedule recognizes the use of additional skills and therapies beyond the national scope of practice for a paramedic and also recognizes the additional costs of training, medical technology, and interventions for inter-hospital transport of stable patients. However, the SCT RVU does not recognize or adequately reimburse the additional resources needed for a patient who is clinically unstable or has the potential for life threatening clinical instability that may contribute to morbidity or mortality and who requires more advanced and costly medical interventions, equipment and supplies.

The level of medical care required to transport a critical care patient includes: 1) an expert level of provider knowledge and skills appropriate to the medical needs of such patient; 2) a patient care environment commensurate with the critical care provided, including the necessary equipment and supplies; 3) the ability to address the added challenges of transport and initiate and/or maintain the continuity of tertiary or quaternary hospital care during transport; and 4) a vehicle (ground, fixed wing, or rotor wing) equipped to support the delivery of medical care to critical care patients during transport. Both the critical care transport agency and transport teams actually delivering the care to patients must have sufficient capability to meet the medical needs of critical care patients.

The choice of transport modality—ground, fixed wing, or rotor wing -- is based on multiple factors including patient acuity and medical condition, the need for time sensitive care and out-of-hospital time, (i.e. Thoracic Aortic Dissection) and logistical considerations, including distance and weather. Accordingly, critical care transport patients may be transported by any vehicle modality depending on the individual circumstances present at the time, and the choice of a particular vehicle modality does not infer that a transport is or is not a critical care transport.

ACCT's recommended critical care definition would apply to interfacility transports only, recognizing that in interfacility transport, there is a prospective physician assessment with regard to whether the patient requires critical care transport. ACCT recommends further study by MedPAC with regard to whether a CCT RVU for patients transported from the scene is advisable and appropriate based on aggregated data sets and clear outcomes.
**Definition of Critical Care Transport:**
The provision of medical care by a critical care transport team to a patient requiring critical care transport by a critical care transport agency such that the failure to initiate on an urgent basis or maintain during transport acute medical interventions, pharmacological interventions, or technologies would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition\(^2\) (subject to the corresponding definitions below).

**Definition of Patient Requiring Critical Care Transport:**
A patient requiring critical care transport has a critical illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition during transport. Examples of vital organ system failure that may contribute to morbidity or mortality include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

**Definition of Critical Care Transport Team:**
Critical care transport services are delivered by critical care a transport team with the requisite decision making skills of high complexity to assess, manipulate, and support vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition during transport.

1. The team consists of a minimum of two caregivers each of whom is able to provide acute medical interventions, pharmacology, and technological life support systems exceeding those able to be provided by the national scope of practice of a paramedic as currently defined by NHTSA’s National EMS Scope of Practice Model, DOT HS 810 657, February 2007 (and as redefined in the evolution of practice by NHTSA).

2. In addition, each caregiver on the transport team has a minimum of 3 years' experience in their respective fields, with documented competency and experience (as defined below) in the care and transport of critical care patients. All critical care transport team members should be employed by or affiliated with the agency providing (except as provided in (iv) below) transport.

   i. At least one provider is licensed as an RN, PA, NP, or physician with documented competency and experience in the provision of critical care as a primary caregiver in a tertiary intensive care unit commensurate with the type and acuity of patients transported and receives training in the transport environment pursuant to the agency's policy. To the extent that a state may develop credentialing for a Critical Care Provider that includes other licensed caregivers who meet the qualification requirements under (1) above and that requires such caregivers to have the comparable equivalent of three years experience in a tertiary intensive care unit as

\(^2\) Follows CPT code for critical care service 99291 and 99292 relevant to the transport environment.
the primary caregiver, such credential should be considered for recognition as qualifying under this requirement.

ii. At least one provider has specialty certification in critical care transport (e.g. CFRN, CTRN, CNPT, FP-C & CCP-C) achieved through a validated exam administered by an independent entity not associated with a specific course or program of education. The agency needs to have a policy requiring transport certification.

iii. When treating patients within special patient populations (e.g. obstetric, pediatric or neonatal), additional experience, training, and technology must be incorporated into the team and its delivery of critical care as appropriate to the medical conditions of the patient.

iv. A critical care transport team may be augmented by adding tertiary teams of particular providers trained to deliver care to patients with certain characteristics or medical conditions. Such providers may be employed by an entity other than the critical care transport agency but should meet the minimum requirements consistent with the applicable tertiary care standard for the patient being transported (e.g. ECMO, NICU, PICU, HROB).

**Definition of Critical Care Transport Agency:**
The critical care transport agency must have essential systems and oversight in place to meet the medical needs of critical care patients, including:

1) The agency must be licensed and/or credentialed to operate in the state in which it is based and at the highest clinical level provided by the State, and ideally at the level of critical care to the extent that the State has an approved Scope of Practice for Critical Care Transport.

2) The agency has physician medical oversight consistent with the acuity and conditions of the critical care patients being transported. This may be a combination of medical directors or a physician team supplemented by the addition of consulting specialists. Such appropriate medical oversight includes an actively practicing physician with competency in critical care transport medicine and board certification in a specialty relevant to the provider agency mission or experience in critical care transport medicine consistent with the types, acuity and severity of patients transported.

3) The agency has structured physician directed clinical quality management and clinical performance improvement programs consistent with the condition of critical care patients being transported which demonstrates a continuous process for improving care including standards that require active involvement by physician medical directors to ensure quality and adherence to appropriate standards and reporting requirements related to quality assurance, utilization review, outcomes, proficiency measures, and patient safety.
ACRONYMS

PICU: Pediatric Intensive Care Unit
NICU: Neonatal Intensive Care Unit
HROB: High Risk Obstetrical
ECMO: Extracorporeal Membrane Oxygenation
PA: Physician Assistant
NP: Nurse Practitioners
RN: Registered Nurse
CCT: Critical Care Transport

Specialty Exams:
CFRN: Certified Flight Registered Nurse
CTRN: Certified Transport Registered Nurse
CNPT: Certified-Neonatal Pediatric Transport
FP-C: Flight Paramedic-Certified
CCP-C: Critical Care Paramedic-Certified