American Hospital Association

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July 25, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1317-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1317-P, Medicare Program; Revisions to the Payment Policies of Ambulance Services under the Fee Schedule for Ambulance Services; Proposed Rule.

Dear Dr. McClellan:

On behalf of the American Hospital Association's (AHA) 4,800 member hospitals, health care systems and other health care organizations, and our 35,000 individual members, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule changing the fee schedule for ambulance services.

CBSAs-REVISED OMB METROPOLITAN AREA DEFINITIONS

CMS proposes fully incorporating the Office of Management and Budget's (OMB) revised standards defining Metropolitan Statistical Areas, including its new definitions of Core-Based Statistical Areas (CBSAs), into the ambulance fee schedule. CMS notes that the updated geographical areas may increase payment for a beneficiary who is picked up in an area that was previously classified as urban but now is considered rural, or decrease payment in an area that was previously considered rural but now is urban. However, CMS does not recommend implementing any transition or hold-harmless provision similar to those used under other payment systems. For instance, CMS provided a three-year, hold-harmless provision under the inpatient prospective payment system (PPS) for hospitals that transitioned from an urban to a rural wage index. The new payment systems for which CMS did not provide such protections (e.g., the psychiatric hospital PPS) already included blended payments of the old cost-based systems and new prospective systems, which had the same effect as a transition. **CMS should provide a three-year, hold-harmless provision for providers that serve beneficiaries in areas formerly classified as rural. These services are crucial to health care access in rural areas and should not be subject to a sudden decrease in payment.**

SPECIALTY CARE TRANSPORT

We do not believe that CMS' "clarification" regarding specialty care transport meets the intent of the regulation as originally negotiated. There are many situations in which a patient being transferred from a non-hospital provider to another provider might require the assistance of specialty personnel. For instance, a ventilator-dependent patient at a skilled-nursing facility (SNF) may need transport to a hospital-based or freestanding dialysis facility if the SNF does not provide such services. Physicians should be able to order the appropriate level of care and associated personnel given a patient's condition, and the ambulance provider should be paid accordingly. **We urge CMS not to change the regulation language from "interfacility transportation" to "hospital-to-hospital."**

EMERGENCY RESPONSE

CMS is singling out hospital-based ambulance providers by essentially proposing that such entities should not receive emergency response payments. Patients needing emergency transport from one hospital to another hospital need ambulances that can respond immediately, at any time, with basic life support and advanced life support levels. CMS should not make changes that discourage hospitals from owning and operating ambulances services or making hospital-to-hospital emergency transfers. **CMS' proposed changes to the definition are neither clear nor appropriate.**

The AHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Danielle Lloyd, AHA senior associate director for policy, at (202) 626-2340 or dlloyd@aha.org.

Sincerely,

Rick Pollack
Executive Vice President