

PS COMMITTEE #5
June 26, 2008

MEMORANDUM

June 24, 2008

TO: Public Safety Committee

FROM: *MF* Michael Faden, Senior Legislative Attorney
MKD Minna K. Davidson, Legislative Analyst

SUBJECT: Overview: Emergency Medical Services Transport Fee (Bill 25-08)

The following individuals are expected to be present:

Kathleen Boucher, Assistant Chief Administrative Officer
Tom Carr, Fire Chief, Montgomery County Fire and Rescue Service (MCFRS)
Scott Graham, Assistant Chief, MCFRS
Joe Beach, Director, Office of Management and Budget (OMB)
Anita Aryeetey, Management and Budget Specialist, OMB

Bill 25-08, Emergency Medical Services Transport Fee – Imposition, would authorize the Fire and Rescue Service 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 25-08 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; a proposed regulation is advertised in the June County Register.

Bill 25-08 was introduced on June 10. A public hearing is scheduled for July 8, and a Public Safety Committee worksession is scheduled for July 24. As background for future work on the bill, the June 26 overview will provide an opportunity for Executive staff to brief the Committee on the proposed fee, how it will be implemented, plans for outreach to the public, and revenue assumptions. The Committee will also have an opportunity raise questions to be addressed in the July worksession.

The Executive provided several materials for the overview including a briefing outline (©1-13), responses to Council staff questions on the fee (©14-19), an informational brochure prepared by the Office of Public Information (©20-21), a list of Frequently Asked Questions (©22-25), and a notice of the town hall meetings that are being held in senior centers in June (©26). In addition, items that were previously transmitted to the Council are included for reference, as noted below.

Council staff also requested Executive staff to respond to several questions on the fiscal impact and revenue assumptions for the July worksession (©59-60). Committee members may want to let Executive staff know if any additional questions on fiscal matters should be addressed.

This packet contains:

circle #

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Emergency Medical Transport Fee:
Recommended Process, Rates, and
Uses

Prepared for: Montgomery County
Council Public Safety Committee

June 26, 2008

Background

- Montgomery County Fire and Rescue Service (MCFRS) provides emergency medical services (EMS) and transport through a comprehensive delivery system.
- This system is comprised of career and volunteer personnel, basic and advanced life support first response, as well as basic and advanced life support transports.
- MCFRS staffs 24 basic life support (BLS) ambulances 24/7 and 3 BLS “Flex Units” 12 hours per day, 18 medic units, 18 Advance Life Support (ALS) engine companies, 15 engine companies, 15 truck companies, and 6 heavy rescue squads operating from strategically selected locations.
- MCFRS provides a response to all emergency calls for ambulance transportation within the County. Emergency response is also provided for surrounding jurisdictions under mutual aid agreements. MCFRS responds to approximately 70,000 EMS calls which result in approximately 58,000 transports per year.

Why the Fee is Needed

The demand for EMS response has been growing significantly for the past several years as the County has grown, especially in the Upcounty area. To respond to these service demands additional resources will be needed in the future for the following:

- Implementing four-person staffing.
- Opening new stations in the Upcounty area including Travilah, West Germantown, East Germantown, and Clarksburg.
- Implementing an Apparatus Management Plan that will replace, upgrade and modernize apparatus, and provide additional maintenance staff, supplies, and maintenance facilities.
- Implementing the State required Electronic Patient Care Reporting System (e-PCR). The Maryland Institute for Emergency Medical Services Systems previously announced it will discontinue paper reporting on December 31, 2008.
- Expanding the number of Officers consistent with supervisory and work hour requirements which will result in a reduction to overtime.
- Supporting Local Fire and Rescue Departments (LFRDs) by funding on-going station maintenance and other needs.

Potential Use of Resources

The proposed EMST Fee will provide a substantial portion of the resources needed for these enhancements including those improvements identified below:

	FY09	FY10	FY11	FY12	Total
Operating Budget Impact - Staffing New Stations	\$ 3,017,430	\$ 6,327,000	\$ 6,585,000	\$ 9,284,000	\$ 25,213,430
Apparatus Management Plan***		\$ 7,000,000	\$ 7,840,000	\$ 8,780,800	\$ 23,620,800
4 Person Staffing Phases 3-7		\$ 4,101,000	\$ 8,494,094	\$ 13,200,086	\$ 25,795,179
LFRD Allocation**	\$ -	\$ 1,500,000	\$ 1,575,000	\$ 1,653,750	\$ 4,728,750
Electronic Patient Care Reporting System(EPCR)	\$ 2,500,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 2,800,000
Total (Potential Use of Resources)	\$ 5,517,430	\$ 19,028,000	\$ 24,594,094	\$ 33,018,636	\$ 82,158,159
*** Assumes 12% Cost Escalator in FY10-12					
** Illustrative Only (details pending further discussion with LFRDs and MCVFRA). Assumes a 5% increase per year.					

Projected Net Revenues

	FY09	FY10	FY11	FY12	TOTAL
Gross Revenue Collected	\$ 7,047,790	\$ 14,763,417	\$ 15,471,092	\$ 16,225,692	\$ 53,507,991
<i>Costs</i>					
Third Party Billing (5%)	\$ 352,390	\$ 1,476,341	\$ 1,547,109	\$ 1,622,569	\$ 4,998,409
Community Outreach	\$ 200,000	\$ 50,000	\$ 50,000	\$ 25,000	\$ 325,000
Initial Personnel Training	\$ -	\$ 25,000	\$ 25,000	\$ 25,000	\$ 75,000
Manager Billing Services*	\$ 105,500	\$ 113,014	\$ 121,064	\$ 129,686	\$ 469,264
Quality Compliance (2)*	\$ -	\$ 138,055	\$ 147,888	\$ 158,422	\$ 444,365
IT Specialist - Hardware*	\$ 85,250	\$ 91,325	\$ 97,830	\$ 104,798	\$ 379,203
IT Specialist - Data Analyst*	\$ -	\$ 91,325	\$ 97,830	\$ 104,798	\$ 293,953
Office Service Coordinator*	\$ -	\$ 65,935	\$ 70,631	\$ 75,662	\$ 212,228
Available Revenue	\$ 6,304,650	\$ 12,712,421	\$ 13,313,740	\$ 13,979,757	\$ 46,310,569
* Assumes a 7% increase per year					

Administration of the Fee

1. No person regardless of ability to pay will ever be refused EMS treatment or transport by MCFRS.
2. Each EMS transport will result in a bill for service being sent to the patient's insurance company or the patient depending on two factors: Is the patient a County resident? Is the patient insured?
3. Patients who reside within the County will not receive a bill for services whether they are insured or not. An uninsured patient will receive a request for information regarding insurance coverage.
4. Patients who do not reside within the county will receive a bill for any applicable co-pay or deductible. A Request for Waiver will be included with the bill.
5. Patients who do not reside within the county and are not insured will receive a bill for the services. A Request for Waiver will be included with the bill.
6. Requests for Waivers will be granted by the Fire Chief based on whether the patient's household income is within the federal poverty guidelines.
7. Billing and collection functions will be contracted to a third party that specializes in EMS billing. This will ensure prompt, accurate, and cost effective collection services especially with the rapidly changing requirements of the various insurance services.
8. MCFRS will work with the local hospitals to provide insurance information to the billing contractor.
9. This information will be transmitted electronically to the contracted billing vendor to facilitate collections.
10. The billing vendor will be paid a negotiated fee for services. The Executive's revenue projections assume that the vendor will receive 5% of collected revenues.

Impact on Volunteer Corporations

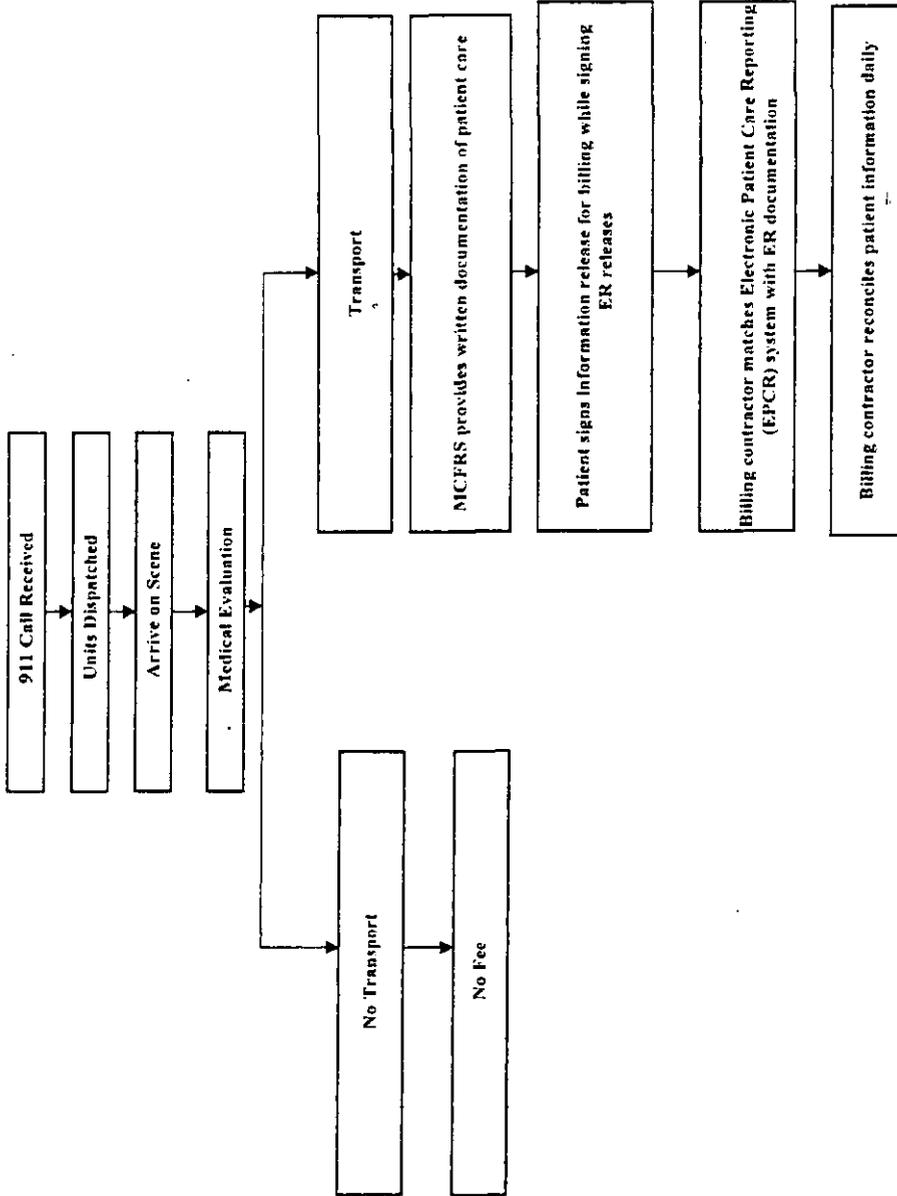
- Ongoing discussion and coordination with the MCVFRA and Local Fire and Rescue Departments (LFRDs)
- Despite repeated inquiries with several jurisdictions, we have found no evidence to support the claim that emergency calls for service or patient transports decline after the imposition of an EMST Fee.
- Also no evidence that EMST Fees impair the development capacity of volunteer fire corporations.
- We will continue to discuss with the LFRDs and the MCVFRA potential opportunities to share a portion of the EMST Fee revenues to provide resources to support their efforts to serve County residents.

Community Outreach

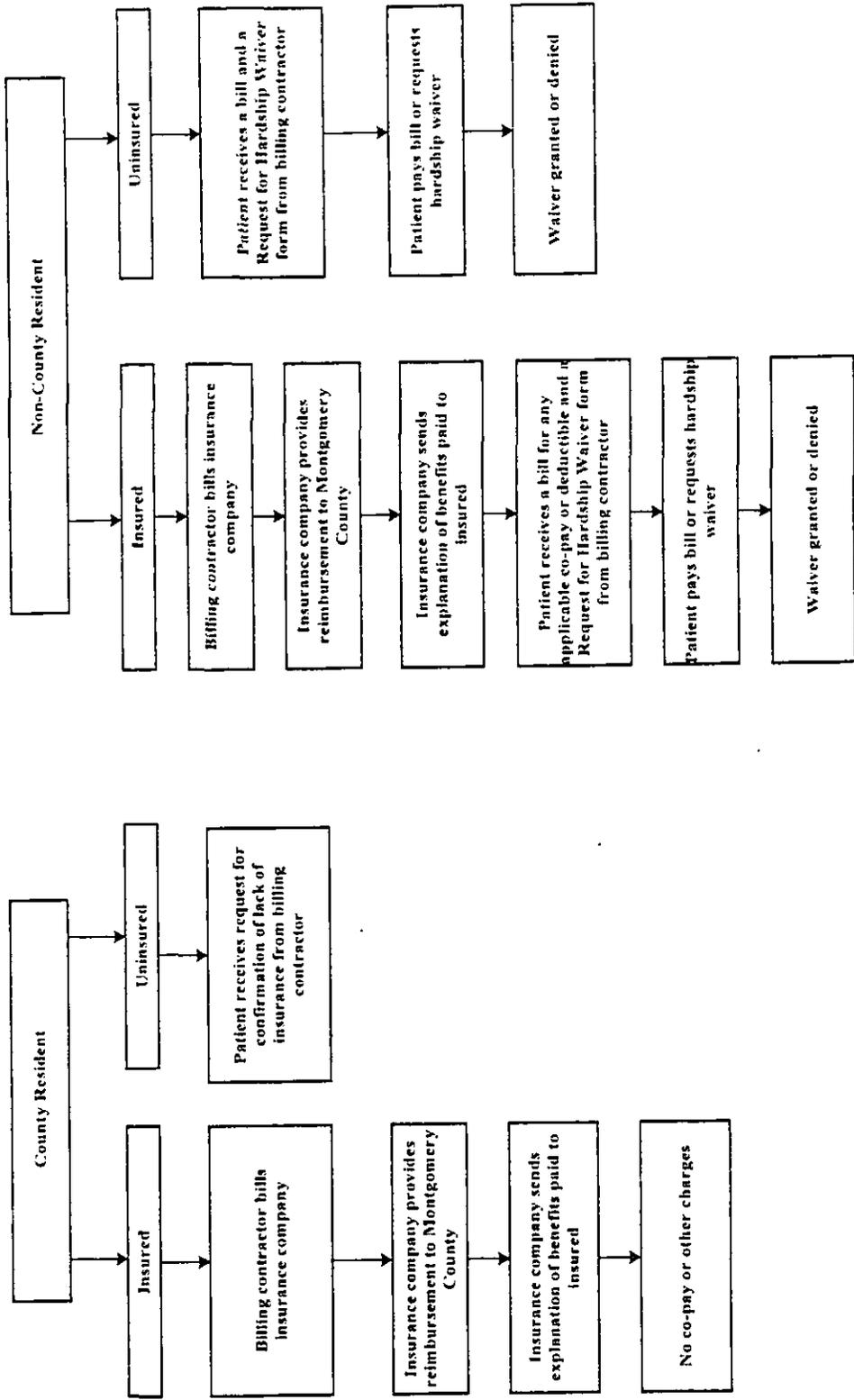
The Executive recommends that \$200,000 be appropriated for a community outreach campaign in the first year of implementation. The campaign would include:

- An informational mailer/card sent to all County households.
- Distribution of information through existing County and community email lists, blogs, and list serves.
- Radio and television public service announcements made available to the electronic media servicing the County.
- News releases and news events featuring information about the program.
- Information translated into Spanish, French, Chinese, Korean, Vietnamese, and other languages, as needed.
- Extensive use of County Cable Montgomery television and all the Public, Educational, and Government channels funded by the County.
- A speakers' bureau available to address community groups.
- Posters and brochures made available at all County events and on Ride One buses and through: Regional Service Centers; Public Libraries; Recreation facilities; senior centers; ESL classes; MCPS; Montgomery College; health care providers; hospitals and clinics; and other venues.
- Informational brochures will be made available to hospitals to provide to patients transported.
- Special outreach to the senior community and to the County's "New American" communities.

Emergency Medical Service Transport Fee Business Process



Emergency Medical Service Transport Fee: Resident vs. Non-Resident



Other Jurisdictions

- Many jurisdictions throughout the nation and regionally have successfully implemented EMST Fees
- We have not found any evidence that EMST Fees have led to a reduction in the number of 911 calls or transports or impaired the development capacity of volunteer corporations.
- The fee programs have consistently produced substantial resources to fund fire and rescue services

EMST Fees In Other Jurisdictions

Emergency Medical Services Transport Fee: Regional Comparison						
	Fairfax County	Arlington County	Alexandria City	Fairfax City	District of Columbia	
Annual Transports	45,000	9,500	7,500	3,860	82,410	
Rates:						
Basic Life Support (BLS)	\$400	\$400	\$400	\$400	\$268	
Advanced Life Support 1 (ALS 1)	\$500	\$500	\$500	\$500	\$471	
Advanced Life Support 2 (ALS 2)	\$675	\$675	\$675	\$675	\$471	
Flat Rate for all services						
Transport Per Mileage Charge	\$10.00	\$10.00	\$10.00	\$8.50	\$0.00	
Agency Type	Combined Volunteer and Career	Career	Career	Career	Career	
Year Program Established	2005	1998	1968	2008	1983	
Amount Collected	\$10,955,015	\$2,997,788	\$1,483,390	Program began January 2008	\$14,168,292	
Annual Transports	Prince Georges County 35,000	Baltimore City 82,577	Anne Arundel County 45,000	Frederick County 14,837		
Rates: *						
Basic Life Support (BLS)	\$400	\$350	n/a	\$360		
Advanced Life Support 1 (ALS 1)	\$500	\$410	n/a	\$450		
Advanced Life Support 2 (ALS 2)	\$750	\$410	n/a	\$525		
Flat Rate for all services						
Transport Per Mileage Charge	\$5.00	n/a	n/a	\$8.00		
Agency Type	Combined Volunteer and Career	Career	Combined Volunteer and Career	Combined Volunteer and Career		
Year Program Established	1986	1989	2008	2003		
Amount Collected **	\$1,500,000	\$11,399,085	Program authorized in May 2008	\$3,353,143		

* Most recent rates adopted by the jurisdiction

** Amount collected is for Calendar Year 2007

The Choices

1. Defer the necessary improvements until there are sufficient resources.
2. Increase the property tax:
 - a. +1 cent = \$16.1 million in FY09;
 - b. +1 cent = \$16.7 million in FY10
3. Reduce funding to other services and redirect to MCFRS priorities.
4. Implement an EMS Transport Fee that is funded through insurance reimbursements rather than from County taxpayers.



OFFICES OF THE COUNTY EXECUTIVE

Isiah Leggett
County Executive

Timothy L. Firestine
Chief Administrative Officer

MEMORANDUM

June 23, 2008

TO: Minna Davidson, Senior Legislative Analyst

FROM: Kathleen Boucher, Assistant Chief Administrative Officer *KB*

RE: Public Safety Committee's June 26th Worksession on Bill 25-08,
Emergency Medical Services Transport Fee – Imposition

I am forwarding a document entitled *Emergency Medical Services Transport Fee: Recommended Process, Rates, and Uses* ("EMST Fee Overview Presentation"), which will be presented to the Public Safety Committee at its June 26th worksession on Bill 25-08, Emergency Medical Services Transport Fee - Imposition. I am also enclosing the following background materials relating to the EMST Fee: (1) an informational brochure prepared by the Office of Public Information; (2) a list of Frequently Asked Questions; and (3) a notice of the town hall meetings being held at senior centers in June.

The following is a response to your questions regarding the County Executive's EMST Fee proposal. This memorandum restates each of your questions and then sets out the Executive's response.

Bill 25-08

1. *Why does Section 21-23A (b) say that MCFRS must impose a fee? Why not may?*

Answer: The word "must" is used to reflect the intent of the bill, which is to require MCFRS to impose an EMST fee on emergency medical service transports. If the Council would like to amend the bill to use the word "may" to provide flexibility in the future, the Executive has no objection.

2. *In the same section, who should be authorized to impose the fee – MCFRS or the Executive? (Section 21-23A(h) says that the Executive must issue an implementing regulation.)*

Answer: Section 21-23A(b) requires MCFRS to impose the fee because MCFRS would be the Executive branch department that implements the EMST fee. If Council would like to amend the bill to require the Executive to impose the fee, the Executive has no objection. The practical result would be the same.

3. *Does the language in Section 21-23A(c) mean that an uninsured County resident will not be billed?*

Answer: Yes.

4. *What is the liability for payment for individuals who work in the County, but do not live here?*

Answer: A patient who works in the County but does not reside in the County would be treated the same as any other patient who does not reside in the County. An insured patient who does not reside in the County will receive a bill for any applicable co-pay or deductible. A Request for Waiver form will be included with the bill. An uninsured patient who does not reside in the County will receive a bill for the EMST service. A Request for Waiver form will be included with the bill.

5. *Why were the federal poverty guidelines selected as the standard for hardship? Could a multiple of the federal poverty guidelines be used instead, as in certain County health and human services programs?*

Answer: The Executive believes that a means test should be used to determine whether a patient is eligible for a waiver of the EMST fee. The federal poverty guidelines, or multiples of them, are used as a means test for numerous federal, State, and County programs. The Executive is open to discussing whether a multiple of the federal poverty guidelines would be the appropriate criterion for a waiver.

6. *Does the law have to specify the threshold for a hardship waiver, or could it be specified by regulation?*

Answer: The criterion for a waiver could be specified in either the County Code or Executive Regulations. The Executive recommends that it be specified in regulations.

7. *What happens to someone who is over the threshold for a hardship waiver, but is unable to pay an EMST bill?*

Answer: Fee waivers are applicable only to patients who are not County residents. A County resident is responsible for the EMST fee only to the extent of insurance coverage so fee waivers will not be needed by County residents. An insured patient who is not a County resident will receive a bill for any applicable co-pay or deductible. If the patient is not eligible for a waiver, the patient is responsible for the co-

pay or deductible. An uninsured patient who is not a County resident will receive a bill for the EMST service. If the patient is not eligible for a waiver, the patient is responsible for payment.

8. *Why is there a requirement for fee revenues to supplement, but not supplant, existing expenditures for EMS and related MCFRS services?*

Answer: The primary reason that the EMST fee is needed is to provide additional resources for urgently needed enhancements to MCFRS. It would not serve the purpose of instituting the fee if it merely supplanted existing resources levels.

9. *What provisions will be made for the LFRDs to receive a portion of the EMST fee revenue? Should the law require the provisions to be included in the implementing regulation?*

Answer: Our efforts to study the feasibility and impacts of implementing an EMST Fee have included discussions with the LFRDs and the Montgomery County Volunteer Fire and Rescue Association (MCVFRA). The primary concerns of the LFRDs appear to be that the EMST Fee would deter some residents from calling for emergency services and that the existence of the fee may impair their fund raising efforts.

We have found no evidence to support the claim that calls for emergency service or patient transports decline after the imposition of an EMST Fee. Similarly, we have found no evidence that EMST Fees impair the fund raising efforts of volunteer fire corporations. The County's policies and budgetary decisions should be driven by data, evidence, and best practices and not by assertions lacking any factual basis.

We have discussed with the LFRDs and the MCVFRA potential opportunities to share a portion of the EMST Fee revenues to provide resources to support their efforts to serve County residents as well as to offset any reduction in fund raising that may be caused by the imposition of an EMST Fee.

The Executive published notice of a proposed Executive Regulation to implement an EMST Fee in the June 2008 County Register. That notice included the following statement:

“An amendment will be considered to establish a process or formula to distribute a portion of the revenue received from the EMS fee to the Local Fire and Rescue Departments. Comment is invited on an appropriate process or formula for distributing revenue from the EMS fee to the Local Fire and Rescue Departments.”

The Executive intends to recommend a process and formula for distributing revenues from the EMST Fee to the LFRDs after the public comment period on the proposed Executive Regulation closes on July 1, 2008.

Regulation

1. *Section 2(a): What kind of financial information would the Fire Chief require that would be necessary for the collection of the fee?*

Answer: The Fire Chief will need to obtain financial information from patients who request fee waivers in order to determine eligibility for a waiver.

2. *Section 2(b): This section requires each insured individual to execute an assignment of benefits form. What happens to an uninsured individual?*

Answer: A County resident is responsible for the EMST fee only to the extent of insurance coverage. An uninsured patient who is a County resident may receive a request for information to confirm lack of insurance coverage. An uninsured patient who is not a County resident will receive a bill for the EMST service. If the patient is not eligible for a waiver, the patient is responsible for payment.

3. *Section 2(d): The Fire Chief **must** increase the fees annually... Why not **may**?*

Answer: Section 2.c provides that 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 Services. The word "must" is used to reflect the intent of the regulation, which is to require that an inflation adjustment occur annually. If the Council believes that the regulation should use the word "may" to provide flexibility in the future, the Executive has no objection.

4. *The regulation includes the fee schedule and provisions for the collection of information, but it does not spell out how the fee collection process would work for an individual who receives an EMS transport. Where would that information be provided?*

Answer: The EMST Fee Overview Presentation (pages 6, and 10-11) includes a description of the primary components of the fee collection process. We do not believe that the details of the fee collection process should be included in Bill 25-08 or Executive Regulations implementing the bill because all of the relevant details of this process will not be known until the County executes a contract with a billing vendor.

5. *Should any rules about the collection process be included in the regulation?*

Answer: See answer to question 4.

Implementation Plan

1. *Please explain what collection activities an individual who receives an EMS transport would experience while they are being transported, at the hospital, and afterwards.*

Answer: The EMST Fee Overview Presentation (see pages 10-11) includes a flow chart which describes the primary components of the fee collection process during transport, at the hospital, and afterwards.

2. *If the Council approved the fee, what would be the timeframe for implementation?*

Answer: Implementing the EMST Fee will consist of 2 primary components: (1) hiring the additional full-time MCFRS personnel outlined in the fiscal impact statement for Bill 25-08; and (2) retaining a third party billing vendor to collect the fee. The timeframe for the former is 3-5 months, which includes the time necessary to prepare position descriptions, advertise, and fill the positions. The timeframe for the latter depends on whether the County bridges an existing contract or seeks a new contract through the RFP process. If the County bridges an existing contract, a billing vendor could likely be obtained within 3 months. If the County uses the RFP process, a bill vendor could likely be obtained within 6 months.

3. *What would be the timeframe for rolling out the public outreach?*

Answer: The Executive has already initiated a community outreach campaign to educate the public about the potential implementation of an EMST Fee in the County, including distribution of informational brochures and meetings with senior citizens, the County's 5 citizen advisory boards, and the MCVFRA. The EMST Fee Overview Presentation (page 6) includes an outline of the components of a comprehensive community outreach campaign that will be implemented after Bill 25-08 is enacted.

4. *When would decisions be made regarding the LFRD allocation?*

Answer: See Answer to Question 9 under the subheading "Bill 25-08".

5. *What IT resources would be needed for the implementation of the fee? How long would it take to obtain them? How much training would MCFRS staff or others need in order to use them?*

Answer: The primary IT resource needed to implement that EMST Fee is the Electronic Patient Care Reporting (e-PCR) System. Currently, MCFRS uses paper reporting. The Maryland Institute for Emergency Medical Services Systems previously announced that it will discontinue paper reporting on December 31, 2008. MCFRS must move quickly to implement the e-PCR system to comply with that deadline, as well as to prepare for implementing an EMST Fee. MCFRS personnel would need to receive training on the e-PCR system as well as HIPAA requirements. In addition, in the first year of implementation of the system MCFRS will require an IT Specialist to manage IT

issues related to the EMST fee including the e-PCR. In the second year of implementation an IT Specialist will be required for supporting the management of the data in the e-PCR.

Attachments (4)

cc:

Timothy L. Firestine, Chief Administrative Officer

Thomas Carr, Fire Chief

Joseph F. Beach, Director, Office of Management and Budget

Patrick Lacefield, Director, Office of Public Information

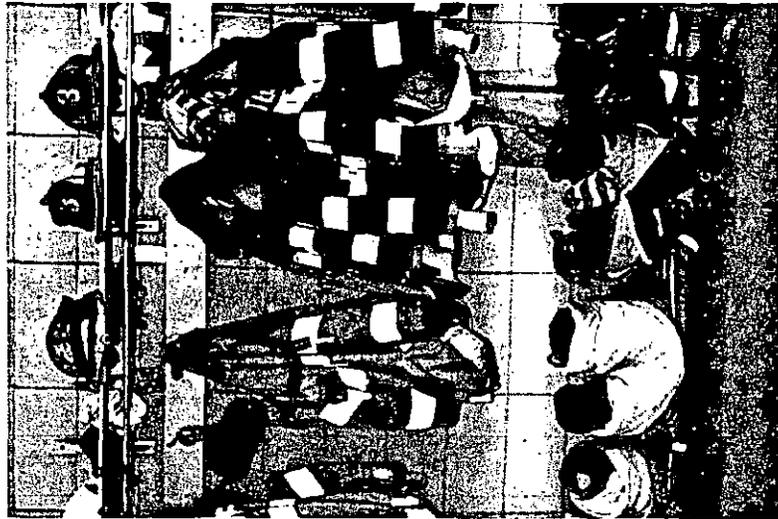
Scott Graham, Assistant Chief, Fire and Rescue Service

Anita Aryeetey, Sr. Management and Budget Specialist, OMB

continued from previous panel

The quality of patient care will continue to be the highest priority for Montgomery County's Fire & Rescue Service. A resident's ability or non-ability to pay will never be considered when providing service.

When a resident makes that 911 call, the first priority will be to take care of that patient's immediate medical needs. If deemed necessary, the patient will be transported to the hospital. If not, the EMS fee will not be charged to the insurance company.



If you have questions or concerns about the proposed EMS fee, **contact Scott Graham in the Montgomery County Fire & Rescue Service at 240-777-2493 or scott.graham@montgomerycountymd.gov.** For information about fire and life safety education programs or non-emergency fire and rescue issues, call 240-777-2400.

EMERGENCY HELP Dial 911



Montgomery County
Office of Public Information
www.montgomerycountymd.gov

Emergency Medical Services Transport Fee



Maintains and
Strengthens Services at
No Cost to Residents



Here are the facts:

- **An EMS transport fee will raise \$14-\$17 million a year in revenue** that will be dedicated to maintaining and enhancing Montgomery County's world-class emergency medical services.
- **County residents will not pay anything under the new fee, and they will never see a bill**, pay a co-pay or file a form for emergency medical transport. The fee will be billed directly to residents' insurance companies, which have already factored the cost of patient transport into their rate schedules. The fee will be waived for uninsured residents.
- **Montgomery County is one of the few jurisdictions in the region that is not already (or in the process of) collecting an EMS fee** from insurance companies. Fairfax County collects the fee, as well as Frederick, Prince George's, Carroll, Charles, Arlington, and Washington counties; Cities such as Alexandria, Baltimore, and the District of Columbia also collect the fee.
- **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. Montgomery County will fund a public education campaign to make sure that residents know there are no charges to them for emergency medical services and no changes in service.
- **Insurance rates will not rise because of this fee**, since it is already factored into the insurance company rate calculations. Individual insurance coverage will be considered payment in full, and the fee will be waived for uninsured residents.
- **Montgomery County will have agreements with area hospitals to provide insurance information** for patients who are transported. A third party billing company will be contracted by the County to collect the fee from the insurance companies, including Medicare. Any costs associated with collecting the EMS fee will be greatly offset by the new revenue.



continues on next panel

Frequently Asked Questions

Emergency Medical Services Transport Fee

1. What is the Emergency Medical Services Transport (EMST) Fee?

The EMST Fee will be charged electronically to health insurance companies of County and non-County residents who are transported to County hospitals by the Montgomery County Fire & Rescue Service (MCFRS). The net proceeds of the EMST Fee will go entirely to strengthening and improving fire and emergency services in Montgomery County. The imposition of the fee will not affect access to the excellent services now provided by MCFRS – except insofar as it strengthens those services by directing more resources to those needs.

2. Will I see any difference in Montgomery County EMS service?

No. MCFRS will continue to provide the very best service to any individual in need regardless of ability to pay – just the way it's always worked.

3. Who pays the fee?

The health insurance companies of County residents and non-County residents. County residents with health insurance will not be responsible for co-pays or deductibles. County residents without health insurance will not be charged. Non-County residents with health insurance may be responsible for co-pays and deductibles depending on their policies. Non-County residents without health insurance will receive a bill, along with a request to waive the fees under hardship guidelines

4. Why is the fee necessary?

The demand for EMS response has been growing significantly for the past several years as the County has grown, especially in the Upcounty area. To respond to these service demands, improve response time, and enhance firefighter/rescuer officer safety, several enhancements have been initiated within MCFRS and will require additional resources in the future including:

- Implementing four-person staffing.
- Opening four new stations in the Upcounty area.
- Implementing an Apparatus Management Plan that will replace, upgrade and modernize apparatus, and provide additional maintenance staff, supplies, and maintenance facilities.
- Implementing the State required Electronic Patient Care Reporting (e-PCR) System. On December 31, 2008, the Maryland Institute for Emergency Medical Services Systems will discontinue paper reporting. Currently MCFRS utilizes this method. MCFRS must quickly implement on a fast track, an e-PCR program in order to meet State of Maryland requirements as well as be fully capable of complete revenue recovery.
- Expanding the number of officers consistent with supervisory and work hour

- requirements which will result in a reduction to overtime.
- Supporting Local Fire and Rescue Departments (LFRDs) by funding on-going station maintenance and other needs.
- Maintaining high levels of service to all parts of the County.

Also a factor is the pressure on County government budgets caused by economic uncertainty, declining housing markets, the state of Maryland's budget crisis, and other factors. This has caused program reductions and increased property taxes. Clearly, a new revenue source dedicated to MCFRS would help ensure that fire and rescue services are adequately funded in the future.

5. Where will the money raised by the EMST Fee go?

100 percent of the net proceeds of the EMST Fee will go to strengthen and enhance the MCFRS. By law, they will be dedicated to that purpose and cannot be used for anything else.

6. Will there be co-pays and deductibles?

No, not for County residents. Non-County residents may be responsible for co-pays and deductibles, depending on their policies.

7. Do other area governments have an EMST Fee?

Nearly all of our neighboring jurisdictions either have an EMST Fee or are moving to implement one. These jurisdictions include Fairfax County, Frederick County, Prince George's County, the District of Columbia, Arlington County, and the city of Alexandria.

8. How about local governments in other parts of the United States?

The 200 City Survey in the 2006 Journal of Emergency Medical Services (JEMS) reported that, across the U.S., an average of 61% of EMS system funding comes from user fees.

9. Will this fee deter people from calling 911 for ambulance service?

There is no evidence from jurisdictions that have successfully implemented this fee that it deters anyone from calling for needed emergency medical transport assistance.

10. Will this fee cause health insurance rates to increase?

There is no documented evidence that ambulance bills affect underwriting of risks for insurance premiums. Ambulance bills are in the "hundreds" of dollars, compared to hospital, physician, surgeon, rehab, device, and drug bills, which are typically in the "thousands and tens of thousands." Ambulance expenditures account for less than 1% of insurance expenditures. Since most insurance companies determine rates on a regional basis – and most jurisdictions in the region bill insurance companies for this

charge -- in most cases County residents may already be paying for ambulance service as a part of their premiums.

11. What charges will be billed to insurance companies?

Insurance carriers would be billed at the following rates, depending on the level of services necessary:

- 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.

In addition, insurance companies would be billed \$7.50 per mile on emergency transports, a standard charge for most implementing jurisdictions.

If the EMS call does not result in transport to a hospital, the health insurance carrier or the non-County resident without insurance would not be billed for anything.

According to the 2006 JEMS "200 City Survey," here are *average* charges in the 200 largest cities in the U.S.

Average Charges for Transport Providers

	<u>Average</u>	<u>Governmental</u>	<u>Non-Governmental</u>
BLS Non-Emergency	\$396.26	\$375.91	\$411.52
BLS Emergency	\$473.02	\$457.92	\$492.94
ALS Non-Emergency	\$548.04	\$514.50	\$574.87
ALS 1 Emergency	\$625.68	\$573.09	\$700.52
ALS 2 Emergency	\$711.42	\$639.58	\$802.85

12. What if my health insurance plan only pays a certain amount for ambulance services or refuses to pay? Will I have to pay the balance?

The County will accept whatever payment the insurance company has established as "payment in full." County residents will not be responsible for any co-pays or deductibles. Non-County residents will be responsible for any applicable co-pays or deductibles.

The single biggest payor for these services is Medicare. If coverage requirements are met Medicare has no discretion to deny claims. Health insurance companies are required by law to pay covered services, of which ambulance services is one. Any question about any Medicare or insurance company payment would be handled by the third-party vendor and would not involve the covered individual.

13. How will this fee affect Local Fire & Rescue Departments (“Volunteer Companies”)?

Local Fire & Rescue Departments would deliver services just as they do now, the only difference being the entry of a code into the electronic tracking system to enable the contracted billing agent to process insurance company payments or, in the case of non-County residents without insurance, to bill for the service, with accompanying information about hardship waivers.

The County has discussed with Local Fire & Rescue Departments potential opportunities to offset any unexpected reductions in their local fundraising that might conceivably result from the implementation of an EMST fee – although there is no evidence in other jurisdictions of a drop-off in donations owing to the implementation of an EMST Fee.

14. How will the billing to insurance companies work?

Data will be entered by EMS personnel in the Electronic Patient Reporting System, which will be required by the State – independent of any EMST Fee – starting December 31, 2008. Paper reporting, currently used by MCFRS, will no longer be accepted. That information will be examined by the third-party vendor responsible for billing health insurance companies and non-County resident without insurance.

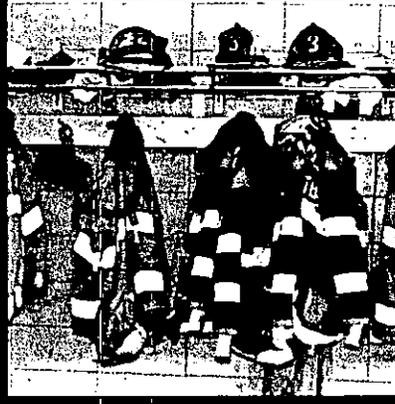
15. What will be the start-up costs for this program? What will be the ongoing expenses?

The County is projecting about \$700,000 in start-up costs for the first half year, half of which is the 5 percent of proceeds payment to the third-party billing vendor. Once the program is up and running, the overhead costs are estimated at 13-14 percent of total revenue – again, including the five percent going to the third-party billing vendor.

16. Will there be efforts to educate County residents about how the system works – and how no County residents will pay out-of-pocket?

While there is no evidence from any of these jurisdictions that adoption of an EMST fee has resulted in any diminution of calls for 911 emergency transport or any reluctance of residents to call for needed services due to a misunderstanding that they might incur a fee, a solid campaign of public outreach and education just makes good sense. Such a campaign would begin several months before the program actually began and extend several months afterward.

Revised June 21, 2008



You're invited to attend a discussion about the proposed

Emergency Medical Services Fee

Montgomery County Fire & Rescue Chief Thomas W. Carr Jr. will host four "town hall" meetings to talk about the proposed emergency medical services transport fee and senior fire safety.

Wednesday, June 11 at 1 p.m.

Damascus Senior Center

Routes 109 & 27

Tuesday, June 24 at 10 a.m.

Holiday Park Senior Center

3950 Ferrara Drive, Wheaton

Thursday, June 26 at 1 p.m.

Margaret Schweinhaut Senior Center

1000 Forest Glen Road, Silver Spring

Friday, June 27 at noon

Long Branch Senior Center

8700 Piney Branch Road, Silver Spring

The meeting is free and open to the public.

For more information, call the Office of Public Information at 240-777-6530.

Bill No. 25-08
Concerning: Emergency Medical
Services Transport Fee – Imposition
Revised: _____ Draft No. ____
Introduced: June 10, 2008
Expires: December 10, 2009
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 ACT to:

- (1) authorize the Fire and Rescue service 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; and
- (5) generally amend County law regarding the provision of emergency medical services.

By adding

Montgomery County Code
Chapter 21, Fire and Rescue Service
Section 21-23A

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

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

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

2 **21-23A Emergency Medical Services Transport Fee.**

3 **(a) Definitions.**

4 In this section the following terms have the meanings indicated:

5 (1) Emergency medical services transport means the transportation
6 by the Fire and Rescue Service of an individual by ambulance.
7 Emergency medical services transport does not include the
8 transportation of an individual under an agreement between the
9 County and a health care facility.

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

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

15 **(b) Imposition of fee.** The Fire and Rescue Service must impose a fee for
16 any emergency medical service transport provided in the County and,
17 unless prohibited, outside the County under a mutual aid agreement.

18 **(c) Liability for fee.**

19 (1) A County resident is responsible for the payment of the
20 emergency medical services transport fee only to the extent of the
21 resident's available insurance coverage.

22 (2) Subject to subsection (d), all other individuals are responsible for
23 payment of the emergency medical services transport fee without
24 regard to insurance coverage.

25 **(d) Hardship waiver.**

26 (1) The Fire Chief must waive the emergency medical services
27 transport fee for any individual who is indigent under the federal

28 poverty guidelines. An individual must request a waiver on a
29 form approved by the Fire Chief.

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

33 **(e) Obligation to transport.** The Fire and Rescue Service must provide
34 emergency medical services transport to each individual without regard
35 to the individual's ability to pay.

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

39 **(g) Use of revenue.** The revenues collected from the emergency medical
40 services transport fee must be used to supplement, and must not
41 supplant, existing expenditures for emergency medical services and
42 other related fire and rescue services provided by the Fire and Rescue
43 Service.

44 **(h) Regulations; fee schedule.** The County Executive must adopt a
45 regulation under method (2) to implement the emergency medical
46 service transport fee program. The regulation must establish a fee
47 schedule based on the cost of providing emergency medical services
48 transport. The fee schedule may include an annual automatic
49 adjustment based on inflation, as measured by an index reasonably
50 related to the cost of providing emergency medical services transports.
51 The regulation may require individuals who receive an emergency
52 medical services transport to provide financial information, including
53 the individual's insurance coverage, and to assign insurance benefits to
54 the County.

LEGISLATIVE REQUEST REPORT

Bill No. 25-08

Emergency Medical Services Transport Fee – Imposition

- DESCRIPTION:** This bill provides the Montgomery County Fire and Rescue Service (MCFRS) with the authority to collect fees for the provision of emergency medical services. The bill includes a waiver provision for individuals who meet certain low income criteria.
- PROBLEM:** The costs incurred in providing emergency medical services are not fully covered by the Fire Tax District property tax. These costs include the Apparatus Management Plan, EMS quality assurance, staffing, enhancing EMS capacity, and acquisition of other equipment and technology to support the provision of emergency medical services.
- GOALS AND OBJECTIVES:** The goal of this bill is to increase the resources available to fund critically needed improvements to the MCFRS.
- COORDINATION:** County Executive's Office, MCFRS
- FISCAL IMPACT:** To be requested.
- ECONOMIC IMPACT:** To be requested.
- EVALUATION:** Subject to the oversight of MCFRS, the County Executive, and the County Council.
- EXPERIENCE ELSEWHERE:** Most area jurisdictions have successfully implemented similar programs which have provided additional resources to fund improvements needed for EMS services. These jurisdictions include Fairfax County, Prince George's County, Baltimore City, Frederick County, Arlington County, and the District of Columbia.
- SOURCE OF INFORMATION:** Scott Graham, Assistant Chief, Fire and Rescue Service
240-777-2493.
- APPLICATION:** Applies to EMS transports within municipalities.
- PENALTIES:** Not applicable.



OFFICE OF THE COUNTY EXECUTIVE
ROCKVILLE, MARYLAND 20850

Isiah Leggett
County Executive

MEMORANDUM

April 11, 2008

TO: Michael J. Knapp, President
Montgomery County Council

FROM: Isiah Leggett, County Executive 

SUBJECT: Emergency Medical Transport Fee

I am attaching for the Council's consideration a bill which would authorize the Montgomery County Fire and Rescue Service (MCFRS) to impose an Emergency Medical Services Transport Fee (EMST Fee). I am also attaching a Legislative Request Report and a draft Executive Regulation which is provided for information purposes only to reflect the Executive's intent regarding implementation of the proposed bill.

The EMST Fee will generate revenues that will allow the County to keep pace with the public safety demands of our growing community by funding: (1) continued support of the approved Apparatus Management Plan; (2) volunteer recruitment and retention; (3) continued implementation of a phased plan to provide four-person staffing on front line fire apparatus to move towards compliance with NFPA Standard 1710 and improve the response times of Advanced Life Support service; and (4) other operating budget support for MCFRS.

Implementing the programs listed above will require incremental improvements under a multi-year plan. The EMST Fee will provide an ongoing revenue source that will help fund that plan. I will continue to make recommendations for critical improvements to the MCFRS in the annual operating budget process.

In most cases, the EMST Fee will be billed directly to an individual's health insurer. County residents without insurance will not pay for emergency transports to the hospital. All of the region's surrounding jurisdictions have implemented similar fees without reducing the willingness of individuals to call for emergency service transports.

I look forward to working with Council in addressing the priority needs of the MCFRS to assure that we adequately meet the public safety needs of our growing community.

IL:jgs

Attachments

2008 APR 11 11 00 29

PROPERTY OF
MONTGOMERY COUNTY
GOVERNMENT



OFFICE OF MANAGEMENT AND BUDGET

Isiah Leggett
County Executive

Joseph F. Beach
Director

MEMORANDUM

April 14, 2008

TO: Michael J. Knapp, Council President
FROM: Joseph F. Beach, Director, Office of Management and Budget
SUBJECT: Expedited Bill, Emergency Medical Service Transportation Fee

2008 APR 14 PM 4:02

RECEIVED
MONTGOMERY COUNTY
COUNCIL

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

LEGISLATION SUMMARY

The expedited bill will provide for a new Emergency Medical Service Transport fee to be implemented in FY09 to provide needed resources for improvements to staffing, apparatus, recruitment and retention and volunteer enhancements.

FISCAL SUMMARY

The primary fiscal impact of this legislation will be to establish an Emergency Medical Services Transportation fee as specified in the legislation.

Revenues

The projected revenues are based on a mix of four payer types: Medicare, Medicaid, Commercial/Auto Insurance and Self Pay and an average revenue per transport rate of \$247 in FY09 up to \$253 in FY12 and a Montgomery County Fire and Rescue Service estimated transport volume of 56,980 for FY09 which is expected to increase to 64,090 in FY12. The legislation is expected to result in revenues of \$7.05 million in FY09, assuming mid-year implementation, and annual revenues of \$14.8 million in FY10, \$15.4 million in FY11 and \$16.2 million in FY12. 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.

Office of the Director

Expenditures

Personnel Costs

It is expected that six additional full-time personnel will be needed for implementation: A Manager III, an Office Services Coordinator, two Quality Assurance personnel, an IT Specialist II, and a Program Manager I (Data Analyst). The Manager III and IT Specialist II will be hired in FY09, with the remainder of the staff phased-in during FY10. The FY09 salary, wages and benefits total \$190,750. The annual total salary, wages and benefits, excluding any wage adjustments, will be \$466,500 annually.

Operating Expenses

Operating expenses for FY09 is comprised of a third party contract expenditures of \$352,390 and \$200,000 for community outreach activities. In addition, funds are set aside in designated reserves in FY09 for acquisition of an Electronic Patient Care Reporting System (EPCR) to efficiently automate the management of patient information. The cost of this system and annual maintenance fees will be dependent on the vendor selected and the terms negotiated with that vendor. 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.

JFB:aaa

Attachment

cc: Timothy L. Firestine, Chief Administrative Officer
Tom Carr, Chief, Montgomery County Fire and Rescue Service
Kathleen Boucher, Assistant Chief Administrative Officer
Rebecca Domaruk, Offices of the County Executive
Brady Goldsmith, OMB
Anita Aryeetey, OMB

PRIVILEGED AND CONFIDENTIAL
ATTORNEY-CLIENT COMMUNICATION

MONTGOMERY COUNTY FIRE RESCUE SERVICES

EMS Transport Revenue Projections

Submitted By:



January 18, 2008

Page, Wolfberg & Wirth, LLC
5010 E. Trindle Road, Suite 202
Mechanicsburg, PA 17050
(717) 691-0100
(717) 691-1226 (fax)
Web Site: www.pwwemslaw.com

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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.

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.

II. Methodology and Assumptions

A. Time Intervals

This report provides four (4) years of revenue projections. We utilized 2008 Medicare rates as a starting figure. 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) 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 currently utilizes a paper patient care reporting approach, which limits both the accuracy and the quantity of available data from which these projections can be made.

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.

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). We believe that, compared to other jurisdictions, we have utilized a conservative mix of ALS vs. BLS transports. Many similar jurisdictions report higher ALS percentages. We felt it was best to estimate a lower percentage of transports classified with an ALS level of service, because there are several key variables which effect this determination that have yet to be made by MCFRS. A key variable is the implementation (and integration with the billing system) of a dispatch protocol that utilizes ALS/BLS response determinants. Another key variable in this area is the quality of field documentation, particularly whether the crews adequately document the elements necessary to bill for "ALS assessments" under applicable payor guidelines. This involves the documentation of the nature of dispatch, an immediate response, and the performance of an assessment by an ALS-level provider.

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.

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 such invasive interventions as endotracheal intubation.

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, all transports of Medicare Advantage patients are included in the "Medicare" category. 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. Residents (and employees of business situated within the County) 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). As a result, we assume a conservative 10% of collections from the projected universe of self-pay patients. In other words, we assume that the vast majority of services will be provided to County residents.

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 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 projections assume a GPCI of 1.08, which is the 2007 GPCI for Maryland Locality 01.

Medicare rates increase annually by a modest inflation factor. In 2007, Medicare announced an Ambulance Inflation Factor (AIF) of 2.7% for dates of service January 1, 2008 – December 31, 2008. We assumed a 2.5% Medicare AIF for years 2-4. We also assumed a 2.5% increase in amounts allowed by commercial insurers. 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. We conservatively assume in this model a copayment collection rate of zero.

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 10% for self-pay accounts, 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. In an EMS system that has not previously billed for services, it can be expected that field personnel will not be sufficiently oriented to the importance of the documentation that is required from a revenue recovery perspective. Detailed documentation training will be required of all EMS personnel in the County to fully realize these revenue projections. Montgomery County policymakers and budget officials might want to take this factor into account when considering their anticipated EMS revenue budgets and reduce the projections by some estimated factor (for instance, 40% in Year One, 30% in Year Two, 20% in Year Three and 10% in Year Four) to account for this unpredictable variable.

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 million. Years Two – Four projections are approximately \$14.7 million, \$15.4 million and \$16.2 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 range from \$247 in Year One to \$253 in Year Four, 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. While these data does 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, realized an average revenue per transport of \$217. On the other side of the spectrum, 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 run in the 47%-49% 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 (10%), 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

Payor Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	N/A	Estimated Self-Pay %	Total Self-Pay Cash Receipts
BLS-NE (A0426)	1%	\$ 300	160		\$ 47,861		10%	\$ 4,766
BLS-E (A0429)	42%	\$ 400	6,700		\$ 2,680,198		10%	\$ 268,020
ALS1-NE (A0426)	1%	\$ 350	160		\$ 55,837		10%	\$ 5,584
ALS1-E (A0427)	55%	\$ 500	8,774		\$ 4,387,229		10%	\$ 438,723
ALS2 (A0433)	1%	\$ 700	160		\$ 111,675		10%	\$ 11,167
SCT (A0434)	0%	\$ 800	-		\$ -		10%	\$ -
Loaded Miles (A0425) (Average/Trip)	5	\$ 8	79,770		\$ 638,160		10%	\$ 63,816
							TOTAL	\$ 792,096
GRAND TOTALS - CHARGES/APPROVED CHARGES					\$ 29,008,320	\$ 15,251,444		
GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR ONE								
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT								
GROSS COLLECTION PERCENTAGE								
NET COLLECTION PERCENTAGE								
Notes and Assumptions:								
Transport volume is based on estimates provided by Montgomery County Fire Rescue								
Estimated number of Medicare transports per level of service estimated based on comparable MDVA jurisdictions								
Increases in future years assume GPCI for MD Locality 01 of 1.08 and annual increases of 2.5% for all payors except MD Medicaid and self-pay								
2008 Medicare rates based on 2007 rates for MD Locality 01, plus 2.7% inflation factor for 2008								
Revenue model assumes annual increases in charges of 5%								
ALS v BLS level of service estimates subject to implementation of appropriate dispatch protocols and ALS/BLS response determinants								
Assumes complete documentation necessary to support billing decisions; crew documentation training recommended								
Patient Pay collection rate of 10% reflects an "insurance only" billing policy for County residents								
Conservatively assumes zero deductible/copayment collections, given that most Medicare recipients who utilize the ambulance will be County residents								
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.								
					\$ 14,095,567			\$ 247
								\$ 49%
								\$ 92%

Appendix B Year Two Revenue Projections

Payor	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	N/A	Estimated Self-Pay %	Total Self-Pay Cash Receipts
Payor Self-Pay (28%)								
BLS-NE (A0428)	1%	\$ 315	166	N/A	\$ 52,264	N/A	10%	\$ 5,226
BLS-E (A0429)	42%	\$ 420	6,969	N/A	\$ 2,926,772	N/A	10%	\$ 292,677
ALS1-NE (A0426)	1%	\$ 368	166	N/A	\$ 60,974	N/A	10%	\$ 6,097
ALS1-E (A0427)	55%	\$ 525	9,125	N/A	\$ 4,790,848	N/A	10%	\$ 479,085
ALS2 (A0433)	1%	\$ 735	166	N/A	\$ 121,949	N/A	10%	\$ 12,195
SCT (A0434)	0%	\$ 840	-	N/A	\$ -	N/A	10%	\$ -
Loaded Miles (A0425) (Average/Trip)	5	\$ 8.40	79,770	N/A	\$ 670,068	N/A	10%	\$ 67,007
TOTAL \$ 862,288								
GRAND TOTALS - CHARGES/APPROVED CHARGES \$ 30,764,603 \$ 15,897,796								
GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR TWO \$ 14,763,417								
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT \$ 249								
GROSS COLLECTION PERCENTAGE 48%								
NET COLLECTION PERCENTAGE 93%								
Notes and Assumptions:								
Transport volume is based on estimates provided by Montgomery County Fire Rescue								
Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions								
Increases in future years assume GPCI for MD Locality 01 of 1.08 and annual increases of 2.5% for all payors except MD Medicaid and self-pay								
2008 Medicare rates based on 2007 rates for MD Locality 01, plus 2.7% inflation factor for 2008								
Revenue model assumes annual increases in charges of 5%								
ALS v BLS level of service estimates subject to implementation of appropriate dispatch protocols and ALS/BLS response determinants								
Assumes complete documentation necessary to support billing decisions; crew documentation training recommended								
Patient Pay collection rate of 10% reflects an "insurance only" billing policy for County residents								
Conservatively assumes zero deductible/copayment collections, given that most Medicare recipients who utilize the ambulance will be County residents								
<u>Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.</u>								
<u>This is an estimate only and does not constitute a guarantee.</u>								

Appendix C Year Three Revenue Projections

Montgomery County, MD EMS Transport Fee - Revenue Projections Year Three		Total Projected Transport Volume	Est. Medicare Transport (40%)	Est. Medicaid Transport (4%)	Est. Commercial/ Auto Transport (28%)	Est. Self-Pay Transport (28%)		
Est. % of Transports	Charge	Medicare Approved Charge	Est. Medicare Transport Volume	Total Charges	Total Medicare Approved Charges	Medicare Allowable	Total Medicare Cash Receipts	
	1% \$ 331	\$ 221.52	228	\$ 75,468	\$ 50,507	80%	\$ 40,406	
BLS-NE (A0428)								
BLS-E (A0429)	42% \$ 441	\$ 354.43	9,572	\$ 4,221,252	\$ 3,392,604	80%	\$ 2,714,083	
ALS1-NE (A0426)	1% \$ 386	\$ 265.83	2,281	\$ 880,466	\$ 606,358	80%	\$ 485,087	
ALS1-E (A0427)	55% \$ 551	\$ 420.90	12,535	\$ 6,906,785	\$ 5,275,982	80%	\$ 4,220,786	
ALS2 (A0433)	1% \$ 772	\$ 609.20	228	\$ 176,016	\$ 138,898	80%	\$ 111,118	
SCT (A0434)	0% \$ 882	\$ 719.96	-	\$ -	\$ -	80%	\$ -	
Loaded Miles (A0425) (Average/Trip)	5 \$ 8.82	\$ 6.74	113,955	\$ 1,005,083	\$ 768,057	80%	\$ 614,446	
						TOTAL	\$ 6,185,922	
Est. % of Transports	Charges	Medicaid Approved Charge	Est. Medicaid Transport Volume	Total Charges	Total Medicaid Approved Charges	Medicaid Allowable	Total Medicaid Cash Receipts	
	1% \$ 331	\$ 100	23	\$ 7,613	\$ 2,300	100%	\$ 2,300	
BLS-NE (A0428)								
BLS-E (A0429)	42% \$ 441	\$ 100	957	\$ 422,037	\$ 95,700	100%	\$ 95,700	
ALS1-NE (A0426)	1% \$ 386	\$ 100	23	\$ 8,878	\$ 2,300	100%	\$ 2,300	
ALS1-E (A0427)	55% \$ 551	\$ 100	1,253	\$ 690,403	\$ 125,300	100%	\$ 125,300	
ALS2 (A0433)	1% \$ 772	\$ 100	23	\$ 17,756	\$ 2,300	100%	\$ 2,300	
SCT (A0434)	0% \$ 882	\$ 100	-	\$ -	\$ -	100%	\$ -	
Loaded Miles (A0425) (Average/Trip)	5 \$ 8.82	\$ -	11,395	\$ 100,504	\$ -	0%	\$ -	
						TOTAL	\$ 27,900	
Est. % of Transports	Charges	Est. Ins. Approved Charge	Est. Commercial/Au to Volume	Total Charges	Total Insurance Approved Charges	Insurance Allowable	Total Insurance Cash Receipts	
	1% \$ 331	\$ 231.95	160	\$ 52,960	\$ 37,113	100%	\$ 37,113	
BLS-NE (A0428)								
BLS-E (A0429)	42% \$ 441	\$ 308.04	6,701	\$ 2,955,141	\$ 2,070,865	100%	\$ 2,070,865	
ALS1-NE (A0426)	1% \$ 386	\$ 270.50	160	\$ 61,760	\$ 43,279	100%	\$ 43,279	
ALS1-E (A0427)	55% \$ 551	\$ 386.12	8,774	\$ 4,834,474	\$ 3,387,839	100%	\$ 3,387,839	
ALS2 (A0433)	1% \$ 772	\$ 540.99	160	\$ 123,520	\$ 86,559	100%	\$ 86,559	
SCT (A0434)	0% \$ 882	\$ 618.08	-	\$ -	\$ -	100%	\$ -	
Loaded Miles (A0425) (Average/Trip)	5 \$ 8.82	\$ 6.18	79,770	\$ 703,571	\$ 493,040	100%	\$ 493,040	
						TOTAL	\$ 6,118,944	

Payor: Self-Pay (28%)	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	N/A	Estimated Self-Pay %	Total Self-Pay Cash Receipts
BLS-NE (A0428)	1%	\$ 331	173		\$ 57,115		10%	\$ 5,711
BLS-E (A0429)	42%	\$ 441	7,247		\$ 3,196,023		10%	\$ 319,602
ALS1-NE (A0426)	1%	\$ 386	173		\$ 66,605		10%	\$ 6,661
ALS1-E (A0427)	55%	\$ 551	9,490		\$ 5,229,213		10%	\$ 522,921
ALS2 (A0433)	1%	\$ 772	173		\$ 133,211		10%	\$ 13,321
SCT (A0434)	0%	\$ 882	-		\$ -		10%	\$ -
Loaded Miles (A0425) (Average Trip)	5	\$ 8.82	79,770		\$ 703,571		10%	\$ 70,357
GRAND TOTALS - CHARGES/APPROVED CHARGES					\$ 32,629,425	\$ 16,578,999	TOTAL	\$ 538,574
GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR THREE								
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT								
GROSS COLLECTION PERCENTAGE								
NET COLLECTION PERCENTAGE								
Notes and Assumptions:								
Transport volume is based on estimates provided by Montgomery County Fire Rescue								
Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions								
Increases in future years assume GPCI for MD Locality 01 of 1.08 and annual increases of 2.5% for all payors except MD Medicaid and self-pay								
2008 Medicare rates based on 2007 rates for MD Locality 01, plus 2.7% inflation factor for 2008								
Revenue model assumes annual increases in charges of 5%								
ALS v BLS level of service estimates subject to implementation of appropriate dispatch protocols and ALS/BLS response determinants								
Assumes complete documentation necessary to support billing decisions; crew documentation training recommended								
Patient Pay collection rate of 10% reflects an "insurance only" billing policy for County residents								
Conservatively assumes zero deductible/copayment collections, given that most Medicare recipients who utilize the ambulance will be County residents								
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.								
\$ 15,471,092								
\$ 251								
47%								
93%								

Appendix D Year Four Revenue Projections

	Est. % of Transports	Charges	Est. Self-Pay Transport Volume	N/A	Total Self-Pay Charges	N/A	Estimated Self-Pay %	Total Self-Pay Cash Receipts
Payor: Self-Pay (28%)								
BLS-NE (A0428)	1%	\$ 348	179	N/A	\$ 62,370	N/A	10%	\$ 6,237
BLS-E (A0429)	42%	\$ 463	7,537		\$ 3,490,065		10%	\$ 349,005
ALS1-NE (A0426)	1%	\$ 405	179		\$ 72,679		10%	\$ 7,268
ALS1-E (A0427)	55%	\$ 579	9,870		\$ 5,710,297		10%	\$ 571,030
ALS2 (A0433)	1%	\$ 811	179		\$ 145,466		10%	\$ 14,547
SCT (A0434)	0%	\$ 928	-		\$ -		10%	\$ -
Loaded Miles (A0425) (Average/Trip)	5	\$ 9.26	79,770		\$ 738,670		10%	\$ 73,867
GRAND TOTALS - CHARGES/APPROVED CHARGES					\$ 34,624,464	\$ 17,301,410	TOTAL	\$ 1,021,954
GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR FOUR \$ 16,225,692								
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT \$ 253								
GROSS COLLECTION PERCENTAGE 47%								
NET COLLECTION PERCENTAGE 94%								
Notes and Assumptions:								
Transport volume is based on estimates provided by Montgomery County Fire Rescue								
Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions								
Increases in future years assume GPCI for MD Locality 01 of 1.08 and annual increases of 2.5% for all payors except MD Medicaid and self-pay								
2008 Medicare rates based on 2007 rates for MD Locality 01, plus 2.7% inflation factor for 2008								
Revenue model assumes annual increases in charges of 5%								
ALS v BLS level of service estimates subject to implementation of appropriate dispatch protocols and ALS/BLS response determinants								
Assumes complete documentation necessary to support billing decisions; crew documentation training recommended								
Patient Pay collection rate of 10% reflects an "insurance only" billing policy for County residents								
Conservatively assumes zero deductible/copayment collections, given that most Medicare recipients who utilize the ambulance will be County residents								
<u>Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.</u>								
<u>This is an estimate only and does not constitute a guarantee.</u>								

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



Doug Wolfberg is an attorney with Page, Wolfberg & Wirth LLC, a national EMS industry law firm. The law firm works with clients in developing legally defensible patient-refusal policies and forms, and provides training in documentation skills and medical legal issues for EMS personnel. For more information, visit the firm's Web site at www.pwwemslaw.com or send an e-mail to Doug Wolfberg at dwolfberg@pwwemslaw.com.

This column is not intended as legal advice or legal counsel in the confines of an attorney-client relationship. Consult an attorney for specific legal advice concerning your situation.

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,

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.

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.



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/osharegs/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/governmental relations at ldeaton@iafc.org.

Bill 25-08, Emergency medical Services Transport Fee –Imposition
Fiscal Impact

Questions

Assumptions for Revenues and Fees

1. Please list the number and type of EMS calls for service and transports in each fee category over the past 3 years.
2. What was the basis for the increases in EMS transport volume that were assumed in years 2 to 4 in the revenue estimate?
3. How did Page, Wolfberg, Wirth determine the breakout of payor types: Medicare 40%; Medicaid 4%; Commercial/Auto 28%; Self-Pay 28%?
4. How was the proposed fee structure chosen? What alternatives were considered?

Field Documentation

5. The Page, Wolfberg, Wirth report (p. 7) says that EMS billing is only as good as the field documentation that supports it, and that detailed training will be needed to fully realize revenue projections.
 - a. How much training per staff member will be needed?
 - b. Who will provide the training?
 - c. What will the training cost? Is that cost included in the fiscal impact statement?
 - d. How will the training be provided – on straight time or overtime? Will the training result in any cost to backfill positions?
6. The report also suggests reducing revenue projections by an estimated factor to account for initial limits in field documentation collection (for example, 40% in Year 1, 30% in Year 2, 20% in Year 3, and 10% in Year 4).
 - a. If the County implements an automated field documentation collection system, what are the likely rates of incomplete data collection or errors?
 - b. What has been the initial experience with field documentation in other jurisdictions? Has their field documentation start-up resulted in decreased revenue collections similar to the examples in the report?

Implementation Resources

7. Why are 6 new positions needed to implement the EMS fee? Please explain what each position would do.
8. If a third party vendor is hired to administer the fee, why would 2 County IT positions be necessary?
9. Where would office space for the positions be located? Would additional rental space be needed?
10. What is the basis for the assumption that a third party vendor would cost 5% of revenues? What is the experience in other jurisdictions in the area?
11. What is involved in hiring a third party vendor? How long would the procurement process take?
12. The new Electronic Patient Care Reporting (EPCR) system is needed to comply with State requirements for electronic reporting by the end of 2008. What arrangements are being made to acquire the system?
13. How would the EPCR system relate to the third party billing process?



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 titled "Emergency Medical Services Transport
Fee – Imposition" becomes effective

Comment Deadline: _____

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. \$7.50 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. Each individual who receives an emergency medical services transport must furnish to the County, or its designated agent or contractor: (i) information pertaining to the individual's health insurer (or other applicable insurer); and (ii) financial information that the Fire Chief determines is necessary for collection of the fee.
- b. Each insured individual who receives an emergency medical services transport must execute an assignment of benefits form 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 Services.



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 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 the Bill titled "Emergency Medical Services Transport Fee – Imposition" becomes effective.

Approved:

Isiah Leggett, County Executive



Proposed Executive Regulations

[Return to Table of Contents](#)

★ **MCER NO. 20-08: PROPOSED MONTGOMERY COUNTY FIRE AND RESCUE REGULATION – *Emergency Medical Service Transport Fee***

SUMMARY: The proposed regulation establishes (1) an Emergency Medical Services Transport Fee (EMS 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. The fee schedule, including the mileage rate, may be amended based on any additional financial analysis received before approval of the final regulation. An amendment will be considered to establish a process or formula to distribute a portion of the revenue received from the EMS fee to the Local Fire and Rescue Departments. Comment is invited on an appropriate process or formula for distributing revenue from the EMS fee to the Local Fire and Rescue Departments.

COMMENTS: Written comments must be submitted by July 1, 2008, to Assistant Chief Scott Graham, MCFRS, Montgomery County Fire and Rescue Service/Office of the Fire Chief, 101 Monroe Street, 12th Floor, Rockville, Maryland 20850; 240/777-2493.
scott.graham@montgomerycountymd.gov

AUTHORIZATION AND PROCEDURAL METHOD: Montgomery County Code, 2004, Section 21-23A.
Method 2.

COPIES OF THE PROPOSED REGULATION: A copy of the proposed regulation may be obtained from to Assistant Chief Scott Graham, MCFRS, Montgomery County Fire and Rescue Service/Office of the Fire Chief, 101 Monroe Street, 12th Floor, Rockville, Maryland 20850; 240/777-2493.
scott.graham@montgomerycountymd.gov

~~**MCER NO. 21-08: PROPOSED ETHICS COMMISSION REGULATION – *Lobbyist Registration Fee***~~

~~**SUMMARY:** The proposed regulation implements section 19A-23(e) which permits the Ethics Commission to charge an annual registration fee for lobbyists.~~

~~**COMMENTS:** Written comments must be submitted by June 30, 2008, to Barbara McNally, 100 Maryland Avenue, #204, Rockville, Maryland 20850; 240/777-6670.
barbara.mcnelly@montgomerycountymd.gov~~

~~**AUTHORIZATION AND PROCEDURAL METHOD:** Montgomery County Code, 2004, Section 19A-23(e). Method 2.~~

~~**COPIES OF THE PROPOSED REGULATION:** A copy of the proposed regulation may be obtained from Barry Alpher, Ethics Commission, 100 Maryland Avenue, #204, Rockville, Maryland 20850. barry.alpher@montgomerycountymd.gov~~

~~**MCER NO. 22-08: PROPOSED OFFICE OF HUMAN RESOURCES REGULATION –**~~

BILL 25-08



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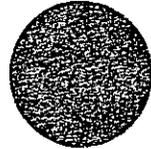
OFFICES OF THE COUNTY EXECUTIVE

Isiah Leggett
County Executive

Timothy L. Firestine
Chief Administrative Officer

MEMORANDUM

May 13, 2008



TO: Michael J. Knapp, Council President
FROM: Timothy L. Firestine, Chief Administrative Officer
SUBJECT: Emergency Medical Services Transport Fee

2008 MAY 13 5:12:59

RECEIVED
MONTGOMERY COUNTY
COUNCIL

On April 11, 2008, County Executive Isiah Leggett forwarded to Council a bill that would authorize the Montgomery County Fire and Rescue Service (MCFRS) to impose an Emergency Medical Services Transport Fee (EMST Fee). He also forwarded a draft Executive Regulation which would implement that bill. In order to ensure that all relevant details of the EMST Fee are considered as a package, the proposed Executive Regulation will be published in the June 2008 Montgomery County Register.

With this memorandum, I am forwarding an Implementation Plan for the (EMST) Fee. While this type of fee will be new to Montgomery County, similar fees have already been implemented in hundreds of jurisdictions nationally and by several local governments in this region including Fairfax County, Arlington County, the District of Columbia, and Prince George's County. In addition, the County Government, the Department of Finance, and MCFRS administer fee collection operations that match or exceed the complexity and magnitude of the proposed EMST Fee. The attached plan indicates that both in inception and in implementation the EMST Fee will:

- Support the continued provision of first-class emergency medical services transport to all in need;
- Charge Medicare and health insurance companies for emergency medical service transport costs incurred by County residents and non-County residents;
- Result in no out-of-pocket expenses for insured County residents and no charge for uninsured County residents;
- Produce substantial non-tax supported resources to provide urgently needed enhancements to the County's combined Fire and Rescue Services; and
- Support the activities of the Local Volunteer Fire and Rescue Departments.

I look forward to discussing this plan with the Council.

TLF:jgs

Michael J. Knapp
May 13, 2008
Page 2

Attachment

cc: Isiah Leggett, County Executive
Thomas W. Carr, Fire Chief
Leon Rodriguez, County Attorney
Patrick Lacefield, Director, Office of Public Information
Joseph F. Beach, Director, Office of Management and Budget
Jennifer E. Barrett, Director, Department of Finance
Kathleen Boucher, Assistant Chief Administrative Officer

**IMPLEMENTATION OF AN EMERGENCY
MEDICAL SERVICES TRANSPORT FEE IN
MONTGOMERY COUNTY, MARYLAND**

Prepared by:
Fire and Rescue Service
Office of Management and Budget
Public Information Office
Offices of the County Executive

May 13, 2008

Background

Montgomery County Fire and Rescue Service (MCFRS) provides emergency medical services (EMS) and transport through a comprehensive delivery system. This system is comprised of career and volunteer personnel, basic and advanced life support first response, as well as basic and advanced life support transports.

MCFRS staffs 24 basic life support (BLS) ambulances 24/7 and 3 BLS "Flex Units" 12 hours per day, 18 medic units, 18 Advance Life Support (ALS) engine companies, 15 engine companies, 15 truck companies, and 6 heavy rescue squads operating from strategically selected locations. MCFRS provides a response to all emergency calls for ambulance transportation within the County. Emergency response is also provided for surrounding jurisdictions under mutual aid agreements. MCFRS responds to approximately 70,000 EMS calls per year.

Problem

The demand for EMS response has been growing significantly for the past several years as the County has grown, especially in the Upcounty area. To respond to these service demands, improve response time, and enhance firefighter/rescuer officer safety, several enhancements have been initiated within MCFRS and will require additional resources in the future including:

- Implementing four-person staffing. The County has initiated the first two phases of this seven phase plan.
- Opening new stations in the Upcounty area including Travilah, West Germantown, East Germantown, and Clarksburg.
- Implementing an Apparatus Management Plan that will replace, upgrade and modernize apparatus, and provide additional maintenance staff, supplies, and maintenance facilities.
- Implementing the State required Electronic Patient Care Reporting System (e-PCR). On December 31, 2008, the Maryland Institute for Emergency Medical Services Systems will discontinue paper reporting. Currently MCFRS utilizes this method. MCFRS must quickly implement on a fast track, an e-PCR program in order to meet State of Maryland requirements as well as be fully capable of complete revenue recovery.
- Expanding the number of Captains consistent with supervisory and work hour requirements which will result in a reduction to overtime.
- Supporting Local Fire and Rescue Departments (LFRDs) by funding on-going station maintenance and other needs.

The table below summarizes the projected costs of some of these initiatives.

Potential Use of Resources	FY09	FY10	FY11	FY12	Total
Operating Budget Impact - Staffing New Stations	\$ 3,017,430	\$ 6,327,000	\$ 6,585,000	\$ 9,284,000	\$ 25,213,430
Apparatus Management Plan***		\$ 7,000,000	\$ 7,840,000	\$ 8,780,800	\$ 23,620,800
4 Person Staffing Phases 3-7		\$ 4,101,000	\$ 8,494,094	\$ 13,200,086	\$ 25,795,179
Total (Potential Use of Resources)	\$ 3,017,430	\$ 17,428,000	\$ 22,919,094	\$ 31,264,886	\$ 74,629,409
*** Assumes 12% Cost Escalator in FY10-12					

Proposed Solution

The proposed EMST Fee will provide a substantial portion of the resources needed for these enhancements. In addition, the EMST Fee will be a dedicated revenue source that will be collected by the MCFRS and deposited in the Fire Tax District Fund. However, if these resources are not available, the County will either, not implement or partially implement these enhancements, reduce services substantially in a different part of the government, or increase property taxes to fund these improvements.

Program Revenues and Expenditures

To study the feasibility of implementing an EMST Fee, the County contracted with Page, Wolfberg, and Wirth, L.L.C. (PWW), a nationally recognized law firm specializing in Emergency Medical Services law. In conjunction with PWW, MCFRS developed the detailed financial projections for the EMST Fee. The table below summarizes the projected costs and revenues for implementing of the EMST Fee.

	FY09	FY10	FY11	FY12	TOTAL
Gross Revenue Collected	\$ 7,047,790	\$ 14,763,417	\$ 15,471,092	\$ 16,225,692	\$ 53,507,991
					\$ -
Costs					
Third Party Billing (5%)	\$ 352,390	\$ 1,476,341	\$ 1,547,109	\$ 1,622,569	\$ 4,998,409
Community Outreach	\$ 200,000	\$ 50,000	\$ 50,000	\$ 25,000	\$ 325,000
Initial Personnel Training	\$ -	\$ 25,000	\$ 25,000	\$ 25,000	\$ 75,000
Manager Billing Services*	\$ 105,500	\$ 113,014	\$ 121,064	\$ 129,686	\$ 469,264
Quality Compliance (2)*	\$ -	\$ 138,055	\$ 147,888	\$ 158,422	\$ 444,365
IT Specialist - Hardware*	\$ 85,250	\$ 91,325	\$ 97,830	\$ 104,798	\$ 379,203
IT Specialist - Data Analyst*	\$ -	\$ 91,325	\$ 97,830	\$ 104,798	\$ 293,953
Office Service Coordinator*	\$ -	\$ 65,935	\$ 70,631	\$ 75,662	\$ 212,228
Available Revenue	\$ 6,304,650	\$ 12,712,421	\$ 13,313,740	\$ 13,979,757	\$ 46,310,569
* Assumes a 7% increase per year					

To ensure that the revenue projections were realistic, MCFRS assumed a relatively low total transport number of 56,977. Assumptions regarding the types of transports (e.g. Basic Life Support – Emergency (BLS-E), Advance Life Support – Emergency (ALS-E), etc.) were based on MCFRS records. Fees were set in a manner consistent with other

jurisdictions and the cost of providing the services, and assumptions about payor types (e.g. Medicare, Medicaid, and Commercial Insurance) were also based on experience in other jurisdictions.

Administration of the Fee

- No person regardless of ability to pay will ever be refused EMS treatment or transport by MCFRS.
- Each EMS transport will result in a bill for service being sent to the patient's insurance company or the patient depending on two factors: Is the patient a County resident? Is the patient insured?
- Patients who reside within the county will not receive a bill for services whether they are insured or not.
- Patients who do not reside within the county and are insured will receive a bill only for the cost of the co-pay and deductible. A Request for Waiver will be included with the bill.
- Patients who do not reside within the county and are not insured will receive a bill for the services, but a Request for Waiver will be included with the bill.
- Requests for Waivers will be granted by the Fire Chief based on whether the patient's household income is within the federal poverty guidelines.
- Billing and collection functions will be contracted to a third party that specializes in EMS billing. With the rapidly changing requirements of the various insurance services, it is necessary to employ experts in this field to insure a prompt and accurate payment program.
- MCFRS will work with the local hospitals to provide insurance information to the billing contractor.
- This information will be transmitted electronically to the contracted billing vendor to facilitate collections.
- The billing vendor will be paid a negotiated fee for services. This fee is budgeted at 5% of collected revenue.

Impact on Local Fire and Rescue Departments

Our efforts to study the feasibility and impacts of implementing the EMST Fee have included numerous discussions with the LFRDs and the Montgomery County Volunteer Fire and Rescue Association (MCFVRA). The primary concerns of the LFRDs would appear to be that the EMST Fee would deter some residents from calling for emergency services and that the existence of the fee may impair their fund raising efforts.

We have found no evidence to support the claim that emergency calls for service or patient transports decline after the imposition of an EMST Fee. Similarly there is also no evidence that EMST Fees impair the development capacity of volunteer fire corporations. The County's policies and budgetary decisions should be driven by data, evidence, and best practices and not on assertions lacking any factual basis.

We have discussed with the LFRDs and the MCVFRA potential opportunities to share a portion of the EMST Fee revenues to provide resources to support their efforts to serve County residents as well as to offset any reduction in development that may result from the establishment of an EMST Fee.

Community Outreach Plan

To ensure that County residents understand how the billing process will work and assure them that service will not be denied regardless of ability to pay we are developing a comprehensive community outreach plan.

Communities that have implemented an EMST Fee program have accompanied that program with a public outreach and education campaign. While there is no evidence from any of these jurisdictions that adoption of an EMST Fee has resulted in any diminution of calls for 911 service or emergency transport or any reluctance of residents to call for needed services due to a misunderstanding that they might incur a fee, a solid campaign of public outreach and education just makes good sense. Such a campaign would begin several months before the program actually began and extend several months afterward.

The proposal as advanced by the County Executive includes up to \$200,000 for just such a campaign, to be undertaken by the County Office of Public Information in conjunction with MCFRS. Such a campaign could include:

- An informational mailer/card sent to all County households.
- Distribution of information through existing County and community email lists, blogs, and list serves.
- Radio and television public service announcements made available to the electronic media servicing the County.
- News releases and news events featuring information about the program.
- Information translated into Spanish, French, Chinese, Korean, Vietnamese, and other languages, as needed.
- Extensive use of County Cable Montgomery television and all the Public, Educational, and Government channels funded by the County.
- A speakers' bureau available to address community groups.
- Posters and brochures made available at all County events and on Ride One buses and through: Regional Service Centers; Public Libraries; Recreation facilities; senior centers; ESL classes; MCPS; Montgomery College; health care providers; hospitals and clinics; and other venues.
- Special outreach to the senior community and to the County's "New American" communities.

Through these means – and others yet to be determined – the County could communicate that, as always, the MCFRS stands ready to assist all those in need, regardless of ability to pay.

Summary

The establishment of an EMST Fee can be accomplished during FY09 which would produce substantial non-tax supported resources to support the urgently needed enhancements for the MCFRS. The table below summarizes the projected revenues, program costs, and the potential uses of the resulting fee revenues. The table also includes a comparison of the revenues that would be raised by an increase in the County's property tax rate. An increase in the property tax rate is the most feasible alternative to the EMST Fee since the property tax provides over 95 percent of the revenues for the County's Consolidated Fire Tax District Fund.

MCFRS Emergency Medical Service Transport Fee - Revenues and Use of Potential Use of Resources					
	FY09	FY10	FY11	FY12	TOTAL
Gross Revenue Collected	\$ 7,047,790	\$ 14,763,417	\$ 15,471,092	\$ 16,225,692	\$ 53,507,991
Costs					
Third Party Billing (5%)	\$ 352,390	\$ 1,476,341	\$ 1,547,109	\$ 1,622,569	\$ 4,998,409
Community Outreach	\$ 200,000	\$ 50,000	\$ 50,000	\$ 25,000	\$ 325,000
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Office Service Coordinator*	\$ -	\$ 65,935	\$ 70,631	\$ 75,662	\$ 212,228
Available Revenue	\$ 6,304,650	\$ 12,712,421	\$ 13,313,740	\$ 13,979,757	\$ 46,310,569
LFRD Allocation **	\$ -	\$ 1,500,000	\$ 1,575,000	\$ 1,653,750	\$ 4,728,750
CFTD Reserves (For Electronic Patient Care Reporting System (EPCR) PC Modules and Licensing)	\$ 2,500,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 2,800,000
Total (Program-related Expenditure)	\$ 2,500,000	\$ 1,600,000	\$ 1,675,000	\$ 1,753,750	\$ 7,528,750
Net Revenue (After Program-related Expenditure)	\$ 3,804,650	\$ 11,112,421	\$ 11,638,740	\$ 12,226,007	\$ 38,781,819
Other Use of Resources ****					
Operating Budget Impact - Staffing New Stations	\$ 3,017,430	\$ 6,327,000	\$ 6,585,000	\$ 9,284,000	\$ 25,213,430
Apparatus Management Plan***		\$ 7,000,000	\$ 7,840,000	\$ 8,780,800	\$ 23,620,800
4 Person Staffing Phases 3-7		\$ 4,101,000	\$ 8,494,094	\$ 13,200,086	\$ 25,795,179
Total (Other Use of Resources)	\$ 3,017,430	\$ 17,428,000	\$ 22,919,094	\$ 31,264,886	\$ 74,629,409
Net Revenue (After other use of resources)	\$ 787,220	\$ (6,315,579)	\$ (11,280,354)	\$ (19,038,879)	\$ (35,847,590)
1 cent increase in Property Tax Rate =	\$ 16,100,000	\$ 16,695,700	\$ 16,979,527	\$ 17,488,913	\$ 67,264,140
Note:					
* Assumes a 7% increase per year					
** Illustrative Only (details pending further discussion with LFRDs and MCVFRA). Assumes a 5% increase per year.					
*** Assumes 12% Cost Escalator					
**** Does not include other potential FRS needs including additional Captains consistent with supervisory and work hour requirements.					