

**MEMORANDUM**

TO: County Council

FROM: *MF* Michael Faden, Senior Legislative Attorney  
*MRD* Minna Davidson, Legislative Analyst

SUBJECT: **Action:** Executive Regulation 6-10AM, Emergency Medical Services Transport Fees

The Council reviewed Regulation 6-10 on May 19, 2010, and requested certain amendments which were recommended by Council staff. (See ©35-36 for discussion of amendments.) The Executive amended Regulation 6-10 as the Council requested, and reissued and re-numbered it Executive Regulation 6-10AM to indicate that it was amended after transmittal to the Council. Regulation 6-10AM is attached on ©2-4. An approval resolution is attached on ©1.

Regulation 6-10AM would: (1) establish the EMST fee schedule; (2) require an individual who receives an EMS transport to provide health insurance information to the County or the County's designee; (3) require an individual who applies for a waiver to provide certain financial information necessary for the Fire Chief to determine eligibility for the waiver; and (4) require the Fire Chief to increase the amount of the fees in the schedule annually by the Medicare Ambulance Inflation Factor.

<u>This packet contains</u>	<u>Circle</u>
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Resolution No.: \_\_\_\_\_  
Introduced: May 20, 2010  
Adopted: \_\_\_\_\_

COUNTY COUNCIL  
FOR MONTGOMERY COUNTY, MARYLAND

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By: County Council

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Subject: Approval of Executive Regulation 6-10AM, *Emergency Medical Service Transport Fees*

Background

1. On May 13, 2010, the Council received proposed Regulation 6-10, *Emergency Medical Service Transport Fees*, from the Executive.
2. The Council must review Regulation 6-10 under method (2) of Section 2A-15 of the County Code.
3. The Council reviewed Regulation 6-10 on May 19, 2010, and requested certain amendments.
4. The Executive amended Regulation 6-10 as the Council requested, and reissued and re-numbered it Executive Regulation 6-10AM to indicate that it was amended after transmittal to the Council.

Action

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

Executive Regulation 6-10AM, *Emergency Medical Service Transport Fees*, is approved.

This is a correct copy of Council action.

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Linda M. Lauer, Clerk of the Council

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# MONTGOMERY COUNTY EXECUTIVE REGULATION

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

<b>Subject</b> Emergency Medical Service Transport Fees	<b>Number</b> 6-10 AM
<b>Originating Department</b> Montgomery County Fire and Rescue Services	<b>Effective Date</b>

Montgomery County Regulation on

## EMERGENCY MEDICAL SERVICE TRANSPORT FEES

Issued by: County Executive

Regulation No. 6-10 AM

COMCOR: Chapter 21

Authority: Montgomery County Code Section 21-23A

Supersedes: N/A

Council Review: Method (2) under Code Section 2A-15

Register Vol. 27, No. 4

Effective Date: Date Bill 13-10, Emergency Medical Services Transport Fee –  
Established becomes effective (July 1, 2010 implementation date)

Comment Deadline: April 16, 2010

RECEIVED  
MONTGOMERY COUNTY  
COUNCIL  
2010 MAY 20 AM 9:24

**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  
Executive Office Building  
101 Monroe Street, 12th Floor  
Rockville, Maryland 20850

### 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.*



# MONTGOMERY COUNTY EXECUTIVE REGULATION

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

<b>Subject</b> Emergency Medical Service Transport Fees	<b>Number</b> 6-10 AM
<b>Originating Department</b> Montgomery County Fire and Rescue Services	<b>Effective Date</b>

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

- i. \$8.50 per mile, one way, from point of pick up to the health care facility; plus
- ii.
  - Basic Life Support – Non-emergency\* \$300.00
  - Basic Life Support – Emergency\* \$400.00
  - Advanced Life Support – Level 1 – Non-emergency\* \$350.00
  - Advanced Life Support – Level 1 – Emergency\* \$500.00
  - Advanced Life Support – Level 2\* \$700.00
  - Specialty Care Transport\* \$800.00

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

## Section 2. Required Information; Assignment of Benefits.

- a. An individual who receives an emergency medical services transport must furnish to the County, or its designated agent, information pertaining to the individual’s health insurer (or other applicable insurer).
- b. An individual who requests a hardship waiver must provide to the Fire Chief any financial information that the Fire Chief determines is necessary for determining eligibility for a waiver of the fee.
- c. Each insured individual who receives an emergency medical services transport must execute an assignment of benefits necessary to permit the County to submit a claim for the fee to the applicable third-party payor.
- d. 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 Fire Chief must publish the new fee schedule in the Register each year when the fee schedule is updated.

## Section 3. Severability.

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



# MONTGOMERY COUNTY EXECUTIVE REGULATION

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

<b>Subject</b> Emergency Medical Service Transport Fees	<b>Number</b> 6-10 AM
<b>Originating Department</b> Montgomery County Fire and Rescue Services	<b>Effective Date</b>

validity of other parts of the regulation.

#### Section 4. Effective Date.

This regulation is effective on the date Bill 13-10, Emergency Medical Services Transport Fee -- Established becomes effective, and must be implemented beginning on July 1, 2010 in accordance with Section 3 of Bill 13-10.

Approved:

A handwritten signature in cursive script, appearing to read "Isiah Leggett".

Isiah Leggett, County Executive

APPROVED AS TO FORM AND LEGALITY.  
OFFICE OF COUNTY ATTORNEY  
BY Marc Hansen  
DATE 5/18/10



OFFICE OF THE COUNTY EXECUTIVE  
ROCKVILLE, MARYLAND 20850

Isiah Leggett  
County Executive

MEMORANDUM

May 13, 2010

056885



2010 MAY 13 PM 4:14

RECEIVED  
MONTGOMERY COUNTY  
COUNCIL

TO: Nancy Floreen  
Council President

FROM: Isiah Leggett  
County Executive

METHOD 2

SUBJECT: Executive Regulation 6-10 - Emergency Medical Service Transport Fee

With this memorandum, I am transmitting Executive Regulation 6-10, Emergency Medical Service Transport Fee, for your approval. This Regulation would implement Expedited Bill 13-10 by: (1) establishing an emergency medical services (EMS) transport fee schedule; (2) requiring an individual who receives an EMS transport to provide health insurance information to the County or the County's designee; and (3) requiring an individual who applies for a waiver of the fee to provide financial information requested by the Fire Chief as necessary to determine eligibility for the waiver.

This Method 2 Regulation was advertised in the April 2010 County Register. No public comments were received. If you have any questions about this Regulation, please contact Assistant Chief Administrative Officer Kathleen Boucher at 240-777-2593 or Assistant Chief Scott Graham at 240-777-2493.

Attachments



OFFICE OF MANAGEMENT AND BUDGET

Isiah Leggett  
County Executive

Joseph F. Beach  
Director

MEMORANDUM

May 13, 2010

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

VIA: Alex Espinosa, Management and Budget Manager

VIA: John Cuff, Management and Budget Specialist

FROM: Blaise DeFazio, Management and Budget Specialist

SUBJECT: Executive Regulation 6-10, Emergency Medical Service  
Transport Fees

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**REGULATION SUMMARY**

The proposed 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.

**FISCAL SUMMARY**

The projected revenues are based on a mix of four payer types—Medicare, Medicaid, Commercial/Auto Insurance and Self Pay, average revenue per transport rate of \$248 in FY11 up to \$261 in FY14, and a Montgomery County Fire and Rescue Service estimated transport volume of 56,977 for FY11 which is expected to increase to 64,091 in FY14. The transport fee is expected to result in revenues of \$14.1 million in FY11<sup>1</sup>, \$14.9 million in FY12, \$15.8 million in FY13 and \$16.7 million in FY14. 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.

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

Office of the Director

**Expenditures**

**Personnel Costs**

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

**Operating Expenses**

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

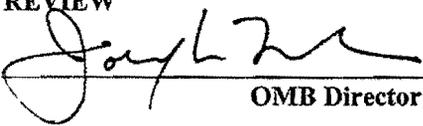
Assistant Chief Scott Graham with the Montgomery County Fire and Rescue Service contributed to and concurred with this analysis.

JFB:bed

- cc: Kathleen Boucher, Assistant Chief Administrative Officer
- Richard Bowers, Chief, Montgomery County Fire and Rescue Service
- Dee Gonzalez, Office of the County Executive
- Dominic Del Pozzo, Fire and Rescue Service
- Blaise DeFazio, Office of Management and Budget
- John Cuff, Office of Management and Budget

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OMB REVIEW

Fiscal Impact Statement approved   
OMB Director

Fiscal Impact Statement not approved, OMB will contact department to remedy.

**PRIVILEGED AND CONFIDENTIAL**  
**ATTORNEY-CLIENT COMMUNICATION**

**MONTGOMERY COUNTY FIRE RESCUE SERVICES**

**Updated 2010 EMS Transport Revenue Projections**

Submitted By:



April 23, 2010

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](http://www.pwwemslaw.com)

## EXECUTIVE SUMMARY

If EMS insurance billing is implemented in Montgomery County, Maryland, the County is projected to generate \$61,597,110 in new revenue over the initial four years of the program. Thereafter, the County would be expected to continue to derive in excess of \$15 million per year of new revenue under the program. Under the proposed Montgomery County EMS transport fee model, none of the projected revenues would be paid out of the pockets of County residents.

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

The updated 2010 report adjusts the total four-year revenue projections downward by \$634,392 (from \$62,231,502 to \$61,597,110) as compared to the four-year projections in the November, 2008 report. The major reasons (none of which were foreseeable at the time of the 2008 projections) for this change, in order of impact, are:

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

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

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## I. Overview

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

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

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

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

## II. Methodology and Assumptions

### A. Time Intervals

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

### B. Estimated Transport Volume

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

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

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

### C. Transport Mix by Payor

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

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

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

#### D. Transport Mix by Level of Service

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

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

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

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

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

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

#### E. Payor Type

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

#### F. Self-Pay Transports

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

#### G. Mileage

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

#### H. Charges

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

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

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

I. Approved Charges

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

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

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

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

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

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

#### J. "Allowables"

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

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

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

#### K. Patient Care Documentation

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

### III. Revenue Projections

#### A. Total Cash Receipts

We have broken down projected cash receipts by each payor, and then calculated an overall total. Year One revenues are projected at approximately \$14.1 million. Years Two – Four projections are approximately \$14.9 million, \$15.7 million and \$16.7 million, respectively. Again, County policymakers and budget officials must take into account the assumptions and limitations discussed above when budgeting anticipated revenues from the EMS transport fee program.

#### B. Average Revenue Per Transport

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

It could be argued that the Average Revenue Per Transport estimates, which range from approximately \$248 - \$262, are optimistic. Of course, this is directly related to the rate structure that the County’s policymakers ultimately decide to put into place. Nevertheless, we have compared Montgomery County to other jurisdictions and believe there are some compelling reasons why these Average Revenue Per Transport estimates are reasonable.

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

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

#### C. Gross and Net Collection Percentages

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

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

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

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

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

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

#### **IV. Conclusion**

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

#### **V. Important Notices**

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

# **Appendix A Year One Revenue Projections**

Updated 04/23/10

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

<b>Payor: Self-Pay (28%)</b>	<b>Est. % of Transports</b>	<b>Charges</b>	<b>Est. Self-Pay Transport Volume</b>	<b>N/A</b>	<b>Total Self-Pay Charges</b>	<b>Total Non-Resident Self-Pay Charges<sup>5</sup></b>	<b>Est. Non-Resident Collection%</b>	<b>Total Self-Pay Cash Receipts</b>				
BLS-NE (A0428)	1%	\$ 300	160		\$ 47,861	4,786	30%	\$ 1,436				
BLS-E (A0429)	54%	\$ 400	8,615		\$ 3,445,969	344,597	30%	\$ 103,379				
ALS1-NE (A0426)	1%	\$ 350	160		\$ 55,837	5,584	30%	\$ 1,675				
ALS1-E (A0427)	42%	\$ 500	6,700		\$ 3,350,248	335,025	30%	\$ 100,507				
ALS2 (A0433)	2%	\$ 700	319		\$ 223,350	22,335	30%	\$ 6,700				
SCT (A0434)	0%	\$ 800	-		\$ -	-	30%	\$ -				
Loaded Miles (A0425) (Average/Trip)	5	\$ 8	79,770		\$ 638,160	63,816	30%	\$ 19,145				
							<b>TOTAL</b>	<b>\$ 232,843</b>				
<b>GRAND TOTALS - CHARGES/APPROVED CHARGES</b>					<b>\$ 27,719,535</b>	<b>\$ 24,998,421</b>						
<b>GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR ONE</b>								<b>\$ 14,143,139</b>				
<b>OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT</b>								<b>\$ 248</b>				
<b>GROSS COLLECTION PERCENTAGE</b>								<b>51%</b>				
<b>NET COLLECTION PERCENTAGE</b>								<b>57%</b>				
<b>Footnotes:</b>												
1 Transport volume is based on estimates provided by Montgomery County Fire Rescue												
2 Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions												
3 2010 Medicare rates taken from 2010 Ambulance Public Use File from the Centers for Medicare and Medicaid Services												
4 Medigap estimate is 52% of total Medicare copayments; Medicare copayments are 20% of Medicare approved charges												
5 Non-resident self-pay charges estimated to comprise 10% of total self-pay charges												
<b><i>Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.</i></b>												
<b><i>This is an estimate only and does not constitute a guarantee.</i></b>												

# Appendix B Year Two Revenue Projections

Updated 04/23/10

<b>Montgomery County, MD EMS Transport Fee - Revenue Projections</b>		<b>Total Projected Transport Volume<sup>1</sup></b>	<b>Est. Medicare Transports (40%)<sup>2</sup></b>	<b>Est. Medicaid Transports (4%)</b>	<b>Est. Commercial/ Auto Transports (28%)</b>	<b>Est. Self-Pay Transports (28%)</b>				
<b>Year Two</b>		59,256	23,702	2,370	16,592	16,592				
<b>Payor: Medicare (40%)</b>		<b>Est. % of Transports</b>	<b>Charge</b>	<b>Medicare Approved Charge<sup>3</sup></b>	<b>Est. Medicare Transport Volume</b>	<b>Total Charges</b>	<b>Total Medicare Approved Charges</b>	<b>Medicare Allowable</b>	<b>Total Medicare Cash Receipts</b>	
BLS-NE (A0428)	1%	\$ 315	\$ 218.02	237	\$ 74,655	\$ 51,671	80%	\$ 41,337		
BLS-E (A0429)	54%	\$ 420	\$ 348.82	12,799	\$ 5,375,580	\$ 4,464,547	80%	\$ 3,571,638		
ALS1-NE (A0426)	1%	\$ 368	\$ 261.62	237	\$ 87,216	\$ 62,004	80%	\$ 49,603		
ALS1-E (A0427)	42%	\$ 525	\$ 414.23	9,955	\$ 5,226,375	\$ 4,123,660	80%	\$ 3,298,928		
ALS2 (A0433)	2%	\$ 735	\$ 599.54	474	\$ 348,390	\$ 284,182	80%	\$ 227,346		
SCT (A0434)	0%	\$ 840	\$ 708.55	-	\$ -	\$ -	80%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 8.40	\$ 6.74	113,955	\$ 957,222	\$ 768,057	80%	\$ 614,445		
						\$ 9,754,120		\$ 7,803,296	Medicare Receipts	
								\$ 1,014,428	Medigap Receipts <sup>4</sup>	
								\$ 8,817,725	Medicare Total	
<b>Payor: Medicaid (4%)</b>		<b>Est. % of Transports</b>	<b>Charges</b>	<b>Medicaid Approved Charge</b>	<b>Est. Medicaid Transport Volume</b>	<b>Total Charges</b>	<b>Total Medicaid Approved Charges</b>	<b>Medicaid Allowable</b>	<b>Total Medicaid Cash Receipts</b>	
BLS-NE (A0428)	1%	\$ 315	\$ 100	24	\$ 7,560	\$ 2,400	100%	\$ 2,400		
BLS-E (A0429)	54%	\$ 420	\$ 100	1,280	\$ 537,600	\$ 128,000	100%	\$ 128,000		
ALS1-NE (A0426)	1%	\$ 368	\$ 100	24	\$ 8,832	\$ 2,400	100%	\$ 2,400		
ALS1-E (A0427)	42%	\$ 525	\$ 100	995	\$ 522,375	\$ 99,500	100%	\$ 99,500		
ALS2 (A0433)	2%	\$ 735	\$ 100	47	\$ 34,545	\$ 4,700	100%	\$ 4,700		
SCT (A0434)	0%	\$ 840	\$ 100	-	\$ -	\$ -	100%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 8	\$ -	11,395	\$ 95,718	\$ -	0%	\$ -		
							<b>TOTAL</b>	\$ 237,000		
<b>Payor: Commercial/Auto (28%)</b>		<b>Est. % of Transports</b>	<b>Charges</b>	<b>Est. Ins. Approved Charge</b>	<b>Est. Commercial/A uto Volume</b>	<b>Total Charges</b>	<b>Total Insurance Approved Charges</b>	<b>Insurance Allowable</b>	<b>Total Insurance Cash Receipts</b>	
BLS-NE (A0428)	1%	\$ 315	\$ 210.11	166	\$ 52,290	\$ 34,877	100%	\$ 34,877		
BLS-E (A0429)	54%	\$ 420	\$ 280.14	8,960	\$ 3,763,200	\$ 2,510,054	100%	\$ 2,510,054		
ALS1-NE (A0426)	1%	\$ 368	\$ 245.46	166	\$ 61,088	\$ 40,746	100%	\$ 40,746		
ALS1-E (A0427)	42%	\$ 525	\$ 350.18	6,969	\$ 3,658,725	\$ 2,440,370	100%	\$ 2,440,370		
ALS2 (A0433)	2%	\$ 735	\$ 490.25	332	\$ 244,020	\$ 162,761	100%	\$ 162,761		
SCT (A0434)	0%	\$ 840	\$ 560.28	-	\$ -	\$ -	100%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 8	\$ 5.60	79,770	\$ 670,068	\$ 446,935	100%	\$ 446,935		
							<b>TOTAL</b>	\$ 5,635,744		

<b>Payor: Self-Pay (28%)</b>	<b>Est. % of Transports</b>	<b>Charges</b>	<b>Est. Self-Pay Transport Volume</b>	<b>N/A</b>	<b>Total Self-Pay Charges</b>	<b>Total Non-Resident Self-Pay Charges<sup>5</sup></b>	<b>Est. Non-Resident Collection%</b>	<b>Total Self-Pay Cash Receipts</b>
BLS-NE (A0428)	1%	\$ 315	166		\$ 52,290	5,229	30%	\$ 1,569
BLS-E (A0429)	54%	\$ 420	8,960		\$ 3,763,200	376,320	30%	\$ 112,896
ALS1-NE (A0426)	1%	\$ 368	166		\$ 61,088	6,109	30%	\$ 1,833
ALS1-E (A0427)	42%	\$ 525	6,969		\$ 3,658,725	365,873	30%	\$ 109,762
ALS2 (A0433)	2%	\$ 735	332		\$ 244,020	24,402	30%	\$ 7,321
SCT (A0434)	0%	\$ 840	-		\$ -	-	30%	\$ -
Loaded Miles (A0425) (Average/Trip)	5	\$ 8	79,770		\$ 670,068	67,007	30%	\$ 20,102
							<b>TOTAL</b>	<b>\$ 253,482</b>
<b>GRAND TOTALS - CHARGES/APPROVED CHARGES</b>					<b>\$ 30,174,850</b>	<b>\$ 26,225,923</b>		
<b>GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR TWO</b>								<b>\$ 14,943,950</b>
<b>OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT</b>								<b>\$ 252</b>
<b>GROSS COLLECTION PERCENTAGE</b>								<b>50%</b>
<b>NET COLLECTION PERCENTAGE</b>								<b>57%</b>
<b>Footnotes:</b>								
1 Transport volume is based on estimates provided by Montgomery County Fire Rescue								
2 Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions								
3 2010 Medicare rates taken from 2010 Ambulance Public Use File from the Centers for Medicare and Medicaid Services								
4 Medigap estimate is 52% of total Medicare copayments; Medicare copayments are 20% of Medicare approved charges								
5 Non-resident self-pay charges estimated to comprise 10% of total self-pay charges								
<b><i>Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.</i></b>								
<b><i>This is an estimate only and does not constitute a guarantee.</i></b>								

# **Appendix C Year Three Revenue Projections**

Updated 04/23/10

<b>Montgomery County, MD EMS Transport Fee - Revenue Projections</b>		<b>Total Projected Transport Volume<sup>1</sup></b>	<b>Est. Medicare Transports (40%)<sup>2</sup></b>	<b>Est. Medicaid Transports (4%)</b>	<b>Est. Commercial/ Auto Transports (28%)</b>	<b>Est. Self-Pay Transports (28%)</b>				
<b>Year Three</b>		61,626	24,650	2,465	17,255	17,255				
<b>Payor: Medicare (40%)</b>		<b>Est. % of Transports</b>	<b>Charge</b>	<b>Medicare Approved Charge<sup>3</sup></b>	<b>Est. Medicare Transport Volume</b>	<b>Total Charges</b>	<b>Total Medicare Approved Charges</b>	<b>Medicare Allowable</b>	<b>Total Medicare Cash Receipts</b>	
BLS-NE (A0428)	1%	\$ 330	\$ 218.02	247	\$ 81,510	\$ 53,851	80%	\$ 43,081		
BLS-E (A0429)	54%	\$ 441	\$ 348.82	13,311	\$ 5,870,151	\$ 4,643,143	80%	\$ 3,714,514		
ALS1-NE (A0426)	1%	\$ 386	\$ 261.62	247	\$ 95,342	\$ 64,620	80%	\$ 51,696		
ALS1-E (A0427)	42%	\$ 551	\$ 414.23	10,353	\$ 5,704,503	\$ 4,288,523	80%	\$ 3,430,819		
ALS2 (A0433)	2%	\$ 771	\$ 599.54	493	\$ 380,103	\$ 295,573	80%	\$ 236,459		
SCT (A0434)	0%	\$ 882	\$ 708.55	-	\$ -	\$ -	80%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 8.82	\$ 6.74	113,955	\$ 1,005,083	\$ 768,057	80%	\$ 614,445		
						\$ 10,113,767		\$ 8,091,014	Medicare Receipts	
								\$ 1,051,832	Medigap Receipts <sup>4</sup>	
								\$ 9,142,846	Medicare Total	
<b>Payor: Medicaid (4%)</b>		<b>Est. % of Transports</b>	<b>Charges</b>	<b>Medicaid Approved Charge</b>	<b>Est. Medicaid Transport Volume</b>	<b>Total Charges</b>	<b>Total Medicaid Approved Charges</b>	<b>Medicaid Allowable</b>	<b>Total Medicaid Cash Receipts</b>	
BLS-NE (A0428)	1%	\$ 330	\$ 100	25	\$ 8,250	\$ 2,500	100%	\$ 2,500		
BLS-E (A0429)	54%	\$ 441	\$ 100	1,331	\$ 586,971	\$ 133,100	100%	\$ 133,100		
ALS1-NE (A0426)	1%	\$ 386	\$ 100	25	\$ 9,650	\$ 2,500	100%	\$ 2,500		
ALS1-E (A0427)	42%	\$ 551	\$ 100	1,035	\$ 570,285	\$ 103,500	100%	\$ 103,500		
ALS2 (A0433)	2%	\$ 771	\$ 100	49	\$ 37,779	\$ 4,900	100%	\$ 4,900		
SCT (A0434)	0%	\$ 882	\$ 100	-	\$ -	\$ -	100%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 8.82	\$ -	11,395	\$ 100,504	\$ -	0%	\$ -		
							<b>TOTAL</b>	\$ 246,500		
<b>Payor: Commercial/Auto (28%)</b>		<b>Est. % of Transports</b>	<b>Charges</b>	<b>Est. Ins. Approved Charge</b>	<b>Est. Commercial/A uto Volume</b>	<b>Total Charges</b>	<b>Total Insurance Approved Charges</b>	<b>Insurance Allowable</b>	<b>Total Insurance Cash Receipts</b>	
BLS-NE (A0428)	1%	\$ 330	\$ 220.11	173	\$ 57,090	\$ 38,079	100%	\$ 38,079		
BLS-E (A0429)	54%	\$ 441	\$ 294.15	9,318	\$ 4,109,238	\$ 2,740,862	100%	\$ 2,740,862		
ALS1-NE (A0426)	1%	\$ 386	\$ 257.46	173	\$ 66,778	\$ 44,541	100%	\$ 44,541		
ALS1-E (A0427)	42%	\$ 551	\$ 367.52	7,247	\$ 3,993,097	\$ 2,663,396	100%	\$ 2,663,396		
ALS2 (A0433)	2%	\$ 771	\$ 514.26	345	\$ 265,995	\$ 177,419	100%	\$ 177,419		
SCT (A0434)	0%	\$ 882	\$ 588.29	-	\$ -	\$ -	100%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 8.82	\$ 5.88	79,770	\$ 703,571	\$ 469,282	100%	\$ 469,282		
							<b>TOTAL</b>	\$ 6,133,578		

<b>Payor: Self-Pay (28%)</b>	<b>Est. % of Transports</b>	<b>Charges</b>	<b>Est. Self-Pay Transport Volume</b>	<b>N/A</b>	<b>Total Self-Pay Charges</b>	<b>Total Non-Resident Self-Pay Charges<sup>5</sup></b>	<b>Est. Non-Resident Collection%</b>	<b>Total Self-Pay Cash Receipts</b>
BLS-NE (A0428)	1%	\$ 330	173		\$ 57,090	5,709	30%	\$ 1,713
BLS-E (A0429)	54%	\$ 441	9,318		\$ 4,109,238	410,924	30%	\$ 123,277
ALS1-NE (A0426)	1%	\$ 386	173		\$ 66,778	6,678	30%	\$ 2,003
ALS1-E (A0427)	42%	\$ 551	7,247		\$ 3,993,097	399,310	30%	\$ 119,793
ALS2 (A0433)	2%	\$ 771	345		\$ 265,995	26,600	30%	\$ 7,980
SCT (A0434)	0%	\$ 882	-		\$ -	-	30%	\$ -
Loaded Miles (A0425) (Average/Trip)	5	\$ 9	79,770		\$ 703,571	70,357	30%	\$ 21,107
							<b>TOTAL</b>	<b>\$ 275,873</b>
<b>GRAND TOTALS - CHARGES/APPROVED CHARGES</b>					<b>\$ 32,841,670</b>	<b>\$ 27,527,190</b>		
<b>GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR THREE</b>								<b>\$ 15,798,797</b>
<b>OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT</b>								<b>\$ 256</b>
<b>GROSS COLLECTION PERCENTAGE</b>								<b>48%</b>
<b>NET COLLECTION PERCENTAGE</b>								<b>57%</b>
<b>Footnotes:</b>								
1 Transport volume is based on estimates provided by Montgomery County Fire Rescue								
2 Estimated number of Medicare transports per level of service estimated based on comparable MDVA jurisdictions								
3 2010 Medicare rates taken from 2010 Ambulance Public Use File from the Centers for Medicare and Medicaid Services								
4 Medigap estimate is 52% of total Medicare copayments; Medicare copayments are 20% of Medicare approved charges								
5 Non-resident self-pay charges estimated to comprise 10% of total self-pay charges								
<b><i>Billing for any health care service involves many variables that cannot be accounted for in a revenue estimate and that are beyond our control.</i></b>								
<b><i>This is an estimate only and does not constitute a guarantee.</i></b>								

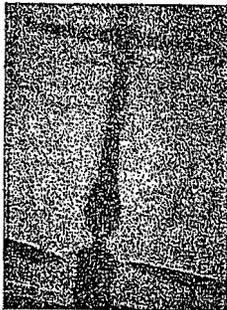
# Appendix D Year Four Revenue Projections

Updated 04/23/10

Montgomery County, MD EMS Transport Fee - Revenue Projections		Total Projected Transport Volume <sup>1</sup>	Est. Medicare Transports (40%) <sup>2</sup>	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)				
Year Four		64,091	25,636	2,564	17,945	17,945				
<b>Payor: Medicare (40%)</b>		<b>Est. % of Transports</b>	<b>Charge</b>	<b>Medicare Approved Charge<sup>3</sup></b>	<b>Est. Medicare Transport Volume</b>	<b>Total Charges</b>	<b>Total Medicare Approved Charges</b>	<b>Medicare Allowable</b>	<b>Total Medicare Cash Receipts</b>	
BLS-NE (A0428)	1%	\$ 346	\$ 218.02	256	\$ 88,576	\$ 55,813	80%	\$ 44,650		
BLS-E (A0429)	54%	\$ 463	\$ 348.82	13,843	\$ 6,409,309	\$ 4,828,715	80%	\$ 3,862,972		
ALS1-NE (A0426)	1%	\$ 405	\$ 261.62	256	\$ 103,680	\$ 66,975	80%	\$ 53,580		
ALS1-E (A0427)	42%	\$ 578	\$ 414.23	10,767	\$ 6,223,326	\$ 4,460,014	80%	\$ 3,568,012		
ALS2 (A0433)	2%	\$ 809	\$ 599.54	513	\$ 415,017	\$ 307,564	80%	\$ 246,051		
SCT (A0434)	0%	\$ 926	\$ 708.55	-	\$ -	\$ -	80%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 9.26	\$ 6.74	113,955	\$ 1,055,223	\$ 768,057	80%	\$ 614,445		
						\$ 10,487,138		\$ 8,389,711	Medicare Receipts	
								\$ 1,090,662	Medigap Receipts <sup>4</sup>	
								\$ 9,480,373	Medicare Total	
<b>Payor: Medicaid (4%)</b>		<b>Est. % of Transports</b>	<b>Charges</b>	<b>Medicaid Approved Charge</b>	<b>Est. Medicaid Transport Volume</b>	<b>Total Charges</b>	<b>Total Medicaid Approved Charges</b>	<b>Medicaid Allowable</b>	<b>Total Medicaid Cash Receipts</b>	
BLS-NE (A0428)	1%	\$ 346	\$ 100	26	\$ 8,996	\$ 2,600	100%	\$ 2,600		
BLS-E (A0429)	54%	\$ 463	\$ 100	1,385	\$ 641,255	\$ 138,500	100%	\$ 138,500		
ALS1-NE (A0426)	1%	\$ 405	\$ 100	26	\$ 10,530	\$ 2,600	100%	\$ 2,600		
ALS1-E (A0427)	42%	\$ 578	\$ 100	1,076	\$ 621,928	\$ 107,600	100%	\$ 107,600		
ALS2 (A0433)	2%	\$ 809	\$ 100	51	\$ 41,259	\$ 5,100	100%	\$ 5,100		
SCT (A0434)	0%	\$ 926	\$ 100	-	\$ -	\$ -	100%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 9.26	\$ -	11,395	\$ 105,518	\$ -	0%	\$ -		
							<b>TOTAL</b>	\$ 256,400		
<b>Payor: Commercial/Auto (28%)</b>		<b>Est. % of Transports</b>	<b>Charges</b>	<b>Est. Ins. Approved Charge</b>	<b>Est. Commercial/A uto Volume</b>	<b>Total Charges</b>	<b>Total Insurance Approved Charges</b>	<b>Insurance Allowable</b>	<b>Total Insurance Cash Receipts</b>	
BLS-NE (A0428)	1%	\$ 346	\$ 230.78	179	\$ 61,934	\$ 41,310	100%	\$ 41,310		
BLS-E (A0429)	54%	\$ 463	\$ 308.82	9,690	\$ 4,486,470	\$ 2,992,475	100%	\$ 2,992,475		
ALS1-NE (A0426)	1%	\$ 405	\$ 270.14	179	\$ 72,495	\$ 48,354	100%	\$ 48,354		
ALS1-E (A0427)	42%	\$ 578	\$ 385.53	7,537	\$ 4,356,386	\$ 2,905,709	100%	\$ 2,905,709		
ALS2 (A0433)	2%	\$ 809	\$ 539.60	359	\$ 290,431	\$ 193,717	100%	\$ 193,717		
SCT (A0434)	0%	\$ 926	\$ 617.64	-	\$ -	\$ -	100%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 9.26	\$ 6.18	79,770	\$ 738,670	\$ 492,693	100%	\$ 492,693		
							<b>TOTAL</b>	\$ 6,674,260		

<b>Payor: Self-Pay (28%)</b>	<b>Est. % of Transports</b>	<b>Charges</b>	<b>Est. Self-Pay Transport Volume</b>	<b>N/A</b>	<b>Total Self-Pay Charges</b>	<b>Total Non-Resident Self-Pay Charges<sup>5</sup></b>	<b>Est. Non-Resident Collection%</b>	<b>Total Self-Pay Cash Receipts</b>		
BLS-NE (A0428)	1%	\$ 346	179		\$ 61,934	6,193	30%	\$ 1,858		
BLS-E (A0429)	54%	\$ 463	9,690		\$ 4,486,470	448,647	30%	\$ 134,594		
ALS1-NE (A0426)	1%	\$ 405	179		\$ 72,495	7,250	30%	\$ 2,175		
ALS1-E (A0427)	42%	\$ 578	7,537		\$ 4,356,386	435,639	30%	\$ 130,692		
ALS2 (A0433)	2%	\$ 809	359		\$ 290,431	29,043	30%	\$ 8,713		
SCT (A0434)	0%	\$ 926	-		\$ -	-	30%	\$ -		
Loaded Miles (A0425) (Average/Trip)	5	\$ 9.26	79,770		\$ 738,670	73,867	30%	\$ 22,160		
							<b>TOTAL</b>	<b>\$ 300,192</b>		
<b>GRAND TOTALS - CHARGES/APPROVED CHARGES</b>					<b>\$ 35,737,389</b>	<b>\$ 28,905,575</b>				
<b>GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR FOUR</b>								<b>\$ 16,711,224</b>		
<b>OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT</b>								<b>\$ 261</b>		
<b>GROSS COLLECTION PERCENTAGE</b>								<b>47%</b>		
<b>NET COLLECTION PERCENTAGE</b>								<b>58%</b>		
<b>Footnotes:</b>										
1 Transport volume is based on estimates provided by Montgomery County Fire Rescue										
2 Estimated number of Medicare transports per level of service estimated based on comparable MD/VA jurisdictions										
3 2010 Medicare rates taken from 2010 Ambulance Public Use File from the Centers for Medicare and Medicaid Services										
4 Medigap estimate is 52% of total Medicare copayments; Medicare copayments are 20% of Medicare approved charges										
5 Non-resident self-pay charges estimated to comprise 10% of total self-pay charges										
<b><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></b>										
<b><u>This is an estimate only and does not constitute a guarantee.</u></b>										

## Appendix E EMS Rate Setting Article



## LEGAL CONSULT

INCISIVE ANALYSIS OF  
EMS LEGAL TOPICS



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](http://www.pwwemslaw.com) or send an e-mail to Doug Wolfberg at [dvwolfberg@pwwemslaw.com](mailto:dvwolfberg@pwwemslaw.com).

# 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

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.

**fyi**

#### Help OSHA Revise Its Emergency-Response Regulations

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

For more information and/or to contribute to this effort, visit [www.dol.gov/osha/regs/unified/agenda/2127.htm](http://www.dol.gov/osha/regs/unified/agenda/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](http://www.iafc.org) or contact Lucian Deaton, IAFC EMS manager/governmental relations at [ideaton@iafc.org](mailto:ideaton@iafc.org).

## **Executive Regulation 6-10, Emergency Medical Service Transport Fees**

On May 13, the Council received proposed Regulation 6-10 to implement the EMST fee. The Executive's transmittal memorandum says that the regulation was advertised in the April 2010 Register and no public comments were received.

Regulation 6-10 would: (1) establish the EMST fee schedule; (2) require an individual who receives an EMS transport to provide health insurance information to the County or the County's designee; (3) require an individual who applies for a waiver to provide certain financial information necessary for the Fire Chief to determine eligibility for the waiver; and (4) require the Fire Chief to increase the amount of the fees in the schedule annually by the Medicare Ambulance Inflation Factor.

Regulation 6-10 must be processed under method (2) of Section 2A-15 of the County Code. Under method (2), if the Council does not approve or disapprove a regulation within 60 days after the Council receives it, the regulation automatically takes effect unless the Council, by resolution, extends the deadline for action.

**If the Council wishes to approve the fee, the Council should approve the regulation so that the Executive can begin the implementation process. If the Council does not wish to approve the fee, the Council should disapprove the regulation so that it does not automatically take effect.**

### **Issues**

If the Council wishes to implement the EMST fee, Council staff would recommend that the Council request that the Executive amend the regulation as discussed below. If the Council agrees with the amendments, the Executive would have to re-issue and re-number the regulation as 6-10AM to indicate that it was amended after transmittal to the Council.

#### **Issue #1**

Section 2.a. says:

If requested by the Fire Chief, each individual who receives an emergency medical services transport must furnish to the County, or its designated agent: (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 determination of granting a waiver of the fee.

In Council staff's view, this language is confusing, and does not make it clear that each individual who receives an emergency medical services transport must furnish health insurance information to the County or its designated agent. Council staff recommends splitting this paragraph into two sections as follows:

An individual who receives an emergency medical services transport must furnish to the County or its designated agent information pertaining to the individual's health insurer (or other applicable insurer).

An individual who requests a hardship waiver must provide to the Fire Chief any financial information which the Fire Chief determines is necessary for determining eligibility for a waiver of the fee.

**Issue #2**

The proposed regulation would require the Fire Chief to increase the amount of the fees in the schedule annually by the amount of the Medicare Ambulance Inflation Factor. Council staff recommends that this provision include a requirement for the Fire Chief to publish the new fee schedule in the Register when it is updated each year. Council staff recommends adding the following sentence (underlined) to the existing Section 2.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. The Fire Chief must publish the new fee schedule in the Register each year when the fee schedule is updated.

This packet contains:	Circle #
Expedited Bill 13-10	1
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