PS ITEM .5
April 26, 2010
Worksession

MEMORANDUM

TO: Public Safety Committee

FROM: Michael Faden, Senior Legislative Attorney
Minna Davidson, Legislative Analyst

SUBJECT: **Worksession:** Expedited Bill 13-10, Emergency Medical Services Transport Fee - Established

Expedited Bill 13-10, Emergency Medical Services Transport Fee - Established, sponsored by the Council President at the request of the County Executive, was introduced on March 23, 2010. A public hearing was held on April 13.

Bill 13-10 would authorize the County to impose and collect a fee to recover costs generated by providing emergency medical service transports. This bill would also provide for a schedule of emergency medical services, transport fees, fee waiver criteria, permitted uses of fee revenues and other procedures to operate the emergency medical services fee program. Bill 13-10 would prohibit a local Fire and Rescue Department from imposing a separate emergency medical services transport fee. The Executive would be required to issue regulations to implement the fee; draft regulations are attached on ©9-11.

Fiscal analysis

County Executive's Budget Assumptions for FY11

For FY11, the Executive originally assumed $14.7 million in revenues from an EMS fee as part of the MCFRS budget. He also assumed expenditures of $1.2 million to implement the fee. The Executive's proposed implementation costs break out as follows.

Item	$	wy
Manager III	105,500	1.0
Information Technology Specialist II	85,250	1.0
Training of MCFRS personnel	25,000	0.2
Third party contractor	800,470	
Community Education	200,000	
Total	**1,216,220**	**2.2**

After the Executive transmitted the FY11 budget to the Council, he received updated EMST fee revenue estimates which reduced the estimated FY11 revenue to $14.1 million. On April 22, the Executive proposed additional adjustments to the FY11 operating budget which, among other things, adjusted for a projected reduction of $557,000 in EMST fee revenues.

On the expenditure side, the Fiscal Impact Statement estimated a reduction of about $30,000 in implementation costs because it may be possible to negotiate a more favorable third party administrator contract.

Fiscal Impact Statement – Revised Revenues

The Fiscal Impact Statement (FIS) for this bill estimated that the EMST fee will result in revenues of $14.1 million in FY11, $14.7 million in FY12, $15.2 million in FY13, and $15.8 million in FY14. These revenues have been adjusted downward from previous estimates that were provided in November 2008. The total revenue estimate for the first 4-year period of implementation has been reduced from $62.2 million to $59.8 million.

Comparison of Estimated EMT Fee Revenues (in millions)

	Year 1	Year 2	Year 3	Year 4	Total
November 13, 2008	14.55	15.19	15.87	16.60	62.21
March 19, 2101	14.14	14.66	15.20	15.76	59.76
Net Change	**-0.41**	**-0.53**	**-0.67**	**-0.84**	**-2.45**

The County requested the new estimates to consider any change in circumstances in health care billing, as well as in the economic or political climate, which may have impacted previous projections. In addition, the County began to use the new Electronic Patient Care Reporting system (ePCR) in January, providing 2 months of actual data which were used to replace previous assumptions that were based on informed estimates.

The Executive Summary in the attached *Updated 2010 EMS Transport Revenue Projections* from Page, Wolfberg & Wirth, LLC, (PWW) lists the following major reasons for the revenue change in order of impact. They are described in more detail under "Methodology and Assumptions" on ©18-22.

- MCFRS dispatch data show a lower-than-anticipated Advanced Life Support (ALS) dispatch rate, resulting in fewer transports eligible for ALS reimbursement under the ALS Assessment rule;

- MCFRS ePCR and dispatch data compelled revising the ALS vs. Basic Life Support (BLS) transport ratio from 57:43 to 45:55.

- Medicare implemented a 0% Ambulance Inflation Factor (AIF) for 2010. While future years' AIF are expected to be positive, uncertainty over counterbalancing Medicare cuts under the federal health reform law conservatively led us to assume a 0% inflationary adjustment in allowed charges in years 2-4 of these projections.

- The Geographic Practice Cost Index (GPCI) (which is used by Medicare to calculate ambulance fee schedule reimbursement rates) for Maryland Locality 01 was adjusted from 1.08 to 1.057 in 2009.

In addition, the limited ePCR data made available by the County also showed a higher volume of Advanced Life Support – Level 2 (ALS2) transports than previously anticipated, though this had a negligible (but slightly positive) impact on the projections.

Issue: Fewer than anticipated ALS dispatches: PWW noted that previously they assumed an ALS/BLS ratio of 57% ALS to 43% BLS. In the January and February 2010 MCFRS dispatch data, approximately 60% of all dispatches were categorized as BLS. PWW noted that these data appeared to under-triage the reporting of ALS conditions at the time of dispatch, compared with their experience in other jurisdictions. They revised the ratio to 45% ALS to 55% BLS.

Under the 1+1 ALS deployment model, "Charlie"-level ALS patients are transported to the hospital by BLS units. (See ©44, footnote #2.) This practice enables ALS providers to remain available to respond to other more serious ALS calls.

- **To what extent is the apparent under-reporting of ALS conditions at the time of dispatch related to the practice of transporting certain ALS patients by BLS units?**

- **If an EMST fee is imposed, would decisions about policies and practices in the field consider or be driven by the impact on EMST fee revenues?**

Self-pay Charges: Because there has been considerable discussion about assumptions regarding self-pay (uninsured) individuals, Council staff notes that the PWW projection assumes that 28% of those billed would be self-pay. Of those, PWW assumes that 90% would be County residents from whom no fee would be collected. Of the remaining 10% -- non-County residents who would be billed -- they assume a collection rate of 30%. Even though self-payers are assumed to make up 28% of the billing population, the amount projected to be collected from this payer category is relatively small. The self-pay calculation for Year One is on ©28.

Medigap Coverage: In the past there have been questions about whether the PWW calculations assume Medigap coverage of Medicare co-payments. Council staff notes that Medigap co-payments are included in the Medicare Payer Category, and are estimated at 52% of the co-payment amount. The Medicare calculation for Year One, including Medigap receipts, is on ©27.

Legislative issues

Fee structure The FIS assumed the following fee structure for a range of levels of service. The fee structure would be established by County regulation (see draft regulation on ©9-11). The service levels (but not the fee amounts) are defined by Federal regulation.

Type of Service	Fee
Transport mileage	$8.50 per mile*
Basic Life Support – Non Emergency	$300.00
Basic Life Support – Emergency	$400.00
Advanced Life Support – Level 1 – Non-Emergency	$$350.00
Advanced Life Support – Level 1 – Emergency	$500.00
Advanced Life Support – Level 2	$700.00
Specialty Care Transport	$800.00

*The PWW analysis assumed $8.00 per mile.

In its fiscal analysis, PWW advised that the County's charges should be a fair amount higher than the prevailing Medicare-approved rates because, under federal law, Medicare pays the lesser of the approved Medicare fee schedule amount or the provider's actual charge. If a provider charges less than the Medicare approved rate, Medicare only pays the provider's charge, and does not pay the full scheduled amount. **The Executive's proposed fee structure would set the EMST fees above the 2010 approved Medicare charges.**

Council staff understands that because the Executive recommended an "insurance only" collection model, raising the fees at this time would not produce much additional revenue. Since the County will cover with taxes the portion of residents' EMST fees that are not paid by an insurer, and will cover the entire fee for residents who are uninsured, a fee increase would only affect co-payments and deductibles from non-County residents, and payment in full from the small percentage of non-County self-payers who would pay the fee.

Waivers As introduced, Bill 13-10 would require the Fire Chief to waive the EMST fee for any individual whose household income is at or below 300% of the federal poverty guidelines. Under the current guidelines (©42) a family of 4 would be eligible for a waiver if their income is at or below $66,150.

County residents, whether insured or uninsured, would not have to pay any EMST fee that is not covered by insurance. Thus, hardship waivers would only be needed for non-County residents.

Are the Federal poverty guidelines an appropriate threshold for hardship waivers for people who work, visit, or pass through the County? In general, there is a sense that the Federal poverty guidelines are low. At the same time, however, the higher the threshold for a hardship waiver, more people would become eligible for waivers and fewer fees would be collected.

In other programs, income eligibility is based on multiples of the federal poverty guideline. For example, the State children's health insurance program has a sliding scale based on 200% and 250% of the federal poverty level. The threshold for eligibility in the County's children's health insurance program is 250%. The threshold for the County's cancer screening program is 250%. The Thornton Commission's requirement for pre-K services for high need, low income children is based on a threshold of 185%. The Maryland Energy Assistance Program (MEAP) and Rental Assistance programs use different standards. For a family of four, the MEAP threshold amount is about 175% of the federal poverty guidelines; the Rental

Assistance amount is about 230%. The standard used by Fairfax County for waiver of their EMS transport fee is 300%.

Timing of Fee Implementation The revenue projections in the FIS assumed mid-year implementation of the fee, with retroactive billing to the beginning of the fiscal year. (This assumes that the Council would enact Bill 13-10 before June 30, 2010.) Federal regulations allow a health care provider to bill retroactively to the effective date in the authorizing legislation. **If the Council agrees with this approach, the bill would have to be amended to allow retroactive billing during the first year start-up period.**

Direct Allocation to the LFRDs When the Executive proposed an EMST fee in the FY10 budget, he recommended $750,000 for a direct allocation of fee revenues to the Local Fire and Rescue Departments (LFRDs). Although the Executive had budgeted for a direct allocation, neither the proposed bill nor the proposed implementing regulation addressed this issue.

For FY11, the Executive did not recommend funding for a direct allocation to the LFRDs. Bill 13-10 and the draft implementation regulation do not address this issue. In response to questions on the budget, MCFRS staff indicated that the Executive is open to discussing options for sharing revenues with the LFRDs.

If the Council wishes to include a direct allocation of EMST fee revenues to the LFRDs, the Council would have to decide the amount of the allocation and the conditions under which it would be provided. The Council would also have to include funds for the direct allocation in the FY11 operating budget.

Supplement vs. Supplant The proposed implementing legislation for the FY10 EMST fee (Bill 25-08 as revised) said that, except for the transfer of funds to cover residents' unpaid EMS transport costs, **the revenues from the EMST fee must be used to supplement, and must not supplant**, existing expenditures for EMS and other related fire and rescue services provided by MCFRS.

Bill 13-10 (see ©3-4, lines 52-58) provides:

> (h) *Use of revenue.* Except for the transfer received from the General Fund under subsection (e) and in the first fiscal year this fee is implemented, the revenues collected from the emergency medical services transport fee must be used to supplement, and must not supplant, existing expenditures for emergency medical services and other related fire and rescue services provided by the Fire and Rescue Service.

Council staff assumes that the Executive intends that the "supplement not supplant" requirement would apply in *all but the first year* of implementation, but others have interpreted this language to mean that it applies *only in the first year*. **Executive staff should clarify the meaning of this subsection.**

The Executive's recommended FY11-16 Fiscal Plan for the Consolidated Fire Tax District is attached on ©41. EMST fee revenues are included in the "Charges for Services" line

together with some fire code enforcement fees. While the EMST fees are not broken out separately, it appears that revenue from the EMST fee would supplant fire tax revenues in FY11.

The picture is not as clear for FY12. An increase in 4-person staffing, new ambulances for Kingsview and Milestone, and an increase for a recruit class are assumed, but the cost of these new initiatives would total only $7.12 million, about half of the projected FY12 EMST fee revenue of $14.66 million. It is not clear whether the fiscal situation in FY12 will allow funding of the new services that are envisioned in the Fiscal Plan. In addition, we would argue that funding for a recruit class should be treated as an ongoing cost of operating MCFRS and thus not count as supplementing.

Council staff would pose the following questions regarding this issue:

1) What is the Executive's intent regarding the "supplement not supplant" requirement? Is this language in Bill 13-10 intended to exempt fee revenue from this requirement only for the first year, or in all years except the first year?

2) Since the fee was originally proposed to supplement the existing MCFRS budget, should the law allow the "supplement not supplant" requirement to be disregarded even for one year?

3) If the exemption is intended to apply in the first year only, is it realistic to assume that it will be possible to use fee revenue only to supplement the existing budget in FY12 and later years?

Fairfax County experience At the public hearing, representatives of the Volunteer Fire and Rescue Association submitted information (see ©45) arguing that ambulance service calls in Fairfax County decreased as a percentage of population after that County imposed its similar fee. However, the EMS Deputy Chief of the Fairfax County Fire and Rescue Department who testified at the same hearing (see testimony, ©46-47) attributed this decrease to a flawed reporting system, and concluded that Fairfax County's implementation of the fee was well planned and successful.

This packet contains:

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Expedited Bill No. 13-10
Concerning: Emergency Medical Services Transport Fee - Established
Revised: 3-22-10 Draft No. 1
Introduced: March 23, 2010
Expires: September 23, 2011
Enacted:
Executive:
Effective:
Sunset Date: None
Ch. ____, Laws of Mont. Co. ____

COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND

By: Council President at the Request of the County Executive

AN EXPEDITED ACT to:

(1) authorize the County to impose and collect a fee to recover costs generated by providing emergency medical service transports;
(2) provide for a schedule of emergency medical services transport fees, fee waiver criteria, permitted uses of fee revenues, and other procedures to operate the emergency medical services fee program;
(3) prohibit a Local Fire and Rescue Department from imposing a separate emergency medical services transport fee;
(4) require the Executive to issue certain regulations to implement an emergency medical services transport fee;
(5) require a certain annual transfer be made as payment of residents' uninsured portion of the emergency medical services transport fee; and
(6) generally amend County law regarding the provision of emergency medical services;

By adding
Montgomery County Code
Chapter 21, Fire and Rescue Services
Section 21-23A. Emergency Medical Services Transport Fee

Boldface	*Heading or defined term.*
Underlining	*Added to existing law by original bill.*
[Single boldface brackets]	*Deleted from existing law by original bill.*
Double underlining	*Added by amendment.*
[[Double boldface brackets]]	*Deleted from existing law or the bill by amendment.*
* * *	*Existing law unaffected by bill.*

The County Council for Montgomery County, Maryland approves the following Act:

Sec. 1. Section 21-23A is added as follows:

21-23A. Emergency Medical Services Transport Fee.

(a) *Definitions.*

In this Section the following terms have the meanings indicated:

(1) *Emergency medical services transport* means transportation by the Fire and Rescue Service of an individual by ambulance or other Fire and Rescue Service vehicle used for a similar purpose. *Emergency medical services transport* does not include transportation of an individual under an agreement between the County and a health care facility.

(2) *Federal poverty guidelines* means the applicable health care poverty guidelines published in the Federal Register or otherwise issued by the federal Department of Health and Human Services.

(3) *Fire and Rescue Service* includes each local fire and rescue department.

(b) *Imposition of fee.* The County must impose a fee for any emergency medical services transport provided in the County and, unless prohibited by other law, outside the County under a mutual aid agreement.

(c) *Liability for fee.* Subject to subsection (d), each individual who receives an emergency medical services transport is responsible for paying the emergency medical services transport fee.

(d) *Hardship waiver.*

(1) The Fire Chief must waive the emergency medical services transport fee for any individual whose household income is at or

below 300 percent of the federal poverty guidelines. An individual must request a waiver on a form approved by the Fire Chief.

(2) The Fire Chief may deny a request for a waiver if an individual who claims financial hardship under this Section does not furnish all information required by the Fire Chief.

(e) *Payment of Residents' Uninsured Portion of the Emergency Medical Services Transport Fee.*

(1) Tax revenues received by the County must be treated as payment, on behalf of County residents, of the balance of each resident's portion of the emergency medical services transport fee that is not covered by the resident's insurance.

(2) The County Council must annually transfer from the General Fund to the Consolidated Fire Tax District Fund an amount that the Council estimates will not be covered by residents' insurance as payment of all residents' uninsured portion of the emergency medical services transport fee.

(f) *Obligation to transport.* The Fire and Rescue Service must provide emergency medical services transport in accordance with applicable medical protocols to each individual without regard to the individual's ability to pay.

(g) *Restriction on Local Fire and Rescue Departments.* A local fire and rescue department must not impose a separate fee for an emergency medical transport.

(h) *Use of revenue.* Except for the transfer received from the General Fund under subsection (e) and in the first fiscal year this fee is implemented, the revenues collected from the emergency medical

services transport fee must be used to supplement, and must not supplant, existing expenditures for emergency medical services and other related fire and rescue services provided by the Fire and Rescue Service.

(i) *Regulations; fee schedule.* The County Executive must adopt a regulation under method (2) to implement the emergency medical services transport fee program. The regulation must establish a fee schedule based on the cost of providing emergency medical services transport. The fee schedule may include an annual automatic adjustment based on inflation, as measured by an index reasonably related to the cost of providing emergency medical services transports. The regulation may require each individual who receives an emergency medical services transport to provide financial information, including the individual's insurance coverage, and to assign insurance benefits to the County.

Sec. 2. Expedited Effective Date.

The Council declares that this legislation is necessary for the immediate protection of the public interest. This Act takes effect on the date when it becomes law.

Approved:

Nancy Floreen, President, County Council — Date

Approved:

Isiah Leggett, County Executive — Date

LEGISLATIVE REQUEST REPORT

Expedited Bill 13-10
Emergency Medical Services Transport Fee – Established

DESCRIPTION: This Bill would authorize the County to impose and collect a fee to recover costs generated by providing emergency medical services transports.

PROBLEM: In order to meet current fiscal challenges facing the County, the County must increase the amount of revenue available to maintain core Government programs and services.

GOALS AND OBJECTIVES: To enhance the amount of revenue available to support core government programs and services.

COORDINATION: Office of Management and Budget; Department of Finance; Fire and Rescue Service

FISCAL IMPACT: To be requested.

ECONOMIC IMPACT: To be requested.

EVALUATION: Subject to the general oversight of the County Executive and the County Council.

EXPERIENCE ELSEWHERE: Many jurisdictions in the regions have imposed an emergency medical services transport fee.

SOURCES OF INFORMATION: Joseph Beach, Director of Management and Budget
Kathleen Boucher, Assistant Chief Administrative Officer
Richard Bowers, Chief, Fire & Rescue Service
Marc Hansen, Acting County Attorney

APPLICATION WITHIN MUNICIPALITIES: Yes.

PENALTIES: To be researched.

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OFFICE OF THE COUNTY EXECUTIVE
ROCKVILLE, MARYLAND 20850

Isiah Leggett
County Executive

MEMORANDUM

March 18, 2010

TO: Nancy Floreen, Council President

FROM: Isiah Leggett, County Executive

SUBJECT: FY 2011 Budget Reconciliation and Financing Act

I am attaching for Council's consideration a Budget Reconciliation and Financing Act (BRFA) which makes changes to the County Code that are necessary to reconcile my recommended FY 2011 operating budget with projected FY 2011 revenues. This bill will help the County address its current fiscal challenges by increasing the amount of revenue available to maintain and enhance core government programs and services. I am also attaching a Legislative Request Report for the bill. A Fiscal Impact Statement will be transmitted to Council soon.

The BRFA consists of five primary components. First, it increases the energy tax rates. Second, it temporarily redirects the portion of recordation tax revenues that are currently reserved for County Government capital projects and rental assistance programs to the general fund for general purposes. Third, it allows revenues generated by the Water Quality Protection Charge to be used to pay debt service on bonds that fund stormwater management infrastructure projects. Fourth, it transfers responsibility for administering equal employment opportunity programs from the Office of Human Resources to the Office of Human Rights. Fifth, it authorizes the Fire and Rescue Service to impose an Emergency Medical Services (EMS) Transport Fee.

As the Council knows, the County's energy tax is actually a tax on fuel oil, natural gas, and electric utility providers which is passed on to all utility customers. Because the energy tax is a broad-based tax, its impact on families is reduced by the fact that it is paid by businesses and households, and all levels of government, including federal agencies located in the County (that currently do not pay any other major County tax). Additionally, the energy tax is a consumption tax based on energy usage. It is not based on the overall size of the utility bill or the cost per unit of energy used as billed to the consumer. Therefore, the amount of the tax can be lessened by reduced energy usage. Based on existing usage patterns for the average homeowner, my recommended FY 2011 budget assumes an average increase in the energy tax of approximately $2.90 per month. I have also recommended additional funding in the Health and

Human Services budget for the County's Energy Assistance Program to minimize the impact to low-income households.

My recommended FY11 budget contains several efforts to restructure County Government to improve responsiveness and efficiency. One of these changes is the transfer of the Equal Employment Opportunity program from the Office of Human Resources to the Office of Human Rights. This shift takes advantage of existing staff resources to reduce costs and leverage the efforts of County staff to produce better outcomes for the community. This bill modifies the County code provisions relating to the responsibilities of the Office of Human Resources and Office of Human Rights to reflect this change.

The EMS Transport Fee is needed to fund fire and rescue services in the County. Without this fee, emergency response to residents will be impaired. EMS Transport Fees are widely employed throughout the nation and by local governments throughout the Washington region. These jurisdictions have not experienced any indication that people decline to use emergency transports as a result of the imposition of an ambulance fee. By creating a prepaid fund for uninsured County residents, the legislation that I am transmitting imposes a fee only on County residents with health insurance which covers EMS Transports. This arrangement more equitably distributes the economic burden of providing EMS transport services in the County between residents and nonresidents. The legislation provides for a hardship waiver for nonresidents who fall below 300 percent of federal poverty guidelines.

To provide the Council with a complete picture of the EMS Transport Fee program created by this bill, I am attaching a copy of the proposed Executive Regulation to implement the fee. This proposed regulation will be published in the April 2010 County Register and submitted to Council after the 30-day public comment period ends on April 30.

Finally, I note that the BRFA is consistent with Bill 31-09, Consideration of Bills – One Subject (enacted on September 29, 2009), which requires that a bill "contain only one subject matter". As noted in the Council staff packet for Bill 31-09, that bill was intended to adopt the "one subject rule" of the Maryland Constitution, which requires all laws enacted by the General Assembly to contain only one subject. The Maryland Attorney General has repeatedly concluded that budget reconciliation and financing bills do not conflict with the one subject rule. For example, in 2005, the Attorney General noted that "[f]or the past fourteen years, 15 budget reconciliation, budget reconciliation and financing acts or variations thereof, have been used to balance budgets, raise revenue, make fund transfers, redistribute funds, cut mandated appropriations and authorize or mandate appropriations."[1] The Attorney General concluded that all of those bills were consistent with the one subject rule because the provisions of the bills were "clearly germane to the single subject of financing State and local government". *See Panitz v. Comptroller of the Treasury*, 247 Md. 501 (1967) (Omnibus supplemental appropriation bill comprised a single subject for purposes of § 29 of Art III of the State Constitution even though

[1] See May 19, 2005 memorandum from Attorney General J. Joseph Curran, Jr. to Governor Robert Ehrlich regarding House Bill 147 (2005).

the bill combined such diverse elements as police aid to local government; teacher salaries and pensions; and general unrestricted grants to local government).

Attachments (3)

cc: Joseph Adler, Director, Office of Human Resources
Jennifer Barrett, Director, Finance Department
Joseph Beach, Director, OMB
Kathleen Boucher, ACAO
Richard Bowers, Fire Chief, MCFRS
Marc Hansen, Acting County Attorney
Robert Hoyt, Director, DEP
Richard Y. Nelson, Jr., Director, DHCA
James Stowe, Director, Office of Human Rights

MONTGOMERY COUNTY EXECUTIVE REGULATION

Offices of the County Executive • 101 Monroe Street • Rockville, Maryland 20850

Subject Emergency Medical Service Transport Fees	**Number**
Originating Department Montgomery County Fire and Rescue Service	**Effective Date**

Montgomery County Regulation on

EMERGENCY MEDICAL SERVICE TRANSPORT FEES

Issued by: County Executive
Regulation No. _____
COMCOR: Chapter 21
Authority: Code Section 21-23A
Supersedes: N/A
Council Review: Method (2) under Code Section 2A-15
Register Vol. ____ No. ____
Effective Date: Date Bill XX-10, "FY 2011 Budget Reconciliation and Financing Act" becomes effective
Comment Deadline: April 16, 2010

Summary: This Regulation establishes: (1) An emergency medical services transport fee schedule; and (2) a requirement that an individual who receives an emergency medical services transport provide certain information and execute an assignment of certain health insurance benefits.

Staff contact: Scott Graham, Assistant Chief, Montgomery County Fire and Rescue Service
(240) 777-2493

Address: Montgomery County Fire and Rescue Service
101 Monroe Street, 12th Floor
Rockville, Maryland 20850

MONTGOMERY COUNTY EXECUTIVE REGULATION

Offices of the County Executive • 101 Monroe Street • Rockville, Maryland 20850

Subject Emergency Medical Service Transport Fees	**Number**
Originating Department Montgomery County Fire and Rescue Service	**Effective Date**

Section 1. Fee Schedule

a. In imposing and collecting the emergency medical services transport fee authorized under Code Section 21-23A, the Fire Chief must comply with all applicable provisions of 42 CFR Parts 410 and 414, *Fee Schedule for payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Non-emergency Ambulance Services.*

b. The Fire Chief must impose the emergency medical services transport fee according to the following schedule:

i. $8.50 per mile, one way, from point of pick up to the health care facility; plus

ii.

• Basic Life Support – Non-emergency*	$300.00
• Basic Life Support – Emergency*	$400.00
• Advanced Life Support – Level 1 – Non-Emergency*	$350.00
• Advanced Life Support – Level 1 – Emergency*	$500.00
• Advance Life Support – Level 2*	$700.00
• Specialty Care Transport*	$800.00

* The terms in the schedule are as defined in 42 CFR Parts 410 and 414.

Section 2. Required Information; Assignment of Benefits.

a. An individual who receives an emergency medical services transport must furnish to the County or the County's designated agent: (i) information pertaining to the individual's health insurer (or other applicable insurer); and (ii) if applicable, financial information that the Fire Chief determines is necessary for determining eligibility for a waiver of the fee.

b. An insured individual who receives an emergency medical services transport must execute an assignment of benefits necessary to permit the County to submit a claim for the fee to the applicable third party payor.

c. The Fire Chief must increase the amount of the fees in the schedule annually by the amount of the Ambulance Inflation Factor (AIF) as published by the Centers for Medicare and Medicaid Services (CMS), United States Department of Health and Human

MONTGOMERY COUNTY EXECUTIVE REGULATION

Offices of the County Executive • 101 Monroe Street • Rockville, Maryland 20850

Subject Emergency Medical Service Transport Fees	**Number**
Originating Department Montgomery County Fire and Rescue Service	**Effective Date**

Services.

Section 3. Severability.

If a court of final appeal holds that any part of this regulation is invalid, that ruling does not affect the validity of other parts of the regulation.

Section 4. Effective Date.

This regulation is effective on the date that Bill XX-10, "FY 2011 Budget Reconciliation and Financing Act" becomes effective.

Approved:

_____

Isiah Leggett, County Executive

(11)

OFFICE OF MANAGEMENT AND BUDGET

Isiah Leggett
County Executive

Joseph F. Beach
Director

MEMORANDUM

April 8, 2010

2010 APR -8 PM 4:47
MONTGOMERY COUNTY COUNCIL

TO: Nancy Floreen, President, County Council

FROM: Joseph F. Beach, Director

SUBJECT: Expedited Bill 13-10, Emergency Medical Service Transportation Fee – Established

The purpose of this memorandum is to transmit a fiscal and economic impact statement to the Council on the subject legislation.

LEGISLATION SUMMARY

The expedited bill proposes the following: authorize the County to impose and collect a fee to recover costs generated by providing emergency medical service transports; provide for a schedule of emergency medical services transport fees, fee waiver criteria, permitted uses of fee revenues, and other procedures to operate the emergency medical services fee program; prohibit a Local Fire and Rescue Department from imposing a separate emergency medical services transport fee; require the Executive to issue certain regulations to implement an emergency medical services transport fee; require a certain annual transfer be made as payment of residents' uninsured portion of the emergency medical services transport fee; and generally amend County law regarding the provision of emergency medical services.

FISCAL SUMMARY

Revenues

The projected revenues are based on a mix of four payer types: Medicare, Medicaid, Commercial/Auto Insurance and Self Pay and average revenue per transport rate of $248 in FY11 down to $246 in FY14 and a Montgomery County Fire and Rescue Service estimated transport volume of 56,977 for FY11 which is expected to increase to 64,091 in FY14.

The legislation is expected to result in revenues of $14.1 million in FY11[1], $14.7 million in FY12, $15.2 million in FY13, and $15.8 million in FY14. The FY11 revenue of $14.1 million is a decrease from the County Executive's recommended FY11 operating budget revenue assumption of $14.7 million due to updated revenue projections that reflect the following factors: available ePCR data (since January 2010) and updated dispatch data; Medicare implementing a 0% inflation factor in 2010, down from 5% in 2009 (due to uncertainty for the federal health care reform); and the lowering of the

[1] Assuming mid-year implementation, with collection of revenues beginning retroactively from the beginning of the fiscal year assuming Council passage of the expedited legislation before June 30, 2010.

Geographic Practice Cost index from 1.08 to 1.057 (used by Medicare to calculate ambulance fee schedule reimbursement rates). For additional details on the basis of these estimates please see the attached EMS Transport Revenue Projections Report prepared for the County by Page, Wolfberg, and Wirth.

Expenditures

Personnel Costs

It is expected that in the first year of implementation two additional full-time personnel will be needed for implementation: a Manager of Billing Services and an Information Technology Specialist. The FY11 salary, wages and benefits total will be $190,750.

Operating Expenses

Operating expenses for FY11 are comprised of third party contract expenditures of $770,870[2] (5.5% of gross revenues collected), $200,000 for community outreach activities, and $25,000 for training. Total annual operating expenses for full year operation of the program are dependent, in part, on the negotiated fee for the third party contractor who will manage the billing program on behalf of the County. Also, the costs of community outreach will be reduced after the initial year of implementation because the need for these outreach activities will not be as significant when the program is fully operational.

ECOMONIC SUMMARY

Since the EMS Transport Fee is employed by local governments throughout the Washington region, it is most likely that the imposition of the fee will have no economic impact on the County.

The following contributed to and concurred with this analysis: Blaise DeFazio, Office of Management and Budget; Scott Graham, Montgomery County Fire and Rescue Service; Dominic Del Pozzo, Montgomery County Fire and Rescue Service; Michael Coveyou, Department of Finance; and David Platt, Department of Finance.

JFB:bdf

Attachment

c: Timothy L. Firestine, Chief Administrative Officer
Richard Bowers, Chief, Montgomery County Fire and Rescue Service
Kathleen Boucher, Assistant Chief Administrative Officer
Jennifer Barrett, Director, Department of Finance
Marc Hansen, Acting County Attorney, Office of the County Attorney
David Dise, Director, Department of General Services
Scott Graham, Montgomery County Fire and Rescue Service
Alexandre Espinosa, Office of Management and Budget
Dominic Del Pozzo, Montgomery County Fire and Rescue Service
John Cuff, Office of Management and Budget
Blaise DeFazio, Office of Management and Budget

[2] The Executive's March 15th recommended operating budget assumed third party contract expenditures of $800,470 or 5.5% of $14.7 million in gross revenues collected. The contractor cost may be revised based on a more favorable contract arrangement

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ATTORNEY-CLIENT COMMUNICATION

MONTGOMERY COUNTY FIRE RESCUE SERVICES

Updated 2010 EMS Transport Revenue Projections

Submitted By:

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EXECUTIVE SUMMARY

If EMS insurance billing is implemented in Montgomery County, Maryland, the County is projected to generate $59,776,918 in new revenue over the initial four years of the program. Thereafter, the County would be expected to continue to derive in excess of $15 million per year of new revenue under the program. Under the proposed Montgomery County EMS transport fee model, none of the projected revenues would paid out of the pockets of County residents.

This report supplements two earlier reports, submitted in January and November of 2008. The County requested this updated report in light of any changed circumstances in health care billing, as well as the economic and federal political climate, that may have impacted our earlier projections. In addition, in January, 2010 the County transitioned its EMS operations from paper-based to electronic patient care reporting, so a limited amount of actual data became available to replace assumptions that could only previously be made using informed estimates.

The updated 2010 report adjusts the total four-year revenue projections downward by $2,454,584 (from $62,231,502 to $59,776,918) as compared to the four-year projections in the November, 2008 report. The major reasons (none of which were foreseeable at the time of the 2008 projections) for this change, in order of impact, are:

- MCFRS dispatch data show a lower-than-anticipated Advanced Life Support (ALS) dispatch rate, resulting in fewer transports being eligible for ALS reimbursement under the ALS Assessment rule;
- MCFRS ePCR and dispatch data compelled revising the ALS vs. Basic Life Support (BLS) transport ratio from 57:43 to 45:55.
- Medicare implemented a 0% Ambulance Inflation Factor (AIF) for 2010. While future years' AIF are expected to be positive, uncertainty over counterbalancing Medicare cuts under the pending federal health care reform legislation have conservatively led us to assume a 0% inflationary adjustment in allowed charges in years 2-4 of these projections; and
- The Geographic Practice Cost Index (GPCI) (which is used by Medicare to calculate ambulance fee schedule reimbursement rates) for Maryland Locality 01 was adjusted from 1.08 to 1.057 in 2009.

In addition, the limited ePCR data made available by the County also showed a higher volume of Advanced Life Support – Level 2 (ALS2) transports than previously anticipated, though this had a negligible (but slightly positive) impact on the projections.

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I. Overview

Montgomery County Fire Rescue Services (MCFRS) is evaluating the potential implementation of an EMS Transport Revenue Recovery Program. MCFRS has engaged Page, Wolfberg & Wirth, LLC (PWW), a national EMS industry law and consulting firm, to assist it in this process. Among the tasks with which PWW is charged is the development of revenue projections that might be realized in the event that the revenue recovery program is implemented. PWW was asked to update these projections in March, 2010. At that time, some of the first electronic patient care reporting (ePCR) data became available, with the system having been implemented countywide in January, 2010. We have stated in this updated report where assumptions were changed based on these data, though it must be noted that two months of data might not be representative of EMS trends in the County. Nevertheless, where actual data are now available to replace prior assumptions in certain aspects of the projections, the data will be used instead of the assumptions.

When assessing potential revenues from any proposed health care billing undertaking, it must be remembered that revenue forecasting is both an art and a science; there is little in the way of published, publicly-accessible data from which meaningful comparisons to similar jurisdictions can be drawn. Whenever possible, key assumptions affecting these projections were kept on the "conservative" side, and many such assumptions are based on our experience in working with EMS systems of all configurations across the United States. All assumptions made in the generation of these projections will be stated so that Montgomery County elected officials, policymakers and Fire Rescue leadership can be guided accordingly.

Our detailed revenue projection spreadsheets for Years One – Four are attached to this report as Appendices A-D.

Previous revenue projection reports dated January 18, 2008 and November 13, 2008 were also provided to the County.

II. Methodology and Assumptions

A. Time Intervals

This report provides four (4) years of revenue projections. We utilized 2010 Medicare rates as a starting figure for this updated report. The reports are presented on a Calendar Year (CY) basis. These projections were made on a CY basis primarily because Medicare (from which the single largest portion of revenues is expected to be derived) typically adjusts its allowed rates on a calendar year basis. CY projections can easily be converted into Fiscal Year (FY) projections by taking a pro-rata share of the annual projections and combining them with the corresponding pro-rata portion of the subsequent calendar year's projections.

B. Estimated Transport Volume

All estimated transport volumes utilized in this report were provided by MCFRS. This statistic is the key driver in any EMS transport fee revenue projection model. We note that MCFRS previously utilized a paper patient care reporting approach, which limits both the accuracy and the quantity of available data from which these projections can be made.

Starting in January, 2010, the County transitioned to an electronic patient care reporting system (ePCR). For the purpose of preparing this updated 2010 report, two months of 2010 data was made available to PWW for review (January and February 2010). Although caution should be taken in generalizing a mere two months of ePCR data (particularly in months where two of the worst weather-related events of the past 25 years hit the region), the data generally confirm the transport volume estimations made by PWW in the 2008 reports. For instance, the estimated ALS1-Emergency transport volume in Year two of the November 2008 PWW report was 12,535, or an average of 1044.58 transports per month. According to the MCFRS ePCR data for January, 2010, the reported number of ALS transports in January, 2010 was 1029, a variation of less than 1.5%. Therefore, the total transport volume estimates have not been modified in this report.

Modest annual increases in call volume, which can be expected as population grows, continue to be assumed in these updated 2010 projections, as they were in the 2008 reports.

C. Transport Mix by Payor

Transport mix estimates are found on the top of each spreadsheet (Exhibits A-D). The "transport mix" is the number and percentage of transports by applicable payor type.

Because MCFRS has not previously billed for EMS transport, these payor mix percentages are estimates which are, if anything, designed to conservatively underestimate revenues. It is possible that in actual experience, the "Self Pay" category (which includes uninsured patients and patients for whom insurance cannot be identified) will be lower than the estimated 28%. In addition, the possible enactment of federal health care reform legislation might ultimately reduce the Self Pay category by moving more of the uninsured into an insured category. Lowering the Self Pay category would move more people into either the Commercial Insured, Medicare or Medicaid categories, which would have a resulting increase on revenues. However, we believe it is best to continue to estimate the

payor mix more conservatively and therefore will continue to use the previous payor mix estimates.

D. Transport Mix by Level of Service

Within each payor category, we utilized a consistently estimated approach to the level of service mix (i.e., BLS vs. ALS). In our 2008 report, we utilized an ALS-BLS ratio of 57/43 (i.e., 57% ALS, 43% BLS). In the two months of 2010 dispatch data provided by the County, we note that approximately 60% of all dispatches were categorized as BLS (59.3% in January, 2010 and 60.3% in February, 2010). These data appear to under-triage the reporting of ALS conditions at the time of dispatch when compared to our experience in other jurisdictions. The 57/43 projections used in the 2008 report were conservative based on our experience in other jurisdictions, and frankly we were surprised to see such a low percentage of ALS dispatches in the January and February 2010 data.

Medicare rules reimburse ambulance services at the ALS1-Emergency level for medically necessary, covered transports when the provider furnishes a qualifying "ALS Assessment," even if no ALS interventions are provided. However, a prerequisite to billing for ALS Assessments is a qualifying ALS-level dispatch. Because MCFRS data suggest under-triage of ALS dispatch conditions, we are revising the ALS/BLS ratio to 45/55. We are selecting 45/55 because, even though the reported percentage of ALS-level dispatches are only 40%, there will undoubtedly be a number of calls where the reported dispatch is condition is BLS but the patient is found to require an ALS intervention. The revision of these service mix estimates will have a negative effect on the revenue projections, though that will of course make the projections even more conservative.

Certainly as more ePCR and CAD data become available, these service mix estimates can be revisited.

It is also important to note that we assigned a small (almost negligible) percentage (1%) of transports to "non-emergency" levels of service. We recognize that MCFRS is solely a 911, emergency provider. However, until dispatch protocols are fully integrated with billing systems, there is a chance that on a small percentage of calls, billers will not have the requisite emergency dispatch information available to them and, acting out of an abundance of compliance, will code the claims as "non-emergencies." That is why non-emergency levels of service are included in the model.

We also included the "Specialty Care Transport" (SCT) level of service on the spreadsheet model, though we did not assign any transports to this category. SCTs are interfacility transports, which we presume would not be handled by MCFRS, though the SCT category is included in case MCFRS would like to investigate the financial impact of providing this type of service in the future.

In our 2008 reports we also assumed a relatively conservative 1% for "ALS2" level transports. This is a more intensive (and higher-reimbursed) level of service that applies when a patient receives invasive interventions such as endotracheal intubation. We note that the January/February 2010 ePCR data reported by MCFRS suggest that the actual ALS2 percentage might be as high as 2.1%. Accordingly, we have adjusted our ALS2 service mix from 1% to 2%. A small positive impact on revenues will result from this change.

E. Payor Type

There are four payor types utilized in these projections: Medicare, Medicaid, Commercial/Auto Insurance and Self-Pay. As a provider of emergency, 911 services only, we assumed that MCFRS will not enter into contracts with Medicare managed care ("Medicare Advantage") organizations or other commercial payors. Therefore, because non-contracted providers are paid by Medicare Advantage plans for emergency transports at the Medicare fee-for-service rates, all transports of Medicare Advantage patients are included in the "Medicare" category. "Medigap" copayments are also included in the Medicare category, with an estimate of 52% of copayments being paid by these Medicare supplemental insurance policies ("Medigap"). Similarly, the "Commercial/Auto Insurance" category includes commercial managed care plans, traditional indemnity "fee-for-service" plans, automobile liability insurance policies, workers compensation payments, and similar types of commercial or self-insurance.

F. Self-Pay Transports

In this model, we assumed that the County would implement an "insurance only" billing policy, under which County residents would be billed only to the extent of available insurance. County residents would not be billed for copayments, deductibles or other charges unmet by their insurance coverage (in addition, no payment would be collected from uninsured residents). We assume that 90% of patients in the Self Pay category will be County residents, and, therefore that only 10% of the Self Pay category are non-residents. We further also assume a collection rate of 30% from the non-resident, self-pay population in this model.

G. Mileage

Medicare and most commercial payors reimburse ambulance services for "loaded" miles, i.e., for those miles which the patient is on board the ambulance, from the point of pickup to the closest appropriate destination. We made the assumption, given the geography, population centers and population density of the County, that the average transport would include five (5) loaded miles. As with all assumptions in this model, this particular assumption can be modified to determine the resulting impact on revenues if desired.

H. Charges

We included a proposed schedule of charges for each level of service. Of course, the selection of a rate schedule is entirely up to County policymakers and is typically a factor of many economic and political considerations. However, the County's charges should, without question, be a fair amount higher than the prevailing Medicare-approved rates, because, under Federal law, Medicare pays the *lesser* of the approved Medicare fee schedule amount *or* the provider's actual charges. In other words, if a provider charges *less* than the applicable Medicare fee schedule payment, Medicare does not "make up the difference." It becomes legitimate revenue that is irretrievably lost and cannot be recovered from any other source. Establishing rates that are comfortably above the approved Medicare fee schedule amounts is a paramount consideration in the establishment of any ambulance rate schedule.

We assumed an annual increase of 5% in the County's ambulance rate schedule (i.e., charges) in years 2-4.

An article dealing with ambulance rate-setting that the County might find helpful is attached to this report as Appendix E.

I. Approved Charges

For each payor category (except, of course, for self-pay), we estimated an "approved charge." This is the amount that Medicare, Medicaid or commercial insurers will approve for the particular level of service. Medicare rates are established annually according to a national fee schedule and vary slightly based on geography (due to the incorporation of the "Geographic Practice Cost Indicator" (GPCI) from the Medicare physician fee schedule into the Medicare ambulance fee schedule. The 2008 projections assumed a GPCI of 1.08, which was at that time the applicable GPCI for Maryland Locality 01. For purposes of this 2010 updated report, we note that the Medicare approved charges reflect a GPCI for Maryland Locality 01 that was slightly adjusted in 2009 by Medicare to 1.057. This will have a negligible, though slightly negative effect on the projections.

We also note that in our 2008 report, we used 2008 approved Medicare charges as the "starting point" upon which all subsequent years' projections were based. For purposes of this updated 2010 report, we are using 2010 approved Medicare charges as the starting point, which are approximately 3.4% higher than they were in 2008.

With regard to the GPCI, a portion of the Medicare Ambulance Fee Schedule is adjusted to reflect geographic cost differences in providing ambulance services in different parts of the country. Because Medicare found it inefficient to develop a national cost index specific to measure the different costs of providing ambulance services across the United States, it simply "borrowed" a geographic cost formula it had already developed for the Physician Fee Schedule and incorporated into the Ambulance Fee Schedule. That formula is the "Practice Expense" portion of the Geographic Practice Cost Index (GPCI) from the Physician Fee Schedule.

Medicare rates have historically increased annually by a modest inflation factor. In 2007, Medicare announced an Ambulance Inflation Factor (AIF) of 2.7% for dates of service in CY 2008. A 5% AIF was adopted for dates of service in CY 2009. Since the adoption of the Medicare ambulance fee schedule in 2002, there has consistently been a positive AIF. Therefore, we conservatively assumed a 2.5% Medicare AIF for years 2-4 of the projections in our 2008 report. However, since the AIF is based on a consumer price index, and because of deterioration in the overall economy, Medicare adopted a 0% AIF for 2010. In addition, as of December 31, 2010, some temporary Medicare ambulance increases expired and were not legislatively renewed. Finally, the pending health care reform legislation would, if enacted, result in Medicare cuts over the next several years, though ambulance reductions are not specifically targeted. Nevertheless, we are modifying our projections to presume a 0% AIF in years 2-4. We do not believe it to be likely that there will be continued 0% growth in approved charges, but in order to keep these projections as conservative as possible, we are assuming 0% inflation in the 2010 base rates for years 2-4 for the Medicare and Commercial categories. As in our 2008 reports, we assumed no annual increase in Maryland Medicaid rates, which are a flat $100 (ALS or BLS) with no allowance for loaded mileage.

For commercial insurers, we assumed an overall percentage of approved charges of 67%. It is very difficult to predict with certainty how this payor class will respond to the implementation of an EMS billing program. Some commercial insurers pay 100% of billed charges for emergencies without question; others take aggressive stands against paying full charges and often will pay some arbitrary amount that they deem to be "reasonable." We believe that an overall figure of 67% of charges takes these variables into account.

The difference between MCFRS's charges and the payor-"approved charges" are ordinarily not collectible. With regard to Medicare, this is considered to be "balance billing" and is prohibited by Medicare law. These mandatory "write offs" are referred to as "contractual allowances."

J. "Allowables"

For each payor category, we included an estimated "allowable" percentage. This can be confusing, but an "allowable" percentage is the percentage of the payor-approved charges that MCFRS can expect to be paid. In other words, once Medicare applies the "contractual allowance" referenced above and determines the "approved charge," Medicare only pays the provider 80% of that approved charge. The remaining 20% is a copayment, which is the responsibility of the patient. As state above, in this model, we assume a Medicare copayment collection rate of 52% from "Medigap" insurers, which generally pay these copayment amounts, without regard to residency status, automatically after Medicare makes the primary payment.

We utilized a 100% "allowable" figure for Medicaid and commercial payors, but, again, remember that this is *not* the same as assuming a 100% "collection rate" from these payors. This merely means, to use Medicaid as an example, that Medicaid can be expected to pay 100% of *its approved charge* for ambulance services (currently, $100) and *not* 100% of MCFRS's actual charges.

We utilized a collection rate of 30% for self-pay accounts (i.e., the estimated 10% of the self-pay category that are non-residents), again reflecting the likely adoption of an "insurance only" billing policy for residents.

K. Patient Care Documentation

One key variable not reflected in these projections is that EMS billing is only as good as the field documentation that supports it. For instance, EMS providers must thoroughly and accurately document information necessary to support proper billing decisions, including patient condition, treatment and other clinical factors, and must collect signatures of patients (when possible) or other authorized signers at the time of service. The County should provide periodic documentation training for all EMS personnel in the County to ensure that legally defensible and compliant documentation is completed in all cases. Inadequate or inaccurate completion of patient care reports can negatively impact projected revenues. The County's January, 2010 implementation of an electronic patient care reporting (ePCR) system will undoubtedly be a significant benefit in producing quality EMS documentation as well as reliable EMS data.

III. Revenue Projections

A. Total Cash Receipts

We have broken down projected cash receipts by each payor, and then calculated an overall total. Year One revenues are projected at approximately $14.1 million. Years Two – Four projections are approximately $14.6 million, $15.2 million and $15.7 million, respectively. Again, County policymakers and budget officials must take into account the assumptions and limitations discussed above when budgeting anticipated revenues from the EMS transport fee program.

B. Average Revenue Per Transport

For each year, we project an Overall Projected Average Revenue Per Transport. This is a simple calculation of gross cash receipts divided by total transport volume in a given year. This takes into consideration all revenues from all payor sources and all levels of transport, but it is a helpful "global perspective" of billing performance.

It could be argued that the Average Revenue Per Transport estimates, which are approximately $247, are optimistic. Of course, this is directly related to the rate structure that the County's policymakers ultimately decide to put into place. Nevertheless, we have compared Montgomery County to other jurisdictions and believe there are some compelling reasons why these Average Revenue Per Transport estimates are reasonable.

First, Montgomery County has a comparatively high median household income. According to U.S. Census bureau statistics, Montgomery County median household income in 2004 was $76,957, compared with $57,019 for all of Maryland. This puts Montgomery County in the highest median household incomes in the United States. Given this statistic alone, some could argue that our Average Revenue Per Transport estimates are *too* conservative.

Second, we compared these Average Revenue Per Transport Estimates with other jurisdictions in the U.S. (using data available to us in 2008). While these data do not always take into account the same factors, and thus creates a potential problem of comparing "apples and oranges," these data can be informative. For instance, in Dayton, Ohio (according to data obtained from that City's ambulance billing contractor), a city with a median household income of $34,978 and approximately 16,000 EMS transports per year, the average revenue per transport was $217. On the other side of the spectrum, in Nassau County, New York, with a median household income ($80,647) comparable to Montgomery County's, and 42,106 annual transports, the average revenue per transport reported by their billing contractor is $380. We therefore believe that the Average Revenue Per Transport estimates in this revenue projection are realistic, again, depending upon the rate structure implemented by Montgomery County.

C. Gross and Net Collection Percentages

One common EMS billing measurement is the "collection percentage." Understanding your projected collection percentage is vital when evaluating the ongoing effectiveness of an outside billing contractor.

When measuring collection percentages, it is critical to distinguish the concepts of "gross" versus "net" collection percentages. Gross collections look at actual cash receipts divided by total charges. Net collections, on the other hand, look at actual cash receipts divided by the amount the provider is allowed to collect for the particular service, after the mandatory contractual allowances required by law are deducted. While both of these measurements of billing performance have their weaknesses, the use of a gross collections percentage as a measurement of billing performance is highly artificial.

Consider the following example. Say that an agency *charges* $600 for a BLS emergency call. Now, say that Medicare only *approves* $250 for a BLS emergency. Under the law, as discussed above, your agency must write off the difference between its charge and the Medicare approved amount. In this example, that "contractual allowance" would be $350. Under a gross collections approach, assuming you were fully paid by Medicare, and succeeded in collecting the 20% patient copayment (which likely would not be the case with Montgomery County residents), you would only have collected 41.7% - or $250/$600. However, under a net collections approach, your agency collected everything it was allowed to collect under the law, so your net collection percentage on this claim was 100%.

The gross vs. net collections approach – as shown in this example – illustrates how relatively easy it is to "manipulate" your "collection percentage" merely by adjusting your actual charges. For instance, say the ambulance service in our example above decides to increase its BLS emergency charge from $600 to $800. Now, its gross collection percentage on the sample claim drops to 31%, or $250/$800. The amount approved by Medicare doesn't increase merely because your charges increased, so the result is a drop in your gross collection percentage. However, the amount of cash you actually received stayed the same. So, on paper, your billing operation, when measured by a gross collection percentage, looks like its performance is getting worse, when actually it may be unchanged, or even better when you look at actual cash received. The reverse of this example is also a potential pitfall: lowering your charges would have the result of artificially *increasing* your net collection percentage, while not necessarily improving your cash receipts, thus perhaps making billing performance seem better than it is.

We projected both gross and net billing percentages for purposes of this report. The estimated gross collection rates are, conservatively, lower than reported national averages. For instance, the Jems 200 City Survey in 2007 reported that the average gross collection percentage for public-sector EMS agencies was 55.9%. Our gross collection percentage estimates for Montgomery County run in the 50-51% range.

It is likely that lower gross collection percentage estimates do result in higher *net* collection percentage estimates. This is because a lower *gross* percentage means that more of the "unallowed" charges have already been written off, leaving more "pure" and collectible revenue on the table. Therefore, one would expect that the *net* collection percentages would be higher. There are no meaningful, national net collection data reported of which we are aware. Nevertheless, again, because the net collection percentage represents income to which the County is legally and legitimately entitled, and already factors in the allowed amounts, contractual write offs and very low estimated self-pay percentage, we believe that the net collection percentages represent realistic expectations for a billing contractor to achieve for a county as affluent as Montgomery County, Maryland.

IV. Conclusion

Though based on many variables that are subject to change, these EMS billing revenue projections demonstrate that there are substantial revenues that could be realized were Montgomery County to implement an EMS transport fee. Of course, the decision on whether or not to do so, and on how any realized revenues would be allocated, is up to the sound discretion of the County's policymakers.

V. Important Notices

These projections are estimates only and not a guarantee of financial performance. All projections are based in large part upon data supplied by the client. Estimating revenues from the provision of any health care services involves many variables that cannot be accounted for in a revenue estimate and that are beyond the control of the estimator. The consultants have stated all key assumptions and have provided a relational spreadsheet that allows the client to modify any assumptions that it finds necessary. The client is responsible to verify all assumptions that affect these projections and to modify them when necessary. This estimate does not constitute the rendering of professional accounting advice, and does not take any expenses into account. Revenue projections can also be impacted by changes in applicable reimbursement laws and regulations. The consultants are not responsible to update this analysis unless asked to do so by the client. Finally, the decision to undertake EMS billing rests entirely with the client, and the client bears all responsibility for appropriate and compliant billing operations..

Appendix A
Year One Revenue Projections

Updated 03/19/10

Montgomery County, MD EMS Transport Fee - Revenue Projections Year One		Total Projected Transport Volume[1]	Est. Medicare Transports (40%)[2]	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)				
		56,977	22,791	2,279	15,954	15,954				
Payor: Medicare (40%)	**Est. % of Transports**	**Charge**	**Medicare Approved Charge[3]**	**Est. Medicare Transport Volume**	**Total Charges**	**Total Medicare Approved Charges**	**Medicare Allowable**	**Total Medicare Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 218.02	228	$ 68,400	$ 49,709	80%	$ 39,767		
BLS-E (A0429)	54%	$ 400	$ 348.82	12,307	$ 4,922,800	$ 4,292,928	80%	$ 3,434,342		
ALS1-NE (A0426)	1%	$ 350	$ 261.62	228	$ 79,800	$ 59,649	80%	$ 47,719		
ALS1-E (A0427)	42%	$ 500	$ 414.23	9,572	$ 4,786,000	$ 3,965,010	80%	$ 3,172,008		
ALS2 (A0433)	2%	$ 700	$ 599.54	456	$ 319,200	$ 273,390	80%	$ 218,712		
SCT (A0434)	0%	$ 800	$ 708.55	-	$ -	$ -	80%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 6.74	113,955	$ 911,640	$ 768,057	80%	$ 614,445		
						$ 9,408,742		$ 7,526,994	Medicare Receipts	
								$ 978,509	Medigap Receipts[4]	
								$ 8,505,503	**Medicare Total**	
Payor: Medicaid (4%)	**Est. % of Transports**	**Charges**	**Medicaid Approved Charge**	**Est. Medicaid Transport Volume**	**Total Charges**	**Total Medicaid Approved Charges**	**Medicaid Allowable**	**Total Medicaid Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 100	23	$ 6,900	$ 2,300	100%	$ 2,300		
BLS-E (A0429)	54%	$ 400	$ 100	1,230	$ 492,000	$ 123,000	100%	$ 123,000		
ALS1-NE (A0426)	1%	$ 350	$ 100	23	$ 8,050	$ 2,300	100%	$ 2,300		
ALS1-E (A0427)	42%	$ 500	$ 100	957	$ 478,500	$ 95,700	100%	$ 95,700		
ALS2 (A0433)	2%	$ 700	$ 100	46	$ 32,200	$ 4,600	100%	$ 4,600		
SCT (A0434)	0%	$ 800	$ 100	-	$ -	$ -	100%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ -	11,395	$ 91,160	$ -	0%	$ -		
							TOTAL	$ 227,900		
Payor: Commercial/Auto (28%)	**Est. % of Transports**	**Charges**	**Est. Ins. Approved Charge**	**Est. Commercial/Auto Volume**	**Total Charges**	**Total Insurance Approved Charges**	**Insurance Allowable**	**Total Insurance Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 200.10	160	$ 48,000	$ 32,016	100%	$ 32,016		
BLS-E (A0429)	54%	$ 400	$ 266.80	8,615	$ 3,446,000	$ 2,298,482	100%	$ 2,298,482		
ALS1-NE (A0426)	1%	$ 350	$ 233.45	160	$ 56,000	$ 37,352	100%	$ 37,352		
ALS1-E (A0427)	42%	$ 500	$ 333.50	6,700	$ 3,350,000	$ 2,234,450	100%	$ 2,234,450		
ALS2 (A0433)	2%	$ 700	$ 466.90	319	$ 223,300	$ 148,941	100%	$ 148,941		
SCT (A0434)	0%	$ 800	$ 533.60	-	$ -	$ -	100%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 5.34	79,770	$ 638,160	$ 425,653	100%	$ 425,653		
							TOTAL	$ 5,176,894		

Payor: Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	Total Non-Resident Self-Pay Charges[5]	Est. Non-Resident Collection%	Total Self-Pay Cash Receipts
BLS-NE (A0428)	1%	$ 300	160		$ 47,861	4,786	30%	$ 1,436
BLS-E (A0429)	54%	$ 400	8,615		$ 3,445,969	344,597	30%	$ 103,379
ALS1-NE (A0426)	1%	$ 350	160		$ 55,837	5,584	30%	$ 1,675
ALS1-E (A0427)	42%	$ 500	6,700		$ 3,350,248	335,025	30%	$ 100,507
ALS2 (A0433)	2%	$ 700	319		$ 223,350	22,335	30%	$ 6,700
SCT (A0434)	0%	$ 800	-		$ -		30%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8	79,770		$ 638,160	63,816	30%	$ 19,145
							TOTAL	$ 232,843
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 27,719,535	$ 24,998,421		

GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR ONE	**$ 14,143,139**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 248**
GROSS COLLECTION PERCENTAGE	**51%**
NET COLLECTION PERCENTAGE	**57%**

Footnotes:

1 Transport volume is based on estimates provided by Montgomery County Fire Rescue

2 Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions

3 2010 Medicare rates taken from 2010 Ambulance Public Use File from the Centers for Medicare and Medicaid Services

4 Medigap estimate is 52% of total Medicare copayments; Medicare copayments are 20% of Medicare approved charges

5 Non-resident self-pay charges estimated to comprise 10% of total self-pay charges

Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.

This is an estimate only and does not constitute a guarantee.

Appendix B
Year Two Revenue Projections

Updated 03/19/10

Montgomery County, MD EMS Transport Fee - Revenue Projections Year Two		Total Projected Transport Volume[1]	Est. Medicare Transports (40%)[2]	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)				
		59,256	23,702	2,370	16,592	16,592				
Payor: Medicare (40%)	**Est. % of Transports**	**Charge**	**Medicare Approved Charge[3]**	**Est. Medicare Transport Volume**	**Total Charges**	**Total Medicare Approved Charges**	**Medicare Allowable**	**Total Medicare Cash Receipts**		
BLS-NE (A0428)	1%	$ 315	$ 218.02	237	$ 74,655	$ 51,671	80%	$ 41,337		
BLS-E (A0429)	54%	$ 420	$ 348.82	12,799	$ 5,375,580	$ 4,464,547	80%	$ 3,571,638		
ALS1-NE (A0426)	1%	$ 368	$ 261.62	237	$ 87,216	$ 62,004	80%	$ 49,603		
ALS1-E (A0427)	42%	$ 525	$ 414.23	9,955	$ 5,226,375	$ 4,123,660	80%	$ 3,298,928		
ALS2 (A0433)	2%	$ 735	$ 599.54	474	$ 348,390	$ 284,182	80%	$ 227,346		
SCT (A0434)	0%	$ 840	$ 708.55	-	$ -	$ -	80%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8.40	$ 6.74	113,955	$ 957,222	$ 768,057	80%	$ 614,445		
						$ 9,754,120		$ 7,803,296	Medicare Receipts	
								$ 1,014,428	Medigap Receipts[4]	
								$ 8,817,725	**Medicare Total**	
Payor: Medicaid (4%)	**Est. % of Transports**	**Charges**	**Medicaid Approved Charge**	**Est. Medicaid Transport Volume**	**Total Charges**	**Total Medicaid Approved Charges**	**Medicaid Allowable**	**Total Medicaid Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 100	24	$ 7,200	$ 2,400	100%	$ 2,400		
BLS-E (A0429)	54%	$ 400	$ 100	1,280	$ 512,000	$ 128,000	100%	$ 128,000		
ALS1-NE (A0426)	1%	$ 350	$ 100	24	$ 8,400	$ 2,400	100%	$ 2,400		
ALS1-E (A0427)	42%	$ 500	$ 100	995	$ 497,500	$ 99,500	100%	$ 99,500		
ALS2 (A0433)	2%	$ 700	$ 100	47	$ 32,900	$ 4,700	100%	$ 4,700		
SCT (A0434)	0%	$ 800	$ 100	-	$ -	$ -	100%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ -	11,395	$ 91,160	$ -	0%	$ -		
							TOTAL	**$ 237,000**		
Payor: Commercial/Auto (28%)	**Est. % of Transports**	**Charges**	**Est. Ins. Approved Charge**	**Est. Commercial/Auto Volume**	**Total Charges**	**Total Insurance Approved Charges**	**Insurance Allowable**	**Total Insurance Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 200.10	166	$ 49,800	$ 33,217	100%	$ 33,217		
BLS-E (A0429)	54%	$ 400	$ 266.80	8,960	$ 3,584,000	$ 2,390,528	100%	$ 2,390,528		
ALS1-NE (A0426)	1%	$ 350	$ 233.45	166	$ 58,100	$ 38,753	100%	$ 38,753		
ALS1-E (A0427)	42%	$ 500	$ 333.50	6,969	$ 3,484,500	$ 2,324,162	100%	$ 2,324,162		
ALS2 (A0433)	2%	$ 700	$ 466.90	332	$ 232,400	$ 155,011	100%	$ 155,011		
SCT (A0434)	0%	$ 800	$ 533.60	-	$ -	$ -	100%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 5.34	79,770	$ 638,160	$ 425,653	100%	$ 425,653		
							TOTAL	**$ 5,367,322**		

Payor: Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	Total Non-Resident Self-Pay Charges[5]	Est. Non-Resident Collection%	Total Self-Pay Cash Receipts
BLS-NE (A0428)	1%	$ 300	166		$ 49,800	4,980	30%	$ 1,494
BLS-E (A0429)	54%	$ 400	8,960		$ 3,584,000	358,400	30%	$ 107,520
ALS1-NE (A0426)	1%	$ 350	166		$ 58,100	5,810	30%	$ 1,743
ALS1-E (A0427)	42%	$ 500	6,969		$ 3,484,500	348,450	30%	$ 104,535
ALS2 (A0433)	2%	$ 700	332		$ 232,400	23,240	30%	$ 6,972
SCT (A0434)	0%	$ 800	-		$ -		30%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8	79,770		$ 638,160	63,816	30%	$ 19,145
							TOTAL	$ 241,409
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 29,312,518	$ 25,917,259		

GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR TWO	**$ 14,663,456**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 247**
GROSS COLLECTION PERCENTAGE	**50%**
NET COLLECTION PERCENTAGE	**57%**

Footnotes:

1 Transport volume is based on estimates provided by Montgomery County Fire Rescue

2 Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions

3 2010 Medicare rates taken from 2010 Ambulance Public Use File from the Centers for Medicare and Medicaid Services

4 Medigap estimate is 52% of total Medicare copayments; Medicare copayments are 20% of Medicare approved charges

5 Non-resident self-pay charges estimated to comprise 10% of total self-pay charges

Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.

This is an estimate only and does not constitute a guarantee.

Appendix C
Year Three Revenue Projections

Updated 03/19/10

Montgomery County, MD EMS Transport Fee - Revenue Projections Year Three		Total Projected Transport Volume[1]	Est. Medicare Transports (40%)[2]	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)				
		61,626	24,650	2,465	17,255	17,255				
Payor: Medicare (40%)	**Est. % of Transports**	**Charge**	**Medicare Approved Charge[3]**	**Est. Medicare Transport Volume**	**Total Charges**	**Total Medicare Approved Charges**	**Medicare Allowable**	**Total Medicare Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 218.02	247	$ 74,100	$ 53,851	80%	$ 43,081		
BLS-E (A0429)	54%	$ 400	$ 348.82	13,311	$ 5,324,400	$ 4,643,143	80%	$ 3,714,514		
ALS1-NE (A0426)	1%	$ 350	$ 261.62	247	$ 86,450	$ 64,620	80%	$ 51,696		
ALS1-E (A0427)	42%	$ 500	$ 414.23	10,353	$ 5,176,500	$ 4,288,523	80%	$ 3,430,819		
ALS2 (A0433)	2%	$ 700	$ 599.54	493	$ 345,100	$ 295,573	80%	$ 236,459		
SCT (A0434)	0%	$ 800	$ 708.55	-	$ -	$ -	80%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 6.74	113,955	$ 911,640	$ 768,057	80%	$ 614,445		
						$ 10,113,767		$ 8,091,014	Medicare Receipts	
								$ 1,051,832	Medigap Receipts[4]	
								$ 9,142,846	**Medicare Total**	
Payor: Medicaid (4%)	**Est. % of Transports**	**Charges**	**Medicaid Approved Charge**	**Est. Medicaid Transport Volume**	**Total Charges**	**Total Medicaid Approved Charges**	**Medicaid Allowable**	**Total Medicaid Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 100	25	$ 7,500	$ 2,500	100%	$ 2,500		
BLS-E (A0429)	54%	$ 400	$ 100	1,331	$ 532,400	$ 133,100	100%	$ 133,100		
ALS1-NE (A0426)	1%	$ 350	$ 100	25	$ 8,750	$ 2,500	100%	$ 2,500		
ALS1-E (A0427)	42%	$ 500	$ 100	1,035	$ 517,500	$ 103,500	100%	$ 103,500		
ALS2 (A0433)	2%	$ 700	$ 100	49	$ 34,300	$ 4,900	100%	$ 4,900		
SCT (A0434)	0%	$ 800	$ 100	-	$ -	$ -	100%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ -	11,395	$ 91,160	$ -	0%	$ -		
							TOTAL	$ 246,600		
Payor: Commercial/Auto (28%)	**Est. % of Transports**	**Charges**	**Est. Ins. Approved Charge**	**Est. Commercial/Auto Volume**	**Total Charges**	**Total Insurance Approved Charges**	**Insurance Allowable**	**Total Insurance Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 200.10	173	$ 51,900	$ 34,617	100%	$ 34,617		
BLS-E (A0429)	54%	$ 400	$ 266.80	9,318	$ 3,727,200	$ 2,486,042	100%	$ 2,486,042		
ALS1-NE (A0426)	1%	$ 350	$ 233.45	173	$ 60,550	$ 40,387	100%	$ 40,387		
ALS1-E (A0427)	42%	$ 500	$ 333.50	7,247	$ 3,623,500	$ 2,416,875	100%	$ 2,416,875		
ALS2 (A0433)	2%	$ 700	$ 466.90	345	$ 241,500	$ 161,081	100%	$ 161,081		
SCT (A0434)	0%	$ 800	$ 533.60	-	$ -	$ -	100%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 5.34	79,770	$ 638,160	$ 425,653	100%	$ 425,653		
							TOTAL	$ 5,564,654		

Payor: Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	Total Non-Resident Self-Pay Charges[5]	Est. Non-Resident Collection%	Total Self-Pay Cash Receipts
BLS-NE (A0428)	1%	$ 300	173		$ 51,900	5,190	30%	$ 1,557
BLS-E (A0429)	54%	$ 400	9,318		$ 3,727,200	372,720	30%	$ 111,816
ALS1-NE (A0426)	1%	$ 350	173		$ 60,550	6,055	30%	$ 1,817
ALS1-E (A0427)	42%	$ 500	7,247		$ 3,623,500	362,350	30%	$ 108,705
ALS2 (A0433)	2%	$ 700	345		$ 241,500	24,150	30%	$ 7,245
SCT (A0434)	0%	$ 800	-		$ -		30%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8	79,770		$ 638,160	63,816	30%	$ 19,145
							TOTAL	$ 250,284
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 29,795,420	$ 26,872,970		

GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR THREE	**$ 15,204,284**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 247**
GROSS COLLECTION PERCENTAGE	**51%**
NET COLLECTION PERCENTAGE	**57%**

Footnotes:

1 Transport volume is based on estimates provided by Montgomery County Fire Rescue

2 Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions

3 2010 Medicare rates taken from 2010 Ambulance Public Use File from the Centers for Medicare and Medicaid Services

4 Medigap estimate is 52% of total Medicare copayments; Medicare copayments are 20% of Medicare approved charges

5 Non-resident self-pay charges estimated to comprise 10% of total self-pay charges

Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.

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Appendix D
Year Four Revenue Projections

Updated 03/19/10

Montgomery County, MD EMS Transport Fee - Revenue Projections Year Four		Total Projected Transport Volume[1]	Est. Medicare Transports (40%)[2]	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)				
		64,091	25,636	2,564	17,945	17,945				
Payor: Medicare (40%)	**Est. % of Transports**	**Charge**	**Medicare Approved Charge[3]**	**Est. Medicare Transport Volume**	**Total Charges**	**Total Medicare Approved Charges**	**Medicare Allowable**	**Total Medicare Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 218.02	256	$ 76,800	$ 55,813	80%	$ 44,650		
BLS-E (A0429)	54%	$ 400	$ 348.82	13,843	$ 5,537,200	$ 4,828,715	80%	$ 3,862,972		
ALS1-NE (A0426)	1%	$ 350	$ 261.62	256	$ 89,600	$ 66,975	80%	$ 53,580		
ALS1-E (A0427)	42%	$ 500	$ 414.23	10,767	$ 5,383,500	$ 4,460,014	80%	$ 3,568,012		
ALS2 (A0433)	2%	$ 700	$ 599.54	513	$ 359,100	$ 307,564	80%	$ 246,051		
SCT (A0434)	0%	$ 800	$ 708.55	-	$ -	$ -	80%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 6.74	113,955	$ 911,640	$ 768,057	80%	$ 614,445		
						$ 10,487,138		$ 8,389,711	Medicare Receipts	
								$ 1,090,662	Medigap Receipts[4]	
								$ 9,480,373	**Medicare Total**	
Payor: Medicaid (4%)	**Est. % of Transports**	**Charges**	**Medicaid Approved Charge**	**Est. Medicaid Transport Volume**	**Total Charges**	**Total Medicaid Approved Charges**	**Medicaid Allowable**	**Total Medicaid Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 100	26	$ 7,800	$ 2,600	100%	$ 2,600		
BLS-E (A0429)	54%	$ 400	$ 100	1,385	$ 554,000	$ 138,500	100%	$ 138,500		
ALS1-NE (A0426)	1%	$ 350	$ 100	26	$ 9,100	$ 2,600	100%	$ 2,600		
ALS1-E (A0427)	42%	$ 500	$ 100	1,076	$ 538,000	$ 107,600	100%	$ 107,600		
ALS2 (A0433)	2%	$ 700	$ 100	51	$ 35,700	$ 5,100	100%	$ 5,100		
SCT (A0434)	0%	$ 800	$ 100	-	$ -	$ -	100%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ -	11,395	$ 91,160	$ -	0%	$ -		
							TOTAL	$ 256,400		
Payor: Commercial/Auto (28%)	**Est. % of Transports**	**Charges**	**Est. Ins. Approved Charge**	**Est. Commercial/Auto Volume**	**Total Charges**	**Total Insurance Approved Charges**	**Insurance Allowable**	**Total Insurance Cash Receipts**		
BLS-NE (A0428)	1%	$ 300	$ 200.10	179	$ 53,700	$ 35,818	100%	$ 35,818		
BLS-E (A0429)	54%	$ 400	$ 266.80	9,690	$ 3,876,000	$ 2,585,292	100%	$ 2,585,292		
ALS1-NE (A0426)	1%	$ 350	$ 233.45	179	$ 62,650	$ 41,788	100%	$ 41,788		
ALS1-E (A0427)	42%	$ 500	$ 333.50	7,537	$ 3,768,500	$ 2,513,590	100%	$ 2,513,590		
ALS2 (A0433)	2%	$ 700	$ 466.90	359	$ 251,300	$ 167,617	100%	$ 167,617		
SCT (A0434)	0%	$ 800	$ 533.60	-	$ -	$ -	100%	$ -		
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 5.34	79,770	$ 638,160	$ 425,653	100%	$ 425,653		
							TOTAL	$ 5,769,757		

Payor: Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	Total Non-Resident Self-Pay Charges[5]	Est. Non-Resident Collection%	Total Self-Pay Cash Receipts
BLS-NE (A0428)	1%	$ 300	179		$ 53,700	5,370	30%	$ 1,611
BLS-E (A0429)	54%	$ 400	9,690		$ 3,876,000	387,600	30%	$ 116,280
ALS1-NE (A0426)	1%	$ 350	179		$ 62,650	6,265	30%	$ 1,880
ALS1-E (A0427)	42%	$ 500	7,537		$ 3,768,500	376,850	30%	$ 113,055
ALS2 (A0433)	2%	$ 700	359		$ 251,300	25,130	30%	$ 7,539
SCT (A0434)	0%	$ 800	-		$ -		30%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8	79,770		$ 638,160	63,816	30%	$ 19,145
							TOTAL	$ 259,509
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 30,894,220	$ 27,865,464		

GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR FOUR	**$ 15,766,039**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 246**
GROSS COLLECTION PERCENTAGE	**51%**
NET COLLECTION PERCENTAGE	**57%**

Footnotes:

1 Transport volume is based on estimates provided by Montgomery County Fire Rescue

2 Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions

3 2010 Medicare rates taken from 2010 Ambulance Public Use File from the Centers for Medicare and Medicaid Services

4 Medigap estimate is 52% of total Medicare copayments; Medicare copayments are 20% of Medicare approved charges

5 Non-resident self-pay charges estimated to comprise 10% of total self-pay charges

Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.

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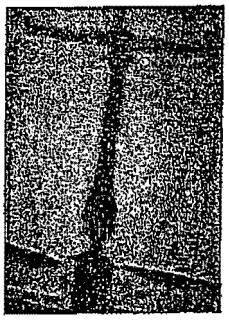
Appendix E
EMS Rate Setting Article



LEGAL CONSULT

INCISIVE ANALYSIS OF EMS LEGAL TOPICS

How Should Your Ambulance Service Set Its Rates?

If your EMS organization charges for its services, you probably spend days, weeks or months learning all the complex rules about billing. But if you ask administrators how they set their rates, many will provide an answer that is only slightly more advanced than "We pull them out of thin air." However, whether your service is public, private or not-for-profit, proper rates are crucial to your organization's overall success, and a rate-setting strategy that complies with the law is fundamental.

First and foremost, start by taking accurate measure of your organization's costs. This includes an assessment not only of such big-ticket line items as personnel, vehicles, equipment and insurance, but also an assessment of fuel, maintenance, heat, electricity and all other overhead elements. Don't forget depreciation; part of your revenues must go toward replacing capital assets in the future as well as to support current operations. These costs must be amortized—or spread over your expected call volume—and must allow for the possibility of bad debt or uncollectible accounts, so your rates reflect the true costs of doing business.

Next, consider whether your organization operates in a rate-regulated environment. While only a small handful of states (e.g., Arizona, Utah and Connecticut) regulate rates at the state level, some local governments may establish ordinances or laws that set ambulance rates or establish maximum fee schedules. Even if your locality has no such local law or ordinance, some contracts between ambulance services and the areas they serve include rate stipulations, so be sure to consult your municipal contracts for any applicable rate restrictions.

An ambulance service that is not rate-regulated generally has a significant degree of flexibility in setting its rates. In fact, your organization can price its services as it sees fit and can generally raise those rates at any time.

Of course, not every payer will reimburse you for 100% of your bill, so you must also factor these mandatory write-offs (called contractual allowances) into your rate-setting. Medicare, for instance, will only pay amounts approved under the Ambulance Fee Schedule, and the patient cannot be "balance billed" for anything above that approved amount (except for his or her deductible—if applicable—or co-payment). So you must write off the difference between your rates and the Medicare fee-schedule rates.

Knowing these contractual allowance amounts will prove critical in measuring your billing performance. Many EMS organizations focus on calculating collection percentages, but be sure you measure performance consistently. Gross collection percentages measure the amount collected versus the total amounts billed. Net collection percentages—which generally provide a more meaningful measurement of billing performance—evaluate the total amount collected versus the total amounts billed, minus the contractual allowances that the law requires you to write off.

Another fundamental decision your organization must make with regard to rates is whether it will bill for services on a bundled or an unbundled basis. A service using bundled billing rolls all charges for supplies, services, etc., into one base rate charge (typically billing only mileage separately). A service that uses unbundled billing may charge separately for such things as oxygen, disposable supplies, wait time and extra attendants.

Though Medicare no longer pays on an unbundled basis and considers all these ancillary charges to be part of the provider's base rate, other payers may still recognize these separate charges. So your service should consider the ramifications of charging those payers on a bundled versus unbundled basis before deciding how to bill them.

Important: Remember when setting your rates that Medicare will pay only the lesser of either the approved fee schedule amount or the amount you bill. In other words, if you charge less than the Medicare-approved amount, Medicare will pay only up to the amount of your bill. For that reason, and because Medicare is the single largest payer for most ambulance services, you should ensure that your rates are higher than the Medicare-approved amounts for your various levels of service; otherwise, your agency leaves legitimate revenue on the table.

Many EMS administrators mistakenly believe that an ambulance service must charge all payers the exact same rates. This

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generally is not the case, however. Ambulance services often charge different rates in different circumstances.

For instance, if your organization participates in a managed care network as a contracted provider, you might have a rate schedule in your agreement with a particular HMO or health plan that is lower than your retail rate schedule. In some cases, rates charged to a facility, such as a hospital or nursing home, also may differ from your agency's retail rates.

Another important reminder: Although providers generally may charge different rates under various circumstances, remember that your rates must comply with such laws as the federal anti-kickback statute.

For example, if you discount the rates you charge a facility, it could appear that those discounts were given in exchange for the facility's referral of Medicare patients to your service, which could constitute an illegal inducement and give rise to a violation of the AKS. (Much has been written about the AKS and its application to ambulance services in the pages of the *EMS Insider* in recent years.)

A final caveat: Setting your rates should not be a group exercise. In other words, to avoid raising issues under state or federal antitrust laws, your organization must not establish its rates based on discussions or agreements with your competitors or with other services in your area. This kind of conduct could be seen as price fixing and can have serious legal consequences.

Although you will need to consider other issues when setting rates, these are the primary considerations. Within the broad parameters of state and federal laws, most ambulance services have great flexibility in establishing rates and charges for their services.

Your organization will be best served if you give your rates the thought and attention they deserve instead of merely pulling them out of thin air.

Although providers generally may charge different rates under various circumstances, remember that your rates must comply with such laws as the federal anti-kickback statute.

fyi

Help OSHA Revise Its Emergency-Response Regulations

The Occupational Safety and Health Administration currently covers emergency responder safety as part of several standards, some of which are decades old and out of date. Consequently, OSHA is working to develop a single, unified set of revised regulations, and is soliciting input from the emergency-response community by May 1 on what the revised regulations should include.

For more information and/or to contribute to this effort, visit www.dol.gov/osha/regs/unifiedagenda/2127.htm.

Wait to Respond to AMR, IAFC Advises Fire Departments

The International Association of Fire Chiefs on Jan. 4 asked fire departments to hold off on responding to an American Medical Response solicitation to EMS providers nationwide to agree to provide ambulance services during large-scale disasters "until the IAFC and the Federal Emergency Management Agency can identify if the fire service can fill the potential need." According to IAFC, FEMA "has placed a hold on this initiative until it can review the work and recommendations of the [IAFC] Mutual Aid System Task force." IAFC predicted that the association and FEMA would be able to "resolve this issue and provide additional guidance by February 2007."

For more information, visit www.iafc. org or contact Lucian Deaton, IAFC EMS manager/govern mental relations at ldeaton@iafc.org.

FY11-16 PUBLIC SERVICES PROGRAM: FISCAL PLAN	CONSOLIDATED FIRE TAX DISTRICT						
FISCAL PROJECTIONS	**FY10 ESTIMATE**	**FY11 REC**	**FY12 PROJECTION**	**FY13 PROJECTION**	**FY14 PROJECTION**	**FY15 PROJECTION**	**FY16 PROJECTION**
ASSUMPTIONS							
Property Tax Rate: Real Property	0.105	0.100	0.103	0.100	0.097	0.092	0.086
Assessable Base: Real Property (000)	168,676,000	170,479,000	174,877,000	183,888,000	193,027,000	206,851,000	222,759,000
Property Tax Collection Factor: Real Property	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%
Property Tax Rate: Personal Property	0.262	0.250	0.258	0.250	0.243	0.230	0.215
Assessable Base: Personal Property (000)	4,102,046	4,144,385	4,210,792	4,265,971	4,328,387	4,415,366	4,480,868
Property Tax Collection Factor: Personal Property	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%	97.5%
Indirect Cost Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
CPI (Fiscal Year)	1.0%	2.1%	2.3%	2.5%	2.6%	2.8%	3.0%
Investment Income Yield	0.3%	0.9%	1.8%	3.3%	4.0%	4.5%	4.8%
BEGINNING FUND BALANCE	13,783,610	0	1,561,120	5,110,260	6,346,330	6,418,730	5,824,500
REVENUES							
Taxes	185,994,490	179,046,630	189,073,920	192,631,310	195,784,990	198,491,650	199,241,610
Licenses & Permits	1,901,460	1,901,460	1,944,240	1,991,870	2,043,660	2,100,880	2,163,910
Charges For Services	1,894,610	16,594,610	16,967,980	17,383,700	17,835,670	18,335,060	18,885,120
Fines & Forfeitures	0	0	0	0	0	0	0
Intergovernmental	2,058,720	1,293,000	1,322,100	1,354,490	1,389,700	1,428,610	1,471,470
Miscellaneous	470,000	310,000	680,000	1,280,000	1,640,000	1,920,000	2,110,000
Subtotal Revenues	192,319,280	199,145,700	209,988,240	214,641,370	218,694,020	222,276,200	223,872,110
INTERFUND TRANSFERS (Net Non-CIP)	(14,832,750)	(9,616,610)	(10,681,610)	(11,710,200)	(12,121,770)	(12,923,050)	(12,052,400)
Transfers To Debt Service Fund	(8,349,570)	(9,745,860)	(10,810,860)	(11,839,450)	(12,251,020)	(13,052,300)	(12,181,650)
GO Bonds	(3,807,570)	(5,236,630)	(6,040,180)	(6,852,850)	(7,902,170)	(8,742,450)	(7,890,200)
Fire and Rescue Fuel Management System	0	0	(311,200)	(568,250)	(568,250)	(568,250)	(568,250)
Fire and Rescue Equipment (Apparatus Mgmt.)	(4,542,000)	(4,509,230)	(4,459,480)	(4,418,350)	(3,780,600)	(3,741,600)	(3,723,200)
Transfers To The General Fund	(6,483,180)	(120,750)	(120,750)	(120,750)	(120,750)	(120,750)	(120,750)
FY10 Fund Balance	(6,362,430)	0	0	0	0	0	0
DCM	(120,750)	(120,750)	(120,750)	(120,750)	(120,750)	(120,750)	(120,750)
Transfers From The General Fund	0	250,000	250,000	250,000	250,000	250,000	250,000
EMST Fee Payment for Uninsured Residents	0	250,000	250,000	250,000	250,000	250,000	250,000
TOTAL RESOURCES	191,270,140	189,529,090	200,867,750	208,041,430	212,918,580	215,771,880	217,644,210
CIP CURRENT REVENUE APPROP.	(35,000)	0	0	0	0	0	0
PSP OPER. BUDGET APPROP/ EXP'S.							
Operating Budget	(191,235,140)	(187,967,970)	(187,967,970)	(187,967,970)	(187,967,970)	(187,967,970)	(187,967,970)
Labor Agreement	n/a	0	312,680	312,680	312,680	312,680	312,680
Annualizations and One-Time	n/a	n/a	(335,380)	(335,380)	(335,380)	(335,380)	(335,380)
Apparatus Replacement	n/a	n/a	148,060	148,060	148,060	216,530	1,061,000
Capital Operating Budget Impacts	n/a	n/a	(64,000)	(1,974,000)	(3,001,000)	(3,025,000)	(3,028,000)
Electronic Patient Care Reporting	n/a	n/a	0	(279,760)	(309,510)	(309,510)	(309,510)
Four Person Staffing	n/a	n/a	(3,492,000)	(6,984,000)	(10,476,000)	(13,968,000)	(17,460,000)
Milestone and Kingsview Ambulances	n/a	n/a	(1,350,000)	(1,350,000)	(1,350,000)	(1,350,000)	(1,350,000)
Motor Pool Rate Adjustment	n/a	n/a	(401,520)	(401,520)	(401,520)	(401,520)	(401,520)
Recruit Class Staffing Cost	n/a	n/a	(2,280,000)	(2,280,000)	(2,280,000)	(2,280,000)	(2,280,000)
SAFER Grant Costs	n/a	n/a	(327,360)	(583,210)	(839,210)	(839,210)	(839,210)
Subtotal PSP Oper Budget Approp / Exp's	(191,235,140)	(187,967,970)	(195,757,490)	(201,695,100)	(206,499,850)	(209,947,380)	(212,597,910)
TOTAL USE OF RESOURCES	(191,270,140)	(187,967,970)	(195,757,490)	(201,695,100)	(206,499,850)	(209,947,380)	(212,597,910)
YEAR END FUND BALANCE	0	1,561,120	5,110,260	6,346,330	6,418,730	5,824,500	5,046,300
END-OF-YEAR RESERVES AS A PERCENT OF RESOURCES	0.0%	0.8%	2.5%	3.1%	3.0%	2.7%	2.3%

Assumptions:

1. The tax rates for the Consolidated Fire Tax District are adjusted to maintain a fund balance of approximately 2.5 percent of resources.
2. The Labor contract with the International Association of Fire Fighters, Local 1664 expires at the end of FY11.
3. The labor contract with the Municipal and County Government Employees Organization, Local 1994 expires at the end of FY11.
4. These projections are based on the Executive's Recommended Budget and include negotiated labor agreements, the operating costs of capital facilities, the fiscal impact of approved legislation or regulations, and other programmatic commitments. They do not include inflation or unapproved service improvements. The projected future expenditures, revenues, and fund balance may vary based on changes to fee or tax rates, usage, inflation, future labor agreements, and other factors not assumed here.
5. The costs of capital facilities will be included in future budgets as projects are completed and their costs defined. Implementation of additional phases of the Four-Person Staffing initiative and other staffing improvements are presented here for illustrative purposes. Staffing decisions will be reviewed and determined on an annual basis.

2009/2010 HHS Poverty Guidelines

SEARCH

- State Programs
  - Plans/Manuals
  - Administration
    - LIHEAP components
  - Client eligibility
    - Benefits
  - Self-sufficiency
    - Leveraging
- Tribal LIHEAP
  - Manual
  - Funding
  - Agreements
  - Applications
    - Benefits
  - Leveraging
    - REACH
- LIHEAP Funding
- Public Benefits
  - State summaries
  - Studies/reports
- Disconnect Policies
- State Supplements
  - Recent year
  - Previous years
- LIHEAP Directors
  - States/websites
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  - Insular areas
- Publications
  - REACH
  - Leveraging
  - Benefits/eligibility
  - Other LIHEAP
- Related Links
  - Community action
    - State/regional
      - Local
  - Low income/energy
  - Federal government

For all states (except Alaska and Hawaii) and for the District of Columbia

Size of family unit	100 Percent of Poverty	110 Percent of Poverty	125 Percent of Poverty	150 Percent of Poverty	175 Percent of Poverty	185 Percent of Poverty	200 Percent of Poverty
1	$10,830	$11,913	$13,538	$16,245	$18,953	$20,036	$21,660
2	$14,570	$16,027	$18,213	$21,855	$25,498	$26,955	$29,140
3	$18,310	$20,141	$22,888	$27,465	$32,043	$33,874	$36,620
4	$22,050	$24,255	$27,563	$33,075	$38,588	$40,793	$44,100
5	$25,790	$28,369	$32,238	$38,685	$45,133	$47,712	$51,580
6	$29,530	$32,483	$36,913	$44,295	$51,678	$54,631	$59,060
7	$33,270	$36,597	$41,588	$49,905	$58,223	$61,550	$66,540
8	$37,010	$40,711	$46,263	$55,515	$64,768	$68,469	$74,020

For family units with more than 8 members, add $3,740 for each additional person at 100% of poverty; $4,114 at 110 %; $4,675 at 125%; $5,610 at 150%; $6,545 at 175%; $6,919 at 185% and $7,480 at 200% of poverty.

Note: For optional use in FFY 2009 and mandatory use in FFY 2010

Page Last Updated: April 5, 2010

responsibility for ALS/BLS quality assurance for a designated area although permitted to respond elsewhere in the County as needed. While progress in achieving the existing recommendation has occurred, five additional EMS Officer positions are needed, including two that had been funded with overtime monies and one for the recommended 6th Battalion (reference: Master Plan Recommendation #33).

Recommendation 41

Revise Recommendation #41 to indicate MCFRS' new ALS service delivery model involving the use of alternatively-staffed medic units and increased use of ALS first-responder apparatus (AFRA). The department's intent is to implement the "1 and 1" ALS deployment model incrementally, whereby minimum staffing composition of medic units is changed from two paramedics to one paramedic and one Emergency Medical Technician (EMT) - typically a firefighter. The second paramedic position on existing medic units would be reassigned to serve as the fourth position (i.e., firefighter-paramedic) on an engine (or in one case on an aerial unit) at the same station as the medic unit, thus creating an AFRA in addition to the medic unit. The AFRA would typically respond along with that station's medic unit, or another available medic unit, to ALS incidents. This ALS delivery model would provide for the collective response of two paramedics and four EMTs (between the AFRA and medic unit), thus increasing the effectiveness of ALS patient care while also meeting NFPA Standard 1710 staffing requirements for engines with regard to fire suppression.

The "1 and 1" ALS deployment model, which has been implemented successfully at several MCFRS stations to date, accomplishes the following objectives:

- **Increases ALS service delivery to the public:** The 1 and 1 ALS deployment model greatly increases the number of MCFRS units capable of providing ALS services to the public; although only medic units have ALS transport capability. By placing a paramedic (firefighter or officer) on designated engines as the fourth person, these engines can provide ALS service, with transport being provided by an EMS Unit. With a greater number of ALS units (i.e., AFRAs and medic units) in service, ALS response time has improved county-wide.

- **Provides for a more effective utilization of available paramedics**: MCFRS data indicates that on only about 7% of ALS incidents are two paramedics needed for providing patient care during transport. On over 90% of ALS incidents, therefore, the AFRA is able to return immediately to service with four personnel on board, including the firefighter-paramedic or officer-paramedic (i.e., fourth person on AFRA), ready for the next ALS, fire, or other type of incident. On less than 10% of ALS incidents does the AFRA paramedic join the EMS transport unit's

paramedic or EMT[2] in transporting patients to the hospital, while the engine returns to service as a three-person unit, minus the paramedic until that individual returns to the station from the hospital.

- **Provides paramedics with an enhanced opportunity to integrate into fire suppression activity**: This broadens career development opportunities for current paramedics and serves as incentive for more firefighters to become firefighter-paramedics, with the knowledge that they can remain in suppression services while serving as paramedics.

The new model is tied directly to the revised phases of fourth-person staffing of suppression units as described in Recommendation #32 above.

Recommendation 68

Replace the matrix of fire-rescue response time goals on page 5-54 with the attached revised matrix (Figure 5.6). Changes are shown in boldface font. The primary change involves EMS response time goals to reflect the five categories of EMS calls – "Alpha, Bravo, Charlie, Delta, Echo" - used in the Emergency Medical Dispatch (EMD) protocol. Other changes include the addition of response time goals for 5th due engine on box alarms, 3rd due aerial unit on high-rise box alarms, and command officers on major fire-rescue incidents. Another revision involves the performance levels (i.e., percentages) associated with the three density zones, where all urban goals have been changed to the 90% performance level, all suburban goals to the 75% level, and all rural goals to the 50% level for consistency purposes.[3] In addition, a column showing corresponding NFPA 1710 response time guidelines has been added for comparison purposes.

One change requiring explanation is the response time associated with the basic life support (BLS) response goal – from 6 to 12 minutes. The increase is due to a philosophical premise: BLS incidents involve non-life threatening occurrences (e.g., sprains, fractures, contusions, unspecified sicknesses, etc.), so a longer response time is acceptable. Because of this, units responding to BLS incidents may, in some cases, not require use of emergency lights and sirens (i.e., travel in routine mode)[4] which would have the added benefit of a reduction in the number of collisions involving MCFRS apparatus. The increase in BLS response time will also allow for greater emphasis on advanced life support-"ALS" response (e.g., life threatening emergencies such as heart

[2] If the ALS incident is of the "Charlie"-level, then a BLS transport unit (staffed by EMTs) would transport the patient. If the ALS incident is of the "Delta" or "Echo"-level, then a medic unit (staffed by one paramedic and an EMT driver) would transport the patient.

[3] The lone exception is the goal for BLS response where the urban goal is 98%, suburban goal is 95%, and rural goal is 90% due to the increased time associated with BLS response.

[4] A decision on allowing response of BLS units in the routine mode for certain Alpha and Bravo-level incidents will be determined at a later date by the Fire Chief.

Review and Analysis of Fairfax County EMS Responses 2002 to 2007

Ambulance fee supporters claim that imposing a charge of $300-$800/transport will not deter people from calling 911, often citing to the experiences of other jurisdictions. For example, the EMS Transport Fee section of the County's website currently says:

> "There is no evidence that those in need of transport will be dissuaded from calling 911 because their insurance is going to be billed or because they are uninsured. In the jurisdictions that have been collecting this fee, there is no evidence of that happening." (1)

Fairfax County began billing for ambulance service in 2005. While total EMS calls in Fairfax County have increased steadily in the past several years, the number of calls when corrected for population increases actually decreased from 2004 to 2005. Since that time, EMS calls (when corrected for population growth) have remained below the 2004 level.

While the reasons for call volume changes are not clear, the statistics raise the question: Why did EMS call volume drop from 2004 to 2005? And why has EMS call volume remained below the 2004 level?

Before any ambulance fee is imposed, credible studies or analyses should be performed (e.g., through surveys of impacted populations) to determine whether, in fact, ambulance fees have deterred some Fairfax County residents from calling 911.

Fiscal Year	Population	Call Volume	EMS Calls	EMS Calls % of Pop	Change in EMS Calls % of Pop
2002	964712	89,246	60,685	6.29%	
2003	984366	87,621	60,306	6.13%	- 0.16
2004	1007800	91,373	62,420	6.19%	+ 0.06
2005	1041200	88,591	61,636	5.92%	- 0.27
2006	1049333	90,086	62,036	5.91%	- 0.01
2007	1077000	92,087	64,088	5.95%	+ 0.04

Sources:

(1) http://www.montgomerycountymd.gov/mcgtmpl.asp?url=/content/pio/ems/facts.asp
(2) http://www.fairfaxcounty.gov/fr/stats/

PH 4-13-10 7:30 pm

My name is Christine Louder, EMS Deputy Chief, Fairfax County Fire and Rescue Department.

I am here tonight to provide information regarding the successful implementation of EMS transport billing in Fairfax County.

In 2004, the FRD convened a Stakeholders Panel to opening discuss the concerns regarding billing for transport services. The panel was comprised of county staff from various disciplines, representatives from volunteer fire departments, advocates representing senior citizen groups, employee labor representatives, and representatives from minority groups in the county. This Stakeholder Panel convened for 4 months in which they reviewed data, such as:

- All Virginia jurisdictions who bill and their rates
- Best practices- implementing a billing system
- Data regarding insurance coverage rates in the Nation, Virginia, and in Fairfax County
- Pertinent demographic data
- Attended seminars for Medicare/Medicaid

The Panel's guiding principle throughout the entire feasibility study was ensuring that the system of providing Emergency Medical Services in Fairfax county remains caring and compassionate, that the ability to pay is never considered when rendering service, and the system continues to provide the highest quality care possible. Implementation of a fee for EMS transport services should never change the way care is provided by the EMS providers in the county.

The panel voted unanimously to recommended that Fairfax County begin billing. The following were their recommendations:

- Compensate the volunteers for documented lost revenue, the county decided to compensate the 12 volunteer stations regardless.
- County enact appropriate controls and procedures to minimize the impact on county residents.
    - Office of Inspector General – co-pays associated with the bill (tax dollars paid)
    - Billing for EMS transports should not impose additional tax burden on residents
    - Insurance company costs should not increase EMS transport fee recover constitutes less than 1 percent of Medical costs covered by insurance companies.
- Rate structure that would maximize reasonable cost recovery
- Contract with a Billing Service, reduce county overhead.

- Institute compassionate billing practice.
    - Hardship waivers
    - Bill waived by Deputy Chief EMS or FC, ex heroic events, disasters, QA
    - Will not use collection companies
- Staffing and additional funding
    - Billing manager
    - Health Insurance Portability and Accountability Act (HIPAA Officer)
    - Patient Advocate (fulltime) not part of the panel joined during implementation
- Public media (9 months)
    - All County citizens received a pamphlet in the mail
    - Video played on the county TV stations and was available at the BOS's offices
    - Many members of the department meet with many homeowners association
- Providers are not involved in insurance information exchange; this is coordinated through the billing company and the hospital

As a result of EMS Transport billing for 5 years has collected $ 59 million.

Volunteer letter at the completion of 1 year of billing. Mark Sevello Vice Chairman Vol. fire Commission

- Additional, operational training required for HIPAA, however training was integrated into existing programs and did not create a burden.
- Fundraising, survey results have been mixed some reported lower return of contributions some received higher levels of contributions.
- "The implementation project team accomplished a tremendous amount of work to meet the implementation timeline establish by the BOS. The result is a billing process that is functioning well and has had minimal impact on the service delivery for either the provider or the patient."

Dispatched EMS incidents: patient care records did decrease between 2004-2005 due to a flawed reporting system.
2000- 55,552
2003- 60,306
2005- 61,636
2006 62,026
2008 64,433