INTERFACE

by Jack Stout

The Inflation-Indexed Charge

If all you have is a great defense, you may delay the inevitable, but eventually you'll lose.

This month's guest "Interface" article by David Werfel explains the latest in a series of threats to the financial stability of the EMS industry: the "Inflation-Indexed Charge" (IIC). Only a short time ago, our industry (led by the American Ambulance Association) successfully fought off a previous threat — the "lowest common level (LCL) charge." And before that . . . well, it really doesn't matter. Regardless of the outcome of this latest threat, unless we stop playing defense and carry the ball ourselves, eventually we will lose.

In next month's Interface article, I'll explain how the current "prevailing rate" approach to Medicare payment for EMS has encouraged proliferation of inefficient production methods, rewarded our industry's least productive providers, and strangled our industry's best-managed firms. I'll also propose a practical alternative to the "prevailing rate" approach, the effect of which would be exactly the opposite of the current policies. David Werfel's article explains the dangers of the inflation-indexed charge. But if our only reponse is to once again marshal our congressional delegations for yet another grand political defense, we will have missed the real message: We must stop playing defense, pick up the ball and run with it ourselves.

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On October 1, 1985, The Health Care Financing Administration (HCFA) added a new factor in determining the amount Medicare will pay for ambulance services. In my opinion this new factor, known as the *inflation indexed charge* (IIC), represents the single greatest financial threat facing the ambulance industry, as it restricts all increases in Medicare reimbursement to an inflation factor without considering factors uniquely related to ambulance providers.

This may not appear to be so terrible at first blush, since physicians and many other healthcare providers have restrictions based on inflation, the lowest charge level, or other factors. What makes this such a real threat to the ambulance industry is the fact that ambulance services are reimbursed differently from all other healthcare providers and the IIC fails to take these differences into account.

For example, in what other group reimbursed by Medicare are volunteers, municipally owned and operated providers, and privately owned providers all mixed in together for reimbursement purposes? Due to the differences in charges by these three groups of ambulance providers, the "reasonable" charges — as determined by Medicare — are already a very real problem.

There is no other group of providers whose charges reflect their subsidies, tax-supported dollars, availability contracts, etc. Further, no other group is rate regulated. Now, even if granted rate increases by the governmental entity that regulates rates, the ambulance provider may not receive increased reimbursement from Medicare when they raise their rates due to a

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quirk in the law that does not make equity adjustments (i.e. adjustments to customary charge) an exception to the IIC.

To better understand this problem, perhaps a little background is in order.

History

For many years, HCFA and Congress have wrestled with the problem of skyrocketing increases in healthcare costs. Various controls have been put into place to restrict the rate of increases in Medicare expenditures. For example, when Congress passed the Deficit Reduction Act of 1984 (DEFRA), it "froze" the customary and prevailing rates of physicians at the July 1983-June 1984 levels. Although it was initially to be a 15-month "freeze," it was later extended by various Emergency Extension Acts and COBRA (the 1985 budget bill) through December 31, 1986. Then, under the Omnibus Reconciliation Act of 1986 (OBRA), a maximum allowable actual charge restriction was placed, not on Medicare reimbursement, but on the amounts non-participating physicians would be allowed to charge Medicare patients. Still further, physician reimbursement was restricted by the Medicare Economic Index (MEI), a cumulative index tied to inflation. (For 1987 the MEI was 3.2 percent. In 1988 it will be 3.6 percent.)

Similarly, under DEFRA, 1984, fee schedules were established to control payments to clinical diagnostic laboratories. Thus, payment to such labs is no longer based on prevailing or customary charges.

Ambulance services, along with durable medical equipment, prosthetic, portable X-ray and other non-physician services, had no inflation-based restriction until HCFA — not Congress — promulgated the IIC.

The IIC was originally proposed in the Federal Register on August 16, 1985 as a Notice of Proposed Rulemaking (50 FR 33324). On October 1, 1985 it was published as a final rule. The 30-day period between publication and effective date was waived. Thus, the IIC became effective for services on or after October 1, 1985.

Definitions

The IIC adds an additional factor to those factors HCFA uses in determining reasonable charges and, therefore, its allowable charge.

The IIC is defined as the lowest of the reasonable charge screens for the previous fee screen year (FSY) updated by an inflation adjustment factor. The screens are defined in Section 5025B of the Medicare Carriers Manual as including not only the prior FSY's customary and prevailing charges *but also the prior IIC* (although the lowest charge level is also one of the screens listed, it is omitted herein as it does not apply to ambulance services). The inflation adjustment factor is based on the CPI for urban consumers for a 12 month period ending 6/30.

The inflation factor for FSY 1986 was set at zero percent. Therefore, while ambulance providers were not "frozen" last year, they received no increase. For FSY 1987, the factor was set at 1.7 percent.

The following example may help:

	FSY 1985	FSY 1986	FSY1987
Prevailing charges	100	110	115
Customary charges	96	100	105
Inflation-indexed charge	N/A	96	97.63

Assuming the customary and prevailing charges were increased

as listed, then the IIC would be as follows:

(FSY 1985 did not apply since it came into effect 10/1/85.)

FSY 1986 (10/1/85-12/31/86) — The IIC is $96 since that was the lowest of the prior year's customary (96) or prevailing (100) plus the inflation adjustment factor (0%). Keep in mind, there was no IIC for the prior year.

FSY 1987 — The IIC is the lowest of the 100, the 110 or the 96 plus the inflation-factor. Therefore, it was $96 + 1.7% or $97.63.

Please note, the IIC will usually be the IIC from the prior year plus the new inflation-adjustment factor. While there are a few — very few — exceptions, this means the reimbursement rate will be the current rate plus the inflation-adjustment factor. Given the increases in costs for labor, particularly for EMTs and paramedics, plus the increases in professional liability, workers compensation, property and casualty insurance, costs of vehicles, etc., ambulance providers will *lose* more and more each year in the ratio of Medicare payments-to-expenses.

Thus, aside from seeing expenses exceed billings, which *must* occur in the not-to-distant future, assuming current trends, providers must ask, what would happen if they lost their subsidy or availability contract, or were rate-regulated? The answer is that they would still get the same Medicare reimbursement plus the inflation adjustment (since the lowest screen will always be the IIC) unless they lowered their rates, were a new provider, or experienced some other unusual occurrence.

Exceptions

There are few exceptions built into the IIC. The IIC will not apply where the customary charge is based on the 50th percentile (e.g. for a new provider); where the customary or prevailing charge is based on conversion factors or price lists; if reasonable charges are based on comparability (i.e., what is paid in the private sector); or where inherent reasonableness is applied.

Since new providers will not be affected by the IIC, they come in at the 50th percentile at a figure higher than would an established provider being reimbursed based on 1983-1984 charges plus 1.7 percent. Therefore, some providers have gone out of business and have been "reincarnated" under a new name, new corporate structure, etc., and may be reimbursed at a higher rate than they otherwise would be allowed. This issue has arisen in different areas of the country and has received different interpretations from HCFA. In California, the Regional Office (RO) has interpreted the situation to mean that a new provider would come in at the *prior* screen's 50th percentile, i.e., the FSY 1986 screens. In Texas, the RO thus far has allowed new providers to come in at the 50th percentile of the *1987* screens — a much higher rate than that of existing providers. The central office of HCFA has sent out a memorandum to avoid reimbursing new providers at higher rates than existing providers. However, there are areas where new providers are getting higher rates than existing providers.

Consider this example — or more appropriately, horror story — from Texas. The existing provider had a subsidy and contract from the city. They were the provider for many, many years, and there were no problems concerning the quality of services, etc. An employee in the billing department of the ambulance provider heard that a new company would get a higher Medicare reimbursement rate. Therefore, he approached the city and advised them that he could service their needs with a lower subsidy. The city agreed and made him the new contractor.

What I cannot believe is that Medicare does not realize that by reimbursing new providers more than existing providers, they will end up paying more with such a policy. Worse, if this policy is not changed, there will be many companies that will die and be reincarnated, legally, in the near future.

Aside from correcting the problem that is caused by allowing new providers to come in at higher rates, HCFA should also allow equity adjustments to be an exception to the IIC. Currently, even if an equity adjustment is granted, it is only a Pyrrhic victory, as it allows increases only in the customary charge screen — not in the amount reimbursed. For that, a provider would have to fit into one of the very few exceptions, the most likely being "inherent reasonableness," meaning rates should be raised because the current rate is grossly deficient.

The bottom line: To providers who have a substantial volume of Medicare patients, probably the biggest financial threat is the IIC. □