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AMBULANCE SERVICES

Medicare Payments Can Be Better Targeted to Trips in Less Densely Populated Rural Areas

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Highlights

Highlights of GAO-03-986, a report to congressional committees

Why GAO Did This Study

The Centers for Medicare & Medicaid Services (CMS) recently implemented a Medicare ambulance fee schedule in which providers are paid a base payment per trip plus a mileage payment. An adjustment is made to the mileage rate for rural trips to account for higher costs. CMS has stated that this rural adjustment may not sufficiently target providers serving sparsely populated rural areas. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) directed GAO to examine rural ambulance costs. GAO identified factors that affect ambulance costs per trip, examined how these factors varied across geographic areas, and analyzed whether Medicare payments account for geographic cost differences. GAO used survey data on ambulance providers and Medicare claims data.

What GAO Recommends

GAO recommends that CMS better target the rural adjustment to trips in less densely populated rural counties by adjusting the base rates for ground ambulance services provided in those counties. CMS stated that the report will be useful as the agency develops a proposed rule to address appropriate payment for ambulance services furnished in rural, low-volume areas.

www.gao.gov/cgi-bin/getrpt?GAO-03-986.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laura A. Dummit, (202) 512-7114.

What GAO Found

Trip volume is the key factor affecting differences in ambulance providers' cost per trip. Ambulance providers' total costs primarily reflect readiness—the need to have an ambulance and crew available when emergency calls are received. Readiness-related costs are fixed, meaning that they do not increase with the number of trips provided, as long as a provider has excess capacity. As a result, providers that make fewer trips tend to have a higher cost per trip than those that make more trips. We also found that the length of providers' trips had little effect on their cost per trip.

The modest variation in Medicare payments to ambulance providers that serve rural counties probably does not fully reflect their differences in costs because the key factor affecting provider costs—the number of trips—varies widely across rural counties. In 2001, the least densely populated quarter of rural counties averaged far fewer trips than the most densely populated quarter. This suggests that the cost per trip is likely higher for providers serving the least populated rural counties. On average ambulance providers are paid somewhat more for trips in the least densely populated rural counties than for those in other rural counties. However, those payment differences are dwarfed by the difference in trip volume. Because trip volume is a strong indicator of costs, the Medicare payment differences across rural counties likely do not fully reflect differences in providers' cost per trip.

In implementing the fee schedule, CMS adjusted the mileage rate for rural trips to account for the higher cost per trip of providers serving rural areas. However, trip volume is a better indicator of providers' cost per trip than is trip length. Thus, adjusting the base rates for rural trips—the portion of Medicare's payment that is designed to pay for providers' fixed costs—is a more appropriate way of accounting for rural low-volume providers' higher cost per trip than adjusting the mileage rate.