



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

[CMS-6063-N7]

### Medicare Program; National Expansion Implementation for All Remaining States and Territories of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Notice.

**SUMMARY:** This notice announces the implementation dates for all remaining states and territories for the national expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports.

**DATES:** This expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports will begin on December 1, 2021 for independent ambulance suppliers garaged in Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas; and no earlier than: February 1, 2022 for independent ambulance suppliers garaged in Alabama, American Samoa, California, Georgia, Guam, Hawaii, Nevada, Northern Mariana Islands and Tennessee; April 1, 2022 for independent ambulance suppliers garaged in Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Puerto Rico, Wisconsin, and U.S. Virgin Islands; June 1, 2022 for independent ambulance suppliers garaged in Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, Rhode Island, and Vermont; and August 1, 2022 for independent ambulance suppliers garaged in Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, and Wyoming.

### FOR FURTHER INFORMATION CONTACT:

Angela Gaston, (410) 786-7409.

Questions regarding the national expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports should be sent to [AmbulancePA@cms.hhs.gov](mailto:AmbulancePA@cms.hhs.gov).

## **SUPPLEMENTARY INFORMATION:**

### **I. Background**

In the November 23, 2020 **Federal Register** (85 FR 74725), we published a notice titled “Medicare Program; National Expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transport,” which announced the national expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports under section 1834(l)(16) of the Act, as added by section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10). The states that participated in the model under section 1115A of the Social Security Act (the Act), which included Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia, previously transitioned to the national model on December 2, 2020. Due to the COVID-19 Public Health Emergency, we delayed the implementation of the expansion to any additional states.

### **II. Provisions of the Notice**

This notice announces the implementation dates for all remaining states and territories for the national expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports under section 1834(l)(16) of the Act, as added by section 515(b) of MACRA (Pub. L. 114-10). This expansion of the model will begin on December 1, 2021 for independent ambulance suppliers garaged in Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas; and no earlier than--

- February 1, 2022 for independent ambulance suppliers garaged in Alabama, American Samoa, California, Georgia, Guam, Hawaii, Nevada, Northern Mariana Islands and Tennessee;

- April 1, 2022 for independent ambulance suppliers garaged in Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Puerto Rico, Wisconsin, and U.S. Virgin Islands;
- June 1, 2022 for independent ambulance suppliers garaged in Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, Rhode Island, and Vermont; and
- August 1, 2022 for independent ambulance suppliers garaged in Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, and Wyoming.

We will continue to test in the remaining states and territories whether prior authorization helps reduce expenditures, while maintaining or improving quality of care, by using the prior authorization process described in the November 23, 2020 **Federal Register** (85 FR 74725) to reduce utilization of services that do not comply with Medicare policy. Prior authorization helps ensure that all relevant clinical or medical documentation requirements are met before services are furnished to beneficiaries and before claims are submitted for payment. It further helps to ensure that payment complies with Medicare documentation, coverage, payment, and coding rules. Prior authorization also allows ambulance suppliers to address coverage issues prior to furnishing services.

The model establishes a process for requesting prior authorization for repetitive, scheduled non-emergent ambulance transports. The use of prior authorization does not create new clinical documentation requirements. Instead, it requires the same information that is already required to support Medicare payment, just earlier in the process.

Submitting a prior authorization request for repetitive, scheduled non-emergent ambulance transports is voluntary. However, an ambulance supplier or beneficiary is encouraged to submit to the Medicare Administrative Contractor (MAC) a request for prior authorization along with all relevant documentation to support Medicare coverage of the transports. If prior authorization has not been requested by the fourth round trip in a 30-day period, the subsequent claims will be stopped for prepayment review. Please see the November 23, 2020 **Federal**

**Register** (85 FR 74725) for additional details on the prior authorization model and process.

We will expand outreach and education efforts on this model to affected ambulance suppliers in all states and territories, through such methods as an operational guide, frequently asked questions (FAQs) on our website, a physician letter explaining the ambulance suppliers' need for the proper documentation, open door forums, and educational events and materials issued by the MACs. We will work to limit any adverse impact on beneficiaries and to educate affected beneficiaries about the model process. Beneficiaries will continue to have all applicable administrative appeal rights for denied claims associated with a non-affirmed prior authorization decision.

Additional information is available on the CMS website at <http://go.cms.gov/PAAmbulance>.

### **III. Collection of Information Requirements**

As required by chapter 35 of title 44, United States Code (the Paperwork Reduction Act of 1995), the information collection burden associated with this national model (Form CMS-10708 – Ambulance Prior Authorization) is currently approved under OMB control number 0938-1380 which expires on August 31, 2023.

### **IV. Regulatory Impact Statement**

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and

safety effects, distributive impacts, and equity). A Regulatory Impact Analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$8.0 million to \$41.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this notice /will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2021, that threshold is approximately \$158 million. This rule will have no consequential effect on state, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct

requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Since this regulation does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: August 24, 2021.

**Lynette Wilson,**

*Federal Register Liaison,*

*Centers for Medicare & Medicaid Services.*

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