

# MANAGEMENT FOCUS

— For Providers of Emergency Medical Services —

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## *THE MEDICARE FEE SCHEDULE AND ITS IMPACT*

Reimbursement changes begin early next year. This is a result of the Negotiated Rule Making (NRM) Committee reaching consensus on February 14 on the relative values and methodology for establishing a national fee schedule for ambulance services.

Many ambulance organizations may view the results of this process as a sweet Valentine's gift. Others are going to compare the impact of this process with the 1929 St. Valentine's Day massacre. Establishing a national fee schedule equalizes reimbursement for ambulance services provided to Medicare beneficiaries. With the wide variation in reimbursement rates, it is inevitable that there will be winners and losers.

The key result was to establish the relative value of various service levels. HCFA will use these relative values to determine the reimbursement level for covered services (e.g. ALS, BLS, air medical, etc.). The table on page three identifies the relative value and potential reimbursement ranges for each of these service levels. The amounts are only estimates and will not be finalized until later this year after further HCFA analysis.

Providers can be divided into three groups based upon the impact of the fee schedule on their organization. Those

that loose, those that win, and services that feel minimal impact.

**The Losers.** Systems that have high operating costs, such as high performance EMS systems with mandated short response times and other costly standards, will be impacted. Many of these systems currently receive high levels of Medicare reimbursement.

Services that have been mandated to provide only ALS and reimbursed at that level will also be impacted. The new fee schedule envisions reimbursement

based on the level of service provided to the patient and not based on the configuration of the ambulance service responding.

Effective January 1, 2001 all ambulance services will be required to take assignment. Those currently not taking assignment and balance billing patients will no longer be able to seek this additional revenue. Reimbursement will be limited to the Medicare fee schedule allowable and services will only be able to bill a patient for the 20% co-insurance.

Current Medicare reimbursement varies widely

from one location to another. Many services have achieved relatively high reimbursement levels through equity and inherit reasonableness adjustments or from the development of higher prevailing rates over time. These services will feel the impact of the schedule.

**The Winners.** Heavily subsidized services that have traditionally had low fees may benefit from NRM by increasing fees to those allowed under the schedule. Services able to operate with lower expenses may also

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## *RURAL METRO WOES*

Rural Metro continues to try to upgrade its financial condition from "critical" to "stable." In recent weeks the beleaguered firm has had multiple key executives resign and watched its stock drop like a rock after the rating agencies downgraded it's ratings.

At this writing, a bankruptcy had not yet occurred but rating agency Standard & Poor's recent action downgrading Rural/Metro's debt due to "the potential for a bankruptcy filing" has many skeptical about the ultimate potential for a full recovery.

Rural/Metro reported in February that it lost \$42.4 million in its second quarter and that it planned to take millions of dollars in charges to restructure its business. That restructuring is expected to take Rural Metro out of about 30 markets and result in roughly 1,000 layoffs by the end of March.

Both cities and employees are nervous. Some competitors are excited about their own prospects in the face of R/M's woes. Others realize that a financial "meltdown" cannot be good for the medical transportation profession.

To survive long term, R/M will have to radically change the way it operates. It must shed overhead at its corporate and regional offices without further crippling the company's ability to provide core services.

In many respects the scenario is not unlike the options faced by AMR nearly two years ago. Laidlaw, AMR's parent corporation, provided the financial resources necessary to begin its healing process. It may be a much more difficult and painful recovery for R/M in the coming months.

# EMS & HOSPITAL TRENDS & NOTES



**Iowa "Paramedics."** Citing the need to bring ALS to rural areas and retain volunteers, Iowa will allow Nationally Registered EMT-Intermediates to be called paramedics. The state also eased CE requirements and will allow EMT's whose credentials have lapsed in the last 6 years to take a refresher and re-certify. Skeptics doubt retention will be enhanced and claim the state's action will erode the standard of care.

**Transporting persons of all ages.** MedServ Air Medical Transport expanded its adult transport mission by teaming

up with Children's Healthcare of Atlanta. The integration of the Children's specialty teams for pediatric transports and, in the immediate future, for neonatal transports, is a unique asset to patients in the northern and central Georgia area. MedServ placed a TwinStar helicopter in service in September 1999. The aircraft is operated and maintained by Corporate Jets. MedServ is an Emprize Group company.

**\$486M Settlement.** A whopping Medicare fraud settlement against Dialysis Provider Fresenius was negotiated in January for paying kickbacks. In addition to the fine, there were five criminal indictments and a permanent exclusion from the Medicare program. Less than

a month later four private insurers also filed copycat lawsuits and seek triple damages.

**Mergers.** Healthcare mergers & acquisitions nose-dived in 1999. A 38% decrease was reported in *Modern Healthcare*.

**Bystander Times.** A recent study in San Francisco and published in the February 2000 issue of *Annals of Emergency Medicine* documented that bystanders do not accurately estimate time intervals in Cardiac Arrest. 67% of those witnessing cardiac arrest estimated the response time *shorter* than it actually was.

**Safe Golfers.** The National Golf Course Owners

Association has completed a national group purchasing agreement facilitating individual courses' purchase of AEDs for clubhouses and marshals' carts. Were they yelling "clear" or "fore" ???

**Healthcare Costs.** Growing 6.5% per year between now and 2010 according to the *Institute for the Future and the Robert Wood Johnson Foundation*. Healthcare will represent 15% of the gross domestic product by the year 2005.

**Supreme Court Ruling.** In a 5-4 decision in late February, the high court made it impossible for providers to bypass HCFA's administrative hearing process taking them directly to federal court.

## HUMAN RESOURCES OUTLOOK

Extended economic growth is tightening the available medical transportation labor market in many areas. Three key issues identified in a recent national human resources survey included recruiting & retention, benefits & compensation, and balancing technology & privacy.

*Recruiting and retention* continue to soar to the top of the list. Competition for entry level workers forced EMS human resource personnel to scramble for staff. Many report that the quality of candidates has declined. The desire to find candidates that fit the culture and customer service needs is high. This is

complicated by the fact that service industry wages are increasing.

Management development and leadership training to boost fundamental job skills are lacking. Service leaders have not yet grasped the connection of poor supervision and increasing frustration among younger personnel.

*Benefits and Compensation.* A recent survey of human resource leaders indicated that 40 percent had made offering attractive, yet affordable benefit packages a high priority this year. 30 percent indicated that they would focus on ensuring competitive salaries, updating

antiquated compensations systems and establishing pay for performance.

*Balancing technology and privacy* throughout the organization was another issue identified unrelated to the tight labor market. New technologies have changed the way we communicate within MTS organizations and in our private and personal lives. Cell phones, pagers, and e-mail can all make us more accessible to others and therefore increase our productivity. But there is no doubt that technology can also invade our privacy, causing resentment and job dissatisfaction that can actually reduce productivity.

MTS organizations need to be mindful of these changing dynamics when setting policies about on and off duty use of company email, pagers and cell phones.

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## MEDICARE FEE SCHEDULE . . .

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benefit under the fee schedule arrangements. These include highly competitive non-emergency transportation organizations where high volume leads to lower per-transport costs. Also, organizations that are not required to meet stringent response times or other high performance mandates may be in a better position to be flexible and tailor operational costs to fee schedule reimbursement levels.

Some services with extremely low reimbursement may see a near doubling of reimbursement levels under the new arrangement.

Critical care is another winner. Previously, Medicare did not recognize CCT. These services were reimbursed at the ALS level. The new fee schedule includes a relative value and a reimbursement level for specialty care transports, which will be higher than the other ground services.

**Air Medical Services.** Relative values for air medical service have not yet been established per se, but a total reimbursement has been defined and a methodology to allocate these funds to air medical programs is envisioned. The big air medical losers under the fee schedule will be hospital based air medical providers that include air medical expenses on their "Part A" cost report. These providers are reimbursed their costs for providing air services. The

new fee schedule will significantly decrease Medicare reimbursement for these programs. The air medical winners will be THE lower cost air medical programs operating with artificially low reimbursement rates under Medicare "Part B."

**Definition Changes.** All providers will have to redesign their systems in order

positive outcome of the NRM process may be the clarification and definition of covered services and medical necessity. A medical work group toiled diligently on defining what level of service should be covered based upon patient conditions and circumstances rather than strictly by ICD-9 diagnosis codes. This clarification of

work needs to be completed for organizations to respond effectively to the financial impact of the ambulance fee schedule.

Many EMS systems will have to be redesigned in order to accommodate significantly reduced reimbursement. This will require education of their jurisdictions in order to implement more cost effective services, change rates, or redesign the ambulance delivery processes.

Most ambulance services will have to change the manner in which they document treatment on calls, the various service lines provided by the organizations, and in many cases the entire organization may have to be made more cost effective. A number of fortunate ambulance services will need to develop plans on how to effectively manage and use the additional revenue provided under

the fee schedule.

Some ambulance services will receive their delayed Valentine's gifts as they are phased-in over the years 2001 to 2004. Other systems and services are going to have to deal with their unique version of the St. Valentine's Day massacre and make significant changes prior to the beginning of the year 2002. At that point, 50% of the reimbursement will be defined by the fee schedules. More detailed and updated information can be found on the Fitch & Associates website at [www.fitchassoc.com/News.htm](http://www.fitchassoc.com/News.htm).

ESTIMATED RELATIVE VALUES AND ALLOWABLES

Level of Service	RVU	Low	High
BLS	1.00	\$133.13	\$193.32
BLS-Immediate	1.60	\$209.91	\$315.65
ALS	1.20	\$158.72	\$234.09
ALS-Immediate	1.90	\$248.30	\$376.82
ALS 2	2.75	\$357.08	\$550.12
ALS 3 (Specialty Care Transport)	3.25	\$421.07	\$652.07
Fixed Wing		\$2,200.00	\$3,190.00
Rotor Wing		\$3,806.00	\$4,150.00

to define the specific categories that Medicare will be using in the fee schedule. These include BLS immediate and non-emergency, ALS1 immediate and non-emergency, ALS2, and ALS3 or specialty care transport. Determining what type of code to use on each transport will be based on the services actually delivered to the patient. The exact definitions and criteria are expected to be released this summer in the form of a proposed rule by HCFA.

**Medical Necessity Definitions.** A potentially

when a service should be covered and at what level should aid the Carriers in more consistent processing of ambulance claims.

**Action is Required.** Regardless of whether your organization stands to benefit or lose with the implementation of the fee schedule, services will have to prepare for changes in revenue from the largest user group of ambulance services. The fee schedules are to be phased-in over four years beginning January 1, 2001. With rate regulation and locked-in EMS system designs, much

## EMS MEGA-FLOPS ...

Not all EMS and healthcare trends predicted for the 1990's were successful. Here is our "top ten list" of flops:

**Expanded Scope.** The positive potential for practice changes were stymied as other healthcare professionals protected their turf.

**Mini-Mods.** While some services loved these lighter, single rear wheel units, so did the manufacturers that sold them replacement units earlier than expected.

**EMS/MCO Contracts.** Many MCOs never expressed serious interest in capitating EMS on a national scale.

**NYC\*EMS.** Sweeping

improvements were predicted for New York City's EMS. Despite moving the unit from Health and Hospitals to the fire department, it remains an embarrassment.

**Volunteers.** The death of volunteer EMS systems didn't happen. Many successfully transitioned to combination paid/volunteer community based organizations.

**Wall Street EMS.** Investor interest in ambulance service was initially hot and then turned as cold as a DOA. AMR/Laidlaw and Rural Metro stock prices both plummeted

to a fraction of previous value.

**The Clinton Reform Plan.** Interest fizzled in the federal government's attempted hostile takeover of healthcare.

**The "CPR Plunger."** After less than six months of trials, the device heralded to save lives was withdrawn from the market.

**Pen Based Computers.** Predicted to be in every ambulance by the end of the decade, hand held PCR systems still show promise but haven't caught on.

**EMS Oligopoly.** Another EMS consultant predicted that there would only be six or eight ambulance services left by the end of the century. Oh well!

## PHYSICIAN CERTIFICATIONS

A HCFA program memo issued February 1, 2000 outlines options if a physician signature cannot be obtained.

Providers must either obtain a physician signature or from a PA, NP, CNS, RN, or discharge planner employed by the facility who has knowledge of the patient's condition. If it cannot be obtained within 21 days, the service must document its attempt to obtain the signed statement from the attending physician.

A copy of the memo is posted on our website at [www.fitchassoc.com/News.htm](http://www.fitchassoc.com/News.htm).

### Fitch & Associates Upcoming Events

#### 2000 LEADERSHIP CONFERENCE

JULY 27-29, 2000

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KANSAS CITY, MISSOURI

*Fitch & Associates can provide keynote speakers and/or workshop leaders for banquets, educational workshops, and conferences sponsored by your organization. A wide variety of topics presented in different styles and formats are available.*

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