Emergency Medical Services in Pennsylvania

The EMS System in Crisis

A Two-Phase Solution

Presented by:

The Ambulance Association of Pennsylvania
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>Background</td>
<td>4</td>
</tr>
<tr>
<td>The Financial Picture for EMS in Pennsylvania</td>
<td>5</td>
</tr>
<tr>
<td>The Solutions</td>
<td>11</td>
</tr>
<tr>
<td>The Cost If We Don't</td>
<td>14</td>
</tr>
<tr>
<td>Summary</td>
<td>14</td>
</tr>
<tr>
<td>Appendices</td>
<td>16</td>
</tr>
<tr>
<td>Works Cited</td>
<td>21</td>
</tr>
</tbody>
</table>
Executive Summary

This report will outline for legislators and other key stakeholders the current crisis facing the entire EMS (emergency medical services) system in the Commonwealth of Pennsylvania and provide a two-phase plan that will help alleviate much of this burden.

As part of that plan, it will propose a long-term solution to the problem faced by many recipients of the Department of Public Welfare (DPW) program. Often, these patients feel they have no access to standard healthcare delivery systems and therefore rely upon the EMS system as their portal or point of entry into the system. Not only does this place a significant burden on an EMS system ill-equipped to manage this burden, it drives up health care costs.

- According to a 2000 study reported in the American Journal of Emergency Medicine, “There was an association between increasing poverty level and use of EMS.”

- Trends and Characteristics of US Emergency Department Visits, 1997-2007
  Ning Tang, MD; John Stein, MD; Renee Y. Hsia, MD, MSc; Judith H. Maselli, MSPH; Ralph Gonzales, MD, MSPH, JAMA. 2010; 304(6):664-670. doi:10.1001/jama.2010.1112

- A study conducted by physicians in West Virginia concludes that homeless people are more likely than other patients to arrive at U.S. hospitals by ambulance, and more than twice as likely than other patients to be uninsured. The study analyzed 500,000 emergency department visits by homeless people. It found that one-third of homeless patients arrived by ambulance, an exercise which costs almost a total of $67 million.

- Emergency Medical Services is an essential public service and frequently the health care safety net for many Commonwealth residents. Act 37 of 2009 – the Emergency Medical Services Act Declaration of Policy.

If implemented this plan would:

1. Improve healthcare delivery and access to care for all citizens through their EMS system
2. Improve access to care for clients of the DPW system
3. Help to significantly strengthen the financial status of an over-burdened EMS system
Background

Ambulance services (EMS Agencies) across the Commonwealth of Pennsylvania and the nation continue to be greatly underfunded. National studies, including a report from the United States General Accounting Office (GAO) completed in 2007 and 2012 found the reimbursement levels significantly below the cost of actually providing the service. Most of these reports focused upon Medicare payments, the Federal Government’s program available primarily for senior citizens. Medical Assistance is the Commonwealth’s program for funding healthcare for people who are economically disadvantaged. This program funds the EMS (emergency medical service) system at levels significantly below the Medicare reimbursement levels.

This chronic underfunding has lead to several challenges which are outlined later in the report. Uncorrected, this funding crisis will continue to exacerbate those problems resulting in reduction in access to care and poor outcomes for patients in need of the highest quality of care.
Increasing expenses

The EMS community has been especially hard hit in the past several years with expenses that are seemingly out of control.

Fuel Expense
Gasoline and helicopter fuel expense increased significantly during the past four fiscal years. Although fuel cost, as of this writing has eased to some degree, it remains an excellent example of the challenge facing EMS services; the reimbursement levels are the same when the fuel is $4.00/gal as they are when it costs less. The only way to offset the increase in expense is to “take it away” from someplace else. We must make the decision about whether to put fuel in the vehicles or fewer ambulances on the streets. (See Appendix I on page 16 for a Sample Chart of the rising cost of fuel and its’ financial impact)

General Liability and other insurances
Liability and other insurance for EMS Agencies, like all “malpractice” insurances in the Commonwealth of Pennsylvania have increased. Most notably, health care insurance, a key recruiting and retention tool, is also one of the most expensive. Projected increases for the next calendar year alone are in the range of 10-30%. (See Appendix II on page 17 for a breakdown of the average on the health insurance premium costs from 2005 to 2009 from Tucker, Johnston & Smeltzer)

Families USA published a 2009 report, “Costly Coverage: Premiums Outpace Paychecks in Pennsylvania,” in which they note in their Key Findings that “Health insurance premiums for Pennsylvania’s working families grew quickly over the last 10 years, increasing by 95.2 percent from 2000 to 2009. (See Appendix II on page 18 for a copy of a Table from their report.)

In addition, cuts are occurring in benefits for EMS employees as a means to reduce costs. (2009 JEMS Salary & Workplace Study)

Patient care and other necessary equipment / technology
The equipment used to deliver patient care and the requirements for the vehicles used to deliver the service continues to change. Technological advances arrive faster and are available in greater numbers than ever before. Great news for patients, but our ability to take advantage of these advances for the improvement of patient care becomes more difficult.

See 41 PA Bulletin 2296, April 30, 2011 for the full listing of required Ground and Air Ambulance Equipment and Supplies

Defibrillator Monitor (AED) Costs
1) Fully equipped ranges from $38,000 to $50,000 depending on Manufacturer
2) Ongoing disposable supplies: Pads ranges from $38 - $50, battery packs range from $150 to $300

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CPAP/Ventilator Costs
1) Stand Alone sets range from $2,000 to $5,000
2) Regulators with onboard oxygen range from $500 and upward
3) Procedure pack with masks, hoses, etc. range from $40 to $50

Providing this equipment in all of the vehicles contained in the 392 licensed ALS (advanced life support) and 618 licensed BLS (basic life support) services (Bureau of EMS Statistics on page 14), many of which have several vehicles that need to be equipped 24 hours a day/7 days a week, can save countless lives.

The American Heart Association notes, “Pre-hospital electrocardiograms (ECGs) can significantly reduce the amount of time to reopen a blocked artery after a STEMI heart attack” (American Heart Association, 2008). Scientifically proven, this diagnostic treatment modality makes a difference in patients’ outcomes but carries a hefty price tag.

Completing this project for one service in Northeastern Pennsylvania (Community Life Support in Clarks Summit) with 6 ALS vehicles has cost $135,000 for Philips MRX Devices. Additionally, cellular carriers charge an additional $50.00 per month or $3,600 per year for the ALS vehicles, allowing for data transmission of the 12 lead reports. Each device is capable of transmitting complete 12 lead ECG tracing to STEMI hospital emergency room, cardiac catheterization lab and on-call interventional cardiologist. Transmissions are sent by combination email and facsimile.

Another service in the Philadelphia area (Burholme EMS) has experienced similar costs for this technology.

Although this technology is an initiative of the American Heart Association, (Mission: Lifeline) including a full ST-elevation myocardial infarction (STEMI) Protocol for EMS and scientifically proven to be of benefit to patients, the technology to provide this life saving technology remain unfunded and has not resulted in an increase in reimbursement from any of the third-party payers, including Pennsylvania’s Medical Assistance program to help offset the cost.

Reimbursements – The “Declining” Reimbursement from DPW

The DPW reimbursement for the provision of EMS services in the Commonwealth of Pennsylvania is as follows:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Support</td>
<td>patient required transport with EMTs but did not require advanced monitoring or treatment</td>
<td>$120.00 – base fee</td>
</tr>
<tr>
<td>Advanced Life Support</td>
<td>patient required monitoring or treatment by EMT-Paramedics or higher</td>
<td>$200.00 – base fee</td>
</tr>
<tr>
<td>Mileage</td>
<td>paid after the first 20 miles. If the patient is transported less than 20 miles, there is no mileage reimbursement.</td>
<td>Only $2.00 per mile after 20 miles</td>
</tr>
</tbody>
</table>

This reimbursement structure has not changed for the past ten years. With annual inflation rates considered, it is easy to see why there is a “declining” reimbursement; there is no
mechanism to adjust for rising expenses. Regardless of what the expenses are or what amount an EMS Agency bills, this is the most we can collect for a patient with DPW coverage.

This fee structure is below the reimbursement level received from Medicare and far below the cost of actually providing the service. As a comparison, Medicare reimbursements are nearly doubled for comparable services at both levels as compared to Medical Assistance.

While that may sound like good news, we must remember that according to national studies, Medicare reimburses between 6 – 14% below the cost of actually providing the service (Ambulance Providers, 2007). Many believe this is a conservative estimate with the actual disparity being much worse.

According to the statistical information gathered by the Ambulance Association of Pennsylvania (AAP), the graphical representation of the “payer mix”, i.e. the volume of patients represented by the entity which pays for the ambulance transport, is:

2007 – Statewide Average (range of individual percentages by EMS agency)
- Medicare: 41% (0 – 80%)
- Commercial: 24% (0 - 63%)
- Medical Assistance: 9% (0 – 45%)

2008 – Statewide Average (range of individual percentages by EMS agency)
- Medicare: 44% (10 – 90%)
- Commercial: 24% (0 – 60%)
- Medical Assistance: 13% (0 – 45%)

Currently, DPW patients account for an average 13% statewide and up to 45% for individual EMS Agencies. This number is only expected to rise with the current economic climate and the uncertainty of the impact of the recent passage of the health care reform act on the EMS system.

“More than 2.2 million Pennsylvanians are eligible for Medicaid....” “It is the highest number on record, representing nearly 18 percent of the population – more than one is six Pennsylvanians....” September 22, 2010 article in the Courier Express entitled, “Medicaid numbers hit record in Pa.”

According to the March 20, 2010 Christian Science Monitor’s Health Care Reform Bill 101, by the year 2014 “The cutoff level would be an income of four times the federal poverty level. For one person, that’s about $44,000 a year. For a family of four, the comparable figure is about $88,000.”

**Interesting to note that many EMS providers will also be eligible to receive Medical Assistance benefits.**

From a financial perspective, these patients whose services are paid for by DPW represent at least 20% of the volume or work load on the system; they contribute less than 9% of the
needed revenue for ground EMS and only 2% of the revenue for air medical use to help support those services (Appendix III on page 19 for a sample of the fiscal impact on an EMS Agency).

*Imagine how long a McDonald’s or any business would continue if nearly one-fourth of their customers paid only 2 – 9% of the cost of their product.*

**The Disturbing Results – “Where the rubber meets the road”**

When costs go up and the revenue that covers those expenses does not, there are limited choices to make and none of them are good for a well-managed service that has no “frills” to cut.

The following is a brief listing of the actual consequences of this underfunding:

1. Inability of EMS Agencies to pay adequate wages to employees in order to recruit and retain adequate staffing, especially EMT-Paramedics who deliver the advanced life support care.
2. Fewer ambulances available at peak demand times which results in longer response times.
3. Ambulance services are unable to leverage technological and clinical enhancements such as new treatment modalities as quickly or at all.
4. Inadequate resources to respond to catastrophic events such as tornadoes, multiple car accidents on interstates and potential terror attacks.

To fully understand the impact of these, we will examine, more in-depth the ramifications of each of these issues.

*Inability of ambulance providers to pay adequate wages...*

The talented and skilled EMTs and EMT-Paramedics that provide service in the Commonwealth of Pennsylvania are, as in any service industry the “life-blood” of the industry. Asked to work long hours, in busy, uncontrolled and dangerous settings, often alongside police officers and firefighters, the EMS personnel are almost always paid far below the level of their brothers and sisters in the other public safety professions.

According to a recent survey completed by the AAP, an EMT-Paramedic in a rural location in Pennsylvania can be paid as low as $10.00 / hour as a starting rate (2007 AAP Salary and Benefits Survey...p 3) or about $22,000 annually. Firefighters as an example can expect to earn around $36,000 annually with less than one year’s experience (Salary Report...2008). With disparities such as these, the EMS profession continues to lose qualified, gifted EMTs and paramedics to other professions such as firefighting and nursing.

*Fewer ambulances available at peak demand times...*

As you can imagine, EMS is not a “9 to 5” business and a majority of it has no routine or set schedule. EMS has to be ready 24 hours a day/7 days a week regardless of the weather. Unlike making an appointment to see a physician, a patient does not choose the time they will awake with chest pain or schedule a fall from a ladder. The best management practice we can use is to look at historical data and “predict” how many ambulances should be on duty at any given
time. When budgets become impossibly tight, finances, rather than historical demand dictate how many units may be available at any given time.

The outcome of this from the patients’ perspective is longer response times and delays in getting definitive treatment. Cardiac arrest patients, the “gold standard” by which EMS system performance is usually measured is among those most affected by even a slight delay. It has been well documented that for every minute a cardiac arrest patient waits for defibrillation, there is a 7-10% less chance of survival (Adams, 2005).

When a patient suffers a critical illness such as the STEMI mentioned earlier or a trauma, both of which are “time dependent” disease processes, the speed with which they can be transferred from a regional, community hospital to a tertiary care center capable of the advanced treatment they require is often the determining factor in their long-term prognosis.

When suspected STEMI patients are identified, they are typically transported directly to the catheterization suite for appropriate interventional treatment. In the first six months of use, this EMS Agency has documented over 12 STEMI interventions where rapid diagnosis allowed patients to undergo almost immediate angioplasty and coronary stenting and AVOIDING costly by-pass surgery as well as prolonged hospitalization. This has saved hospitals thousands of dollars on each of these cases. (Community Life Support in Northeastern Pennsylvania)

“Faster treatment also resulted in the average hospital stay being two days shorter (falling from five days to three days), and the average hospital costs per admission declined by nearly $10,000, from $26,826 to $18,280.” (AHA News 2008, Swift System for Heart Attack Care Improves Treatment, Cuts Costs)

“Every year, almost 400,000 people experience ST-Elevation Myocardial Infarction (STEMI) - the deadliest type of heart attack. Unfortunately, a significant number don’t receive prompt reperfusion therapy, which is critical in restoring blood flow. Worse yet, 30 percent of STEMI victims don’t receive reperfusion treatment at all. Mission: Lifeline™ seeks to save lives by closing the gaps that separate STEMI patients from timely access to appropriate treatments. Although Mission: Lifeline is focusing on improving the system of care for the nearly 400,000 patients who suffer from a STEMI each year, improving that system will ultimately improve care for all heart attack patients.” The American Heart Association Mission: Lifeline

The speed of that transfer or treatment depends upon the resources available from the local EMS system. Those resources are determined to a great degree by the financial status of the system and that financial status continues to be weakened every day by the poor reimbursement structure of the DPW.

Ambulance services unable to leverage technology...
As noted earlier, the speed of change and advancements in both technology and treatment modalities is faster than at any time in our history. There is presently no mechanism to enable the EMS system to offset those expenses without cutting back on services. This leaves us with the difficult decision to remain "status quo" and ignore potentially life-saving processes or implement and gamble in other areas such as longer response times.
Inadequate resources to respond to catastrophic events...
Without adequate resources to meet day to day needs, having the surge capacity to respond to disasters and other catastrophic events becomes greatly compromised. Although no system can respond to every event 100% of the time, this gap between acceptable performance during a disaster and poor performance is widening every day.

The gap widens not just due to lack of personnel and equipment. Training, an essential part of successful performance in situations that happen infrequently, is vital. Training is, however, one of the areas that has to be “scaled back” when budgets are tight.

Abuse of the System

A growing number of Medical Assistance recipients know that if they call 911 and use a number of key terms, like shortness of breath or chest pains, they will have an ambulance at their door. These “patients” are not truly patients with a medical condition but simply want a “ride” to a non-medical destination.

The EMS Agency does not get reimbursed for this expenditure of personnel and equipment, nor can they send a bill to the Medical Assistance beneficiary who abuses the system. In addition, these recipients are taking valuable resources and limiting the access to care from residents who truly need emergency services.

Medical Ambulance Transportation for Non-Emergencies

Across the Commonwealth, many EMS Agencies supply their communities with medically necessary ambulance transportation to and from outpatient services as well as medically necessary medical ambulance transportation upon discharge from inpatient services. Through recent changes in many medical assistance coverage categories, non-emergent ambulance transportation has been dropped or has never been included. EMS Agencies are only permitted to bill Medical Assistance recipients after first “advance noticing” the beneficiary of their payment responsibility for these types of services. In many instances, the EMS Agency has no knowledge of the patient’s insurance coverage until well after the transportation has been provided and therefore has no ability to “advance notice” the beneficiary. This is a vital service that EMS Agencies are performing throughout the Commonwealth and no monies are being paid in support of those efforts.

Act 37 of 2009, Section 8129(c) states, “that operation by an entity...to transport a person who is known or reasonably should be known by the entity to require medical assessment, monitoring, treatment or observation during transportation shall constitute unlawful operation of an ambulance...” And further, “unlawful operation includes, but is not limited to, the transportation of the person to or from a facility, a physician’s office or any other location to receive or from which the person received health care services.”
The Solutions

We believe there are both a short-term fix and a long-term strategy which can help relieve the burden upon EMS systems and continue to improve access to care. It can save the health care system and the DPW money while at the same time, improve the health and quality of life for DPW patients.

Short Term Solution

Reimbursements must increase to make certain the DPW pays their share of the cost of providing the ambulance resources which communities and the DPW patients need. The increase in payments for ambulance transportation is, we believe a small percentage of the total DPW budget. (See Appendix IV on page 20 for the estimated cost to increase the reimbursement rate to the Medicare Allowable).

Increasing the funding to AT LEAST the Medicare fee schedule level and developing a long-term strategy for how to better manage the patients who use the emergency services system simply because they see no other choice will strengthen our EMS system.

55 PA Code § 1150.62. Payment levels and notice of rate setting changes.

(a) The Department will establish maximum payment rates for MA covered services. The established maximum payment rates will not exceed the Medicare upper limit.
(b) The Department will issue public notice of changes in Statewide methods and standards for setting payment rates as required by Federal law.

The AAP and its members across the Commonwealth are ready to work closely with the legislature to find real world solutions to ensure EMS companies receive fair and adequate reimbursement for the transport of Medical Assistance recipients.

Long Term Strategy

One of the reasons that DPW patients make up a disproportionate segment of emergency services, both in ambulance transports and visits to emergency departments is they have few if any options for access to healthcare.

Physician offices, dentists, and other “non-emergent” members of the health care community have the ability to deny service to patients, especially to DPW patients. This helps lessen the financial burden on the practices but leaves these patients without preventive health care and no options with disease processes that could normally be managed with a doctor’s office visit rather than a trip to an emergency department.

DPW Liaison/Ombudsman with Medical Transportation Knowledge
EMS Agencies (ie ambulance service providers/suppliers) fall outside the realm of the normal health care provider/supplier population, ie. hospitals, physicians, outpatient services. Thus, leaving the ambulance service provider organization reimbursement issues unattended. DPW consistently forces the ambulance service provider/suppliers to adhere to policies formed for
main stream health care causing significant gaps in compliance and reimbursement. Therefore, we recommend a dedicated DPW Liaison/Ombudsman with knowledge of the Medical Transportation industry to address ambulance policy and reimbursement issues.

**Reinstitute the crossover payments for dual eligible (Medicare/Medical Assistance) patients**
In 1998, when the legislature removed the crossover payments for these dual eligible Medicare/Medical Assistance patients, the industry lost a significant amount of reimbursement for their essential service. The dual eligible population is not currently tracked by the Department. (Appendix V on page 21 provides an estimate of the costs to reinstitute these costs.) The dual eligible population is not currently tracked by DPW.

**Update Outdated Policies**
Current regulations and policy within DPW/Office of Medical Assistance Programs (OMAP) are significantly outdated and over the years, with the advancements in technology and the delivery of health care, we no longer can continue to provide service based on transport. The payment should be based on delivery of care in accordance with the levels of service Health Care Procedure (HCPCS) codes adopted by OMAP in the 1990’s.

The controlling legislation and regulation for the development, implementation and operation of the EMS system in the Commonwealth is Act 37 OF 2009. Included in the statute are mandates for EMS agencies to obtain and maintain Department of Health licensure, definitions that describe and identify various entities, personnel, end users and other aspects of the EMS system. It appears that several areas of the Department of Public Welfares’ (DPW) regulation, as it relates to the audit, are in conflict with ACT 37. In essence the Commonwealth has mandated a requirement to respond, treat and transport, which includes a DPW beneficiary; however, in many cases now we are being informed that the Commonwealth will not reimburse the EMS agency for that service.

**Emed Health**
EMS providers are highly skilled clinicians capable of providing intensive care for life threatening emergencies. However their role in the healthcare system has been limited to providing medical transportation services in most communities. AAP has partnered with an innovative program out of Pittsburgh known as Emed Health that is trying to improve access to care and broaden the services provided by community EMS agencies to include health promotion and disease management activities.

Many of the desired changes in the healthcare reform initiatives would be best conducted in the community setting. Emed Health’s programs have been able to demonstrate that EMS providers are capable of helping to prevent illness and mitigating the costs of chronic diseases. Not only have these programs been successful at improving the access to and quality of care provided to its patients, but they are capable of generating savings significantly greater than the costs to run the program. For example, one EMS-based asthma management program in a low-income community generated more than $10 in savings for every dollar invested in the program.

AAP strongly encourages legislators to include the AAP, PEHSC, and the Bureau of EMS as an integral part of the planning process for healthcare reform initiatives. By utilizing the clinical skills of our EMS providers in these non-traditional roles ambulance services may be able to...
generate additional revenue to help subsidize the costs of providing emergency medical care 24 hours a day.

**Uncompensated Care Costs in EMS**

Similar to other medical providers, EMS agencies provide a substantial amount of uncompensated care. Estimates of the uncompensated care costs borne by EMS agencies range from 2% to 50% of their total billable revenue. However, unlike other medical providers, EMS agencies are currently unable to submit a bill to patients for providing the medical care that ultimately resolves their medical issue. Current Medical Assistance regulations only reimburse EMS agencies for their transportation to an emergency department, regardless of the medical treatment provided before or during the transport.

Many medical emergencies such as drug overdoses, asthma attacks and certain diabetes emergencies may be successfully remedied in the field by paramedics providing the same medical treatments as would be provided in the emergency department. Commonly, patients who receive the treatment and begin to feel better immediately, refuse to be transported to the emergency department for further evaluation. Despite having treated the patient using advanced life support skills, expensive drugs and medical equipment, the ambulance service providing care cannot recover its costs for providing the lifesaving care if the patient interaction did not result in a medical transport.

The AAP recommends that legislators change the legislation governing Medical Assistance reimbursement to correct this glaring regulatory disparity in reimbursement policy. Providing EMS Agencies the mechanism to receive compensation for providing emergency medical care, regardless of the subsequent need for medical transportation services, would align Medical Assistance reimbursement policies to be consistent with other medical care providers and would reduce the burden of uncompensated care currently carried by community ambulance services.
The Cost If We Don’t

As they say, “the writing is on the wall” if we don’t fix this system. EMS systems are going to continue to decline with more to simply close their doors. Patients in need of better access to care will continue to overuse emergency departments and EMS because it is their only resort. Without fixing this now, everyone who relies upon these vital services will suffer because of the loss of resources.

*Total Number of EMS Agencies in 1999:
  BLS – 672
  ALS – 423

*Total Number of EMS Agencies in July 2010:
  BLS – 618
  ALS – 392

*Information provided by the Bureau of EMS on October 22, 2010.

**Total Number of EMS Agencies in April 2014:
  BLS – 616
  ALS – 385

**Information provided by the Bureau of EMS on April 21, 2014.
Summary

In 2008, the EMS system in the Commonwealth of Pennsylvania responded to over 1.8 million requests for service (Bureau of EMS, 2008 Annual Report). A significant portion of these are patients who will rely upon the Department of Public Welfare (DPW) to pay the cost of the service. The numbers of both total ambulance responses and the percentage of those who are DPW patients will continue to grow.

The payments from DPW to reimburse the ambulance services is far below the cost of providing the service and below the level reimbursed by even the Federal Government via the Medicare program.

The result of this is an “unfunded mandate” from the Commonwealth placed upon all EMS Agencies. These Agencies do not and cannot “pick and choose” their customers, service is rendered without question and concern for who will pay the bill (28 PA Code 1005.10 Licensing and general operating standards and Act 37 of 2009 EMS System Act, 1027.3 with additional caveats). However, in a growing percentage of cases in Pennsylvania, those services are being reimbursed far below the cost of doing business.

This funding gap is one of the primary contributors to the current financial crisis facing the EMS system in Pennsylvania today. This financial crisis is creating shortfalls in staffing and resources which are leading to potentially dangerous response times, limiting access to care, a lack of up-to-date technology and a critical lack of surge capacity to handle extraordinary events such as disasters.

Increasing the funding to at least the level of other third-party payers and developing a long-term strategy for how to better manage the patients who use the emergency services system simply because they see no other choice will strengthen our EMS system. In some locations this may prevent a collapse of the system as well as provide a better “access to care” mechanism for the thousands of disadvantaged patients currently on the DPW roles.
Appendix I – Sample of the Negative economic impact of increasing fuel costs

**Negative economic conditions**

- Cost of fuel 10 cents = $18,800 from bottom line ($13K ground $5.8K air)

![Fuel Cost Graph](image-url)
## Appendix II – Sample of Health Care Costs from Tucker, Johnson & Smeltzer

<table>
<thead>
<tr>
<th>Year</th>
<th>Single Coverage</th>
<th>Family Coverage</th>
<th>Total</th>
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<tbody>
<tr>
<td></td>
<td>Employee Contribution</td>
<td>Employer Contribution</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>$659</td>
<td>$3,536</td>
<td>$4,195</td>
</tr>
<tr>
<td>2006</td>
<td>$898</td>
<td>$3,379</td>
<td>$4,277</td>
</tr>
<tr>
<td>2008</td>
<td>$852</td>
<td>$3,647</td>
<td>$4,499</td>
</tr>
<tr>
<td>2009</td>
<td>$917</td>
<td>$3,832</td>
<td>$4,749</td>
</tr>
</tbody>
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Appendix II Continued – Sample of Health Care Costs

Increases in Premiums for Family Coverage in Pennsylvania, Job-Based Health Insurance, 2000-2009

Source: Estimates prepared by Families USA based on Medical Expenditure Panel Survey (MEPS) data.

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<tr>
<td>Total Premium Spending per Worker (Employer and Worker Share)</td>
<td>$6,721</td>
<td>$13,116</td>
<td>$6,395</td>
<td>95.2%</td>
</tr>
<tr>
<td>Share of Premium Paid by Employer</td>
<td>$5,424</td>
<td>$9,955</td>
<td>$4,531</td>
<td>83.5%</td>
</tr>
<tr>
<td>Share of Premium Paid by Worker</td>
<td>$1,297</td>
<td>$3,161</td>
<td>$1,864</td>
<td>143.7%</td>
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</table>

- For individual health coverage in Pennsylvania, the average annual premium (employer and worker share of premiums combined) rose from $2,467 to $4,782, an increase of $2,315.

- For individual health coverage in the state, the employer’s portion of annual premiums rose from $2,094 to $3,879 (a difference of $1,784), while the worker’s portion rose from $373 to $904 (a difference of $531) (Table Below).

Increases in Premiums for Individual Coverage in Pennsylvania, Job-Based Health Insurance, 2000-2009

* Numbers do not add due to rounding

Source: Estimates prepared by Families USA based on Medical Expenditure Panel Survey (MEPS) data.

<table>
<thead>
<tr>
<th>Premiums By Source of Payment</th>
<th>2000</th>
<th>2009</th>
<th>Dollar Change</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Premium Spending per Worker (Employer and Worker Share)*</td>
<td>$2,467</td>
<td>$4,782</td>
<td>$2,315</td>
<td>93.9%</td>
</tr>
<tr>
<td>Share of Premium Paid by Employer</td>
<td>$2,094</td>
<td>$3,879</td>
<td>$1,784</td>
<td>85.2%</td>
</tr>
<tr>
<td>Share of Premium Paid by Worker</td>
<td>$373</td>
<td>$904</td>
<td>$531</td>
<td>142.6%</td>
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Appendix III

<table>
<thead>
<tr>
<th></th>
<th>Patient %</th>
<th>Gross Rev %</th>
<th>Net Rev %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>10.31%</td>
<td>21.12%</td>
<td>8.14%</td>
</tr>
<tr>
<td>Ground</td>
<td>10.25%</td>
<td>20.66%</td>
<td>9.44%</td>
</tr>
<tr>
<td>Air</td>
<td>17.41%</td>
<td>24.01%</td>
<td>2.02%</td>
</tr>
</tbody>
</table>

Note: Analysis was done using a sample EMS Agencies’ data volumes and payer mix. Anecdotal discussions with other similar services demonstrate this data to be fairly representative.
Appendix IV – Estimated Cost to Increase the Medical Assistance Reimbursement

The data used is based on HEDIS information from the years 2006 and 2007. The information supplied was two years worth of data combined and could not be separated. Therefore the total numbers represented are the combination of the two years. The AAP was not able to obtain more up to date HEDIS data.

<table>
<thead>
<tr>
<th>HCPCS Code and Description</th>
<th>Medicaid</th>
<th>2011 Medicare Minimum</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425 – Ground Mileage</td>
<td>$2.00*</td>
<td>$6.86</td>
</tr>
<tr>
<td>A0426 – ALS Non-emergency</td>
<td>$200</td>
<td>$248.82</td>
</tr>
<tr>
<td>A0427 – ALS Emergency</td>
<td>$200</td>
<td>$393.96</td>
</tr>
<tr>
<td>A0428 – BLS Non-emergency</td>
<td>$120</td>
<td>$207.35</td>
</tr>
<tr>
<td>A0429 – BLS Emergency</td>
<td>$120</td>
<td>$331.76</td>
</tr>
<tr>
<td>A0432 – Paramedic Intercept</td>
<td>$80</td>
<td>$362.86</td>
</tr>
<tr>
<td>A0433 – ALS 2</td>
<td>$200</td>
<td>$570.21</td>
</tr>
<tr>
<td>A0434 – Specialty Care Transport</td>
<td>$200</td>
<td>$673.88</td>
</tr>
</tbody>
</table>

* Medicaid Mileage is paid after the first 20 miles. Medicare pays for all mileage.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Total Number of Calls</th>
<th>Total Amount Paid At DPW Rate</th>
<th>Total Amount Paid At Medicare Min</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425</td>
<td>2,791**</td>
<td>$2,393,658.20</td>
<td>$2,393,658.20***</td>
</tr>
<tr>
<td>A0426</td>
<td>3,521</td>
<td>$745,489.70</td>
<td>$876,095.22</td>
</tr>
<tr>
<td>A0427</td>
<td>37,611</td>
<td>$7,520,806.30</td>
<td>$14,817,229.56</td>
</tr>
<tr>
<td>A0428</td>
<td>20,369</td>
<td>$2,714,000.20</td>
<td>$4,223,512.15</td>
</tr>
<tr>
<td>A0429</td>
<td>40,104</td>
<td>$4,808,912.70</td>
<td>$13,304,903.04</td>
</tr>
<tr>
<td>A0432</td>
<td>11,216</td>
<td>$897,810.00</td>
<td>$897,810.00***</td>
</tr>
<tr>
<td>A0433</td>
<td>1,019</td>
<td>$205,037.80</td>
<td>$581,043.99</td>
</tr>
<tr>
<td>A0434</td>
<td>1,518</td>
<td>$306,334.50</td>
<td>$1,022,949.84</td>
</tr>
</tbody>
</table>

Two year Total | $19,592,049.4 | $38,117,202.00

** The total reflected does not show the total number of miles paid. Only the number of trips for which mileage was paid

*** No increase. Information provided to show costs only.
Appendix V – Estimate of the Cost to Reinstitute the Dual Eligible Crossovers

Assumptions: 1.8 million emergency calls in Pennsylvania in 2009 (per the Department of Health).

The Department of Health has indicated that 40% of all emergency transports are ALS.

A conservative estimate of 40% being Medicare patients equals 720,000 of the 1.8 million calls.

A conservative estimate of 20% of those Medicare patients being dual eligible Medical Assistance patients equals 360,000 of the 1.8 million calls. 216,000 are BLS calls and 144,000 are ALS calls.

<table>
<thead>
<tr>
<th>Medicare Code</th>
<th>Cross Over Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0427 (ALS Emergency)</td>
<td>$79.93</td>
</tr>
<tr>
<td>A0429 (BLS Emergency)</td>
<td>$67.31</td>
</tr>
</tbody>
</table>

Medicare pays 80% of the Medicare Reimbursement for dual eligible patients. The remaining 20% of the Medicare Reimbursement is the cross over payment. Ambulance providers are not permitted to bill any Medical Assistance beneficiary for these cross over payments for any reason.

216,000 BLS calls x $67.31 = $14,538,960.00
144,000 ALS calls x $79.93 = $11,509,920.00

The total estimated to reinstitute the cross over payments for the dual eligible Medicare/Medical Assistance population is: $26,048,880.00
Works Cited

in order of appearance in the document

According to a 2000 study reported in the American Journal of Emergency Medicine, “There was an association between increasing poverty level and use of EMS.”

Trends and Characteristics of US Emergency Department Visits, 1997-2007
Ning Tang, MD; John Stein, MD; Renee Y. Hsia, MD, MSc; Judith H. Maselli, MSPH; Ralph Gonzales, MD, MSPH, JAMA. 2010;304(6):664-670. doi:10.1001/jama.2010.1112
http://jama.ama-assn.org/cgi/content/abstract/304/6/664

A study conducted by physicians in West Virginia concludes that homeless people are more likely than other patients to arrive at U.S. hospitals by ambulance, and more than twice as likely than other patients to be uninsured. The study analyzed 500,000 emergency department visits by homeless people. It found that one-third of homeless patients arrived by ambulance, an exercise which costs almost a total of $67 million.

Act 37 of 2009 – the Emergency Medical Services Act Declaration of Policy
http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2009&sessInd=0&billBody=S&billTyp=B&billNbr=0240&pn=1312


http://www.familiesusa.org/assets/pdfs/costly-coverage/pennsylvania.pdf


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http://www.sciencedirect.com/science?ob=ArticleURL&udi=B6T19-4G002YB-3&user=10&coverDate=08%2F31%2F2005&alid=1516542734&rdoc=1&fmt=high&origin=search&origin=search&zone=rslt_list_item&cdi=4885&sort=r&st=13&docanchor=&ct=5&acct=C000050221&version=1&urlVersion=0&userid=10&md5=04e75a40df1fabd4f3331e0f27e29b1e5&searchtype=a

AHA News 2008, Swift System for Heart Attack Care Improves Treatment, Cuts Costs
http://www.americanheart.org/presenter.jhtml?identifier=3053628

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http://www.heart.org/HEARTORG/HealthcareResearch/MissionLifelineHomePage/Mission-Lifeline-Home-Page_UCM_305495_SubHomePage.jsp

http://www.portal.health.state.pa.us/portal/server.pt/community/emergency_medical_services/14138/ems_in_pa/556954

28 PA Code 1005.10 Licensing and general operating standards and Act 37 of 2009 EMS System Act, 1027.3 with additional caveats

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