MANAGEMENT FOCUS

— For Providers of Emergency Medical Services —

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TRANSITIONING TO THE FEE SCHEDULE…

Lobbying efforts continue but the stark reality is that a fee schedule will be implemented. Reaction has been mixed but surprisingly apathetic. "This will be devastating to both public and private providers by year 2 or 3," according to David Nevins, Director of the California Ambulance Association.

The schedule completely changes how ambulance services are reimbursed. In essence it is a formula that takes into account: the type of service provided, whether an emergency response was required, geographic variations in the cost to produce the service, mileage, and if the assignment was in a rural or urban area.

The fee schedule has an effective date of January 1, 2001 and will be phased in over 36 months (see related story). A link to the proposed rule and an interactive impact calculation worksheet is available at www.fitchassoc.com.

For years, EMS and local government have cost shifted uninsured care expenses to Medicare. Local communities reduced direct tax subsidies and relied upon 3rd party payers. With the implementation of the fee schedule, HCFA shifts a large burden back to local governments. In those communities in which increased efficiencies or subsidies are not possible, EMS service levels may deteriorate if leaders are unable to articulate the issues for their Councils.

While some fire agencies think this is good news, others believe they may be required to assume providing EMS service with limited reimbursement causing additional strain on fire budgets. In communities like San Diego, the impact will be immediate and dramatic. Next year, its annual EMS revenue is estimated to decline $2.5-$3.0 million.

For hospitals, the impact is equally dramatic and negative. On average, hospitals services have been paid for their costs (almost 2/3 more than other providers for the same service). Many hospitals have internally used a blended reimbursement rate making it difficult to discern profit and losses. Beginning next year the losses will become apparent.

Private providers are hardest hit. In many cases, other services can tap subsidies or reserves. Private providers cannot. According to a statement by the AAA, "the fee schedule institutionalizes a policy of reimbursing ambulance services at levels dramatically below the cost of providing services."

This significant revenue reduction comes at a time when the economy is strong. Entry level workers are in short supply. EMS labor organizations are confident and are taking a hard line that they should not shoulder the required cuts. Labor is also resisting scheduling changes, modern deployment and changes that could reduce costs without salary reductions. This trend will modify over the next 3 years as the full fiscal impact of the rule's implementation is felt.

Major EMS system design changes and a wave private sector bankruptcies

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AREAS OF CONCERN

The Proposed Rule and HCFA Transmittal introduce a number of areas for concern. These include:

- The definition of emergency is not the same in the HCFA transmittal to carriers and intermediaries as proposed in the Rule.
- The definitions of ALS and ALS 1 are not consistent within the Rule and do not match the consensus definitions arising out of negotiated rulemaking.
- Prior to the Proposed Rule, multiple patients transported in the same ambulance were reimbursed at the full amount. Some carriers required sharing of the mileage between the patients. The new Rule would apportion the base and mileage rate among all of the patients transported. In other words the allowable would be reduced by 50% if two patients were transported and 67% if three were transported, regardless of payer.
- The definition for coverage of rotary and fixed wing aircraft services does not adequately address the patients' need for timely transport, nor does it consider the higher level of care available in most air medical programs. The Proposed Rule ignores information provided by the Committee's Medical Work Group on coverage of air services based on the patient's condition.
- The intent of the GAF or GPCI modification is to take into account the variable costs of doing business in differing geographic areas. By applying the GPCI to the point of pickup (particularly for air medical services) it does not reflect the cost of the provider/supplier's business. This is especially true for personnel costs. Personnel costs are largely dependent on competition for nursing

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EMS & HOSPITAL TRENDS & NOTES

Taigman "Gets Lucky" EMS author Mike Taigman, stopped at a light on his motorcycle, was struck by a hit & run drunk driver traveling 50 mph last month in Las Vegas. According to Taigman, "you know it's a bad day when you wake up to hear a medic discussing decompressing your chest." After conducting his own assessment, Mike convinced the medic of his bilateral breath sounds. He walked out of the trauma center several hours later with a bad case of road-rash, a different perspective on being a patient and knowing he beat the odds.

Franchise. Final approval for a non-emergency franchise was granted to Southwest Ambulance in Las Vegas in October. AMR will continue to provide emergency services.

Consolidators. Laidlaw tells bondholders it is hopeful the sale of AMR will be finalized in the first quarter of 2001. Rural/Metro's auditors say financial pressures raise questions about the company's ability to stay in business. "These as well as other matters raise substantial doubt about its ability to continue as a going concern."

Currents. Currents in Emergency Cardiovascular Care, the official publication of the American Heart Association and Citizen CPR Foundation, is now available on-line. Published quarterly, Currents is an excellent resource. To receive a free email notice when each issue goes on-line send your email address and request for currents email notice to info@currentsonline.com.

FEE SCHEDULE SEVERELY IMPACTS SERVICES

The fee schedule will negatively affect key service performance areas.

Taking assignment. Beginning 01 January 2001, ambulance services must take assignment. Services that have relied on balance billing to make up for shortfalls in Medicare reimbursement will no longer to be able to bill the patient more than the deductible and 20% co-insurance amounts allowed by Medicare.

ALS reimbursement for all calls or all emergency calls. Some carriers reimbursed at the ALS level for all emergency calls and in some localities for all calls including non-emergency. The new schedule bases reimbursement on the actual treatment received by the patient. There will be no phase-in for this change that will significantly impact services receiving all ALS reimbursement.

Hospitals. Hospital-provided ambulance services (air and ground) have been reimbursed on a reasonable cost basis instead of a fee-for-service basis. This allowed hospitals to recoup their costs through reconciliation of the "cost report." By HCFA's figures, hospital costs were 66% higher than Part B supplier's charges. The new schedule will shift a significant amount from Part A hospital ambulance services to Part B services. HCFA believes it will save at least $19 million dollars. This dramatically understates the total loss to hospitals.

Areas with high reimbursement. May areas of the country have achieved relatively high reimbursement. In a number of states, the reimbursement for ambulances have been increased through equity adjustments and inherent reasonableness by demonstrating to Carriers and HCFA inappropriately low reimbursement levels.

High costs due to mandated performance requirements. Many jurisdictions mandate high performance levels for their ambulance services. The mandated performance levels may include short emergency response times and paramedic personnel on all ambulances. These services will not be able to reduce costs to match reductions in reimbursement without changes in local ordinances or contracts.

Regulated rates by a state or local government. Many jurisdictions including states, counties, parishes, and municipalities regulate ambulance rates. Most of these regulations require certain supplies and services to be charged at stipulated rates. Medicare will no longer allow any charges other than the base and mileage fees. These jurisdictions also regulate the amount that can be charged. It may be impossible for ambulance services to increase rates to mitigate the impact of the Fee Schedule.

Multi-year agreements with jurisdictions. To improve stability of its ambulance providers, jurisdictions have entered into multi-year contracts with ambulance providers. These contracts mandate charge levels and performance standards. With reduced Medicare reimbnursement, services may opt to terminate contracts early.

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ASSESSING THE FEE SCHEDULE IMPACT

Determining the fee schedule impact is the task facing ambulance services throughout the nation. It is complex because the impact is different for each provider. Factors include: cost of living adjustment, rural and urban service area designations, procedure codes, and specific phase-in implications. In addition, the Program Memorandum leaves specifics open to interpretation by carriers.

Cost of Living Differences. The factor used to adjust for regional cost differences is the Geographic Practice Cost Index (GPCI) applied to physician payments. Only the Practice Expense portion of the GPCI is used in the calculation. For ground ambulance services, the GPCI is applied to 70% of the base rate. The GPCI is applied to 50% of the base rate for air ambulance services.

Rural Area Modification. Metropolitan Statistical Areas (MSA) with the Goldsmith modification is used to determine whether a patient is picked up in a rural area. If the patient were picked up outside of a MSA, the provider/supplier would be entitled to add-on amounts.

A ground ambulance service is entitled to an additional 50% for the first 17 loaded miles up to a maximum total allowable of $7.50 per mile. An additional 50% for the base rate and all loaded miles is granted to air medical services for rural patients.

New Codes. New HCPCS codes will be required. The new codes are identified in the proposed rule. Only codes for base rate and mileage will be allowed for Medicare claims. HCFA is considering using a number of conditions and symptoms as the basis for reimbursement rather than the standard ICD-9 codes.

Phase-In. While the phase-in is described as being four years, the impact of the fee schedule (positive or negative) will be experienced over the first three years of the fee schedule.

Program Memorandum. HCFA has already provided a program memorandum (AB-00-88) to the carriers and intermediaries for implementation of the rule. There are some discrepancies between the proposed rule and directions HCFA is providing to the carriers and intermediaries for implementation.

COVERED SERVICE	ALLOWABLE
BLS	$157.52
BLS-Emergency	$252.03
ALS 1	$189.02
ALS 1-Emergency	$299.29
ALS 2	$433.18
Specialty Care Transport	$511.94
Paramedic Intercept	$275.66
FW Air Transport	$2,213.00
RW Air Transport	$2,573.00
Ambulance Loaded Mile	$5.00
FW Loaded Mile	$6.00
RW Loaded Mile	$16.00

These amounts are adjusted for two factors based on the location of patient pickup. One adjustment is for the cost of living differences of providing services in different geographic areas--the Geographic Adjustment Factor (GAF). The second adjustment is aimed to provide a higher level of funding for rural services.

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Areas of Concern

and paramedical personnel. Air services attract these employees from around their local bases, typically a metropolitan area. The vast majority of the air medical Medicare patients are picked up in rural areas that have lower costs of living. Therefore, the GPCI does not have the intended effect of offsetting the variation in the cost of doing business based on geographic factors.

- Literal reading of the Proposed Rule would indicate that an air medical provider would be reimbursed at the BLS base rate ($157.52) if the patient were to die prior to arrival of the aircraft or prior to transport of the patient. Current practice would be for the provider to be reimbursed its normal air base rate in such circumstances.
- There is a huge differential between payments to rotary wing air medical providers that pick up patients in rural areas, versus those services that pick up patients in MSAs. The average allowable for a rural rotary wing patient (base and mileage) will be $5,515.50 while the average for a patient picked up in a MSA will be $3,329. This represents a 71% differential.

Final Concern. One statement in the Proposed Rule should cause serious concern. The Rule states: *"Moreover, the Congress did not require that payment under the ambulance fee schedule be budget neutral to the current reasonable charge system, but rather specified only that the aggregate amount of payments for ambulance services not exceed the amount that would have been paid absent the fee schedule."*

This statement indicates that HCFA is not worried about insuring that the total amount of funds paid for ambulance services are retained at previous levels even after reducing the total by $67 million. It also demonstrates the inability of HCFA, or anyone else, in determining the full impact of the Fee Schedule on the nation's ambulance providers.

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Transitioning...

will result if internal economies cannot be achieved and/or subsidies or relief under the schedule is not granted. The AAA estimates that "over $5 Billion in new Medicare money would be required over the next 5 years" to avoid the reimbursement train wreck. Even though it is an election year, that level of adjustment is unlikely.

Fitch & Associates has developed a "12 step plan" of internal and external strategies to mitigate the impact of the rule's implementation for its clients. Jay Fitch, PhD will be presenting a summary of that information at the AAA annual conference in November. After that presentation, it will be downloadable from the firm's web-site.

LA PARAMEDICS STRUGGLE...

Stress and dispatch errors top the list of problems for the City of Los Angeles. A Psychologist studying LA paramedics indicate that more than half show signs of emotional exhaustion that could affect patient care.

According to Dr. Robert Scott, paramedics wander in with dull eyes and vacant faces, "cynical" and "bitter." Medics handle as many as 20 calls in a 24 hour shift and are forced to remain on duty for overtime shifts, contributing to record attrition levels. Administrators cite seniority rules and other factors that preclude them from shifting medics between slow and busy stations.

Paramedics have long been critical of department management. At a recent hearing a veteran paramedic told commissioners that the department "excels at putting out fires. But when it comes to medicine...I don't think they could manage a lemonade stand." Fire Commission president acknowledged the changing role. "In truth and in fact, we are not a fire department as much as we are an EMS department...that occasionally puts out fires."

To alleviate the staffing shortage, Mayor Richard Riordan announced an emergency initiative to hire 100 paramedics within 6 months. That plan has to be approved by the US Justice Department that has required FD recruitment from within the city since 1974. The emergency plan has been criticized. It is not realistic because "emergency" personnel cannot work for more than eight months, according to city policy. Emergency hires would also not be eligible for standard benefits and pension, according to the President of the firefighters union.

Improper dispatching has been tied to at least five cases this year in which patients died, according to the *LA Times*. The most recent case involved a dropped call that resulted in a nearly 20 minute response time to a heart attack. Medics ultimately responded within 4 minutes from a station several blocks away. In that case, the call taker went home at the end of the shift before dispatching the call. The oncoming dispatcher inadvertently cleared the screen. When the party called again, the 3rd dispatcher gave the call a low priority and noted that the caller was belligerent. None gave the caller pre-arrival instructions.

An internal FD report previously concluded that the dispatch center was in "dire need of complete revision." Two of the dispatchers in the most recent case were reprimanded and another was given a "notice to improve." One of those reprimanded had been previously counseled after a March incident in which a patient died, according to the *Times*.

The department reported that it recently took steps to enhance dispatch oversight, increase training and ensure that dispatchers do not stray from MPDS questions for the 275,000 medical calls it handles annually.

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