Agenda Item 17
June 10, 2008
Introduction

MEMORANDUM

TO: County Council

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

SUBJECT: **Introduction:** Bill 25-08, Emergency Medical Services Transport Fee - Imposition

Bill 25-08, Emergency Medical Services Transport Fee - Imposition, sponsored by the Council President at the request of the County Executive, is scheduled to be introduced on June 10, 2008. A public hearing is tentatively scheduled for July 8 at 7:30 p.m.

Bill 25-08 would authorize the Montgomery County 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 prohibits 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.

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

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

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

21-23A Emergency Medical Services Transport Fee.

(a) Definitions.

In this section the following terms have the meanings indicated:

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

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

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

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

(c) Liability for fee.

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

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

(d) Hardship waiver.

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

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

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

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

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

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

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

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① BILL
② EXEC REG

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CC
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has - MD
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OFFICE OF THE COUNTY EXECUTIVE
ROCKVILLE, MARYLAND 20850

Isiah Leggett
County Executive

034623

MEMORANDUM

April 11, 2008

Method 2

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

(5)

OFFICE OF MANAGEMENT AND BUDGET

Isiah Leggett
County Executive

Joseph F. Beach
Director

MEMORANDUM

April 14, 2008

2008 APR 14 PM 4:02
MONTGOMERY COUNTY COUNCIL

TO: Michael J. Knapp, Council President

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

SUBJECT: Expedited Bill, Emergency Medical Service Transportation Fee

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.

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

TABLE OF CONTENTS

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

Montgomery County, MD EMS Transport Fee - Revenue Projections Year One		Total Projected Transport Volume	Est. Medicare Transports (40%)	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)			
		56,977	22,791	2,279	15,954	15,954			

Payor: Medicare (40%)	Est. % of Transports	Charge	Medicare Approved Charge	Est. Medicare Transport Volume	Total Charges	Total Medicare Approved Charges	Medicare Allowable	Total Medicare Cash Receipts
BLS-NE (A0428)	1%	$ 300	$ 210.85	228	$ 68,400	$ 48,074	80%	$ 38,459
BLS-E (A0429)	42%	$ 400	$ 337.36	9,572	$ 3,828,800	$ 3,229,210	80%	$ 2,583,368
ALS1-NE (A0426)	1%	$ 350	$ 253.02	2,281	$ 798,350	$ 577,139	80%	$ 461,711
ALS1-E (A0427)	55%	$ 500	$ 400.61	12,535	$ 6,267,500	$ 5,021,646	80%	$ 4,017,317
ALS2 (A0433)	1%	$ 700	$ 579.84	228	$ 159,600	$ 132,204	80%	$ 105,763
SCT (A0434)	0%	$ 800	$ 685.27	-	$ -	$ -	80%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 6.42	113,955	$ 911,640	$ 731,591	80%	$ 585,273
							TOTAL	$ 7,791,891

Payor: Medicaid (4%)	Est. % of Transports	Charges	Medicaid Approved Charge	Est. Medicaid Transport Volume	Total Charges	Total Medicaid Approved Charges	Medicaid Allowable	Total Medicaid Cash Receipts
BLS-NE (A0428)	1%	$ 300	$ 100	23	$ 6,900	$ 2,300	100%	$ 2,300
BLS-E (A0429)	42%	$ 400	$ 100	957	$ 382,800	$ 95,700	100%	$ 95,700
ALS1-NE (A0426)	1%	$ 350	$ 100	23	$ 8,050	$ 2,300	100%	$ 2,300
ALS1-E (A0427)	55%	$ 500	$ 100	1,253	$ 626,500	$ 125,300	100%	$ 125,300
ALS2 (A0433)	1%	$ 700	$ 100	23	$ 16,100	$ 2,300	100%	$ 2,300
SCT (A0434)	0%	$ 800	$ 100	-	$ -	$ -	100%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ -	11,395	$ 91,160	$ -	0%	$ -
							TOTAL	$ 227,900

Payor: Commercial/Auto (28%)	Est. % of Transports	Charges	Est. Ins. Approved Charge	Est. Commercial/Auto Volume	Total Charges	Total Insurance Approved Charges	Insurance Allowable	Total Insurance Cash Receipts
BLS-NE (A0428)	1%	$ 300	$ 200.10	160	$ 48,000	$ 32,016	100%	$ 32,016
BLS-E (A0429)	42%	$ 400	$ 266.80	6,701	$ 2,680,400	$ 1,787,827	100%	$ 1,787,827
ALS1-NE (A0426)	1%	$ 350	$ 233.45	160	$ 56,000	$ 37,352	100%	$ 37,352
ALS1-E (A0427)	55%	$ 500	$ 333.50	8,774	$ 4,387,000	$ 2,926,129	100%	$ 2,926,129
ALS2 (A0433)	1%	$ 700	$ 466.90	160	$ 112,000	$ 74,704	100%	$ 74,704
SCT (A0434)	0%	$ 800	$ 533.60	-	$ -	$ -	100%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8	$ 5.34	79,770	$ 638,160	$ 425,653	100%	$ 425,653
							TOTAL	$ 5,283,681

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%	$ 300	160		$ 47,861		10%	$ 4,786
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	**$ 14,095,567**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 247**
GROSS COLLECTION PERCENTAGE	**49%**
NET COLLECTION PERCENTAGE	**92%**

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.

Appendix B
Year Two Revenue Projections

Montgomery County, MD EMS Transport Fee - Revenue Projections Year Two		Total Projected Transport Volume	Est. Medicare Transports (40%)	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)			
		59,256	23,702	2,370	16,592	16,592			
Payor: Medicare (40%)	**Est. % of Transports**	**Charge**	**Medicare Approved Charge**	**Est. Medicare Transport Volume**	**Total Charges**	**Total Medicare Approved Charges**	**Medicare Allowable**	**Total Medicare Cash Receipts**	
BLS-NE (A0428)	1%	$ 315	$ 216.12	228	$ 71,820	$ 49,275	80%	$ 39,420	
BLS-E (A0429)	42%	$ 420	$ 345.79	9,572	$ 4,020,240	$ 3,309,902	80%	$ 2,647,922	
ALS1-NE (A0426)	1%	$ 368	$ 259.35	2,281	$ 838,268	$ 591,577	80%	$ 473,262	
ALS1-E (A0427)	55%	$ 525	$ 410.63	12,535	$ 6,580,875	$ 5,147,247	80%	$ 4,117,798	
ALS2 (A0433)	1%	$ 735	$ 594.34	228	$ 167,580	$ 135,510	80%	$ 108,408	
SCT (A0434)	0%	$ 840	$ 702.40	-	$ -	$ -	80%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 8.40	$ 6.58	113,955	$ 957,222	$ 749,824	80%	$ 599,859	
							TOTAL	$ 7,986,669	
Payor: Medicaid (4%)	**Est. % of Transports**	**Charges**	**Medicaid Approved Charge**	**Est. Medicaid Transport Volume**	**Total Charges**	**Total Medicaid Approved Charges**	**Medicaid Allowable**	**Total Medicaid Cash Receipts**	
BLS-NE (A0428)	1%	$ 315	$ 100	23	$ 7,245	$ 2,300	100%	$ 2,300	
BLS-E (A0429)	42%	$ 420	$ 100	957	$ 401,940	$ 95,700	100%	$ 95,700	
ALS1-NE (A0426)	1%	$ 368	$ 100	23	$ 8,453	$ 2,300	100%	$ 2,300	
ALS1-E (A0427)	55%	$ 525	$ 100	1,253	$ 657,825	$ 125,300	100%	$ 125,300	
ALS2 (A0433)	1%	$ 735	$ 100	23	$ 16,905	$ 2,300	100%	$ 2,300	
SCT (A0434)	0%	$ 840	$ 100	-	$ -	$ -	100%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 8.40	$ -	11,395	$ 95,718	$ -	0%	$ -	
							TOTAL	$ 227,900	
Payor: Commercial/Auto (28%)	**Est. % of Transports**	**Charges**	**Est. Ins. Approved Charge**	**Est. Commercial/Auto Volume**	**Total Charges**	**Total Insurance Approved Charges**	**Insurance Allowable**	**Total Insurance Cash Receipts**	
BLS-NE (A0428)	1%	$ 315	$ 215.36	160	$ 50,400	$ 34,457	100%	$ 34,457	
BLS-E (A0429)	42%	$ 420	$ 287.14	6,701	$ 2,814,420	$ 1,924,149	100%	$ 1,924,149	
ALS1-NE (A0426)	1%	$ 368	$ 251.25	160	$ 58,800	$ 40,200	100%	$ 40,200	
ALS1-E (A0427)	55%	$ 525	$ 358.93	8,774	$ 4,606,350	$ 3,149,246	100%	$ 3,149,246	
ALS2 (A0433)	1%	$ 735	$ 502.50	160	$ 117,600	$ 80,400	100%	$ 80,400	
SCT (A0434)	0%	$ 840	$ 574.29	-	$ -	$ -	100%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 8.40	$ 5.74	79,770	$ 670,068	$ 458,109	100%	$ 458,109	
							TOTAL	$ 6,686,661	

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%	$ 315	166		$ 52,264		10%	$ 5,226
BLS-E (A0429)	42%	$ 420	6,969		$ 2,926,772		10%	$ 292,677
ALS1-NE (A0426)	1%	$ 368	166		$ 60,974		10%	$ 6,097
ALS1-E (A0427)	55%	$ 525	9,125		$ 4,790,848		10%	$ 479,085
ALS2 (A0433)	1%	$ 735	166		$ 121,949		10%	$ 12,195
SCT (A0434)	0%	$ 840	-		$ -		10%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 8.40	79,770		$ 670,068		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

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Appendix C
Year Three Revenue Projections

Montgomery County, MD EMS Transport Fee - Revenue Projections Year Three		Total Projected Transport Volume	Est. Medicare Transports (40%)	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)			
		61,626	24,650	2,465	17,255	17,255			
Payor: Medicare (40%)	**Est. % of Transports**	**Charge**	**Medicare Approved Charge**	**Est. Medicare Transport Volume**	**Total Charges**	**Total Medicare Approved Charges**	**Medicare Allowable**	**Total Medicare Cash Receipts**	
BLS-NE (A0428)	1%	$ 331	$ 221.52	228	$ 75,468	$ 50,507	80%	$ 40,405	
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%	$ 4,220,785	
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%	$ 614,445	
							TOTAL	$ 8,185,924	
Payor: Medicaid (4%)	**Est. % of Transports**	**Charges**	**Medicaid Approved Charge**	**Est. Medicaid Transport Volume**	**Total Charges**	**Total Medicaid Approved Charges**	**Medicaid Allowable**	**Total Medicaid Cash Receipts**	
BLS-NE (A0428)	1%	$ 331	$ 100	23	$ 7,613	$ 2,300	100%	$ 2,300	
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	$ 227,900	
Payor: Commercial/Auto (28%)	**Est. % of Transports**	**Charges**	**Est. Ins. Approved Charge**	**Est. Commercial/Auto Volume**	**Total Charges**	**Total Insurance Approved Charges**	**Insurance Allowable**	**Total Insurance Cash Receipts**	
BLS-NE (A0428)	1%	$ 331	$ 231.95	160	$ 52,960	$ 37,113	100%	$ 37,113	
BLS-E (A0429)	42%	$ 441	$ 309.04	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	$ 6,118,694	

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
							TOTAL	$ 938,574
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 32,629,425	$ 16,578,999		

GRAND TOTAL - PROJECTED CASH RECEIPTS - YEAR THREE	**$ 15,471,092**
OVERALL PROJECTED AVERAGE REVENUE PER TRANSPORT	**$ 251**
GROSS COLLECTION PERCENTAGE	**47%**
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

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Appendix D
Year Four Revenue Projections

Montgomery County, MD EMS Transport Fee - Revenue Projections Year Four		Total Projected Transport Volume	Est. Medicare Transports (40%)	Est. Medicaid Transports (4%)	Est. Commercial/ Auto Transports (28%)	Est. Self-Pay Transports (28%)			
		64,091	25,636	2,564	17,945	17,945			
Payor: Medicare (40%)	**Est. % of Transports**	**Charge**	**Medicare Approved Charge**	**Est. Medicare Transport Volume**	**Total Charges**	**Total Medicare Approved Charges**	**Medicare Allowable**	**Total Medicare Cash Receipts**	
BLS-NE (A0428)	1%	$ 348	$ 227.06	228	$ 79,241	$ 51,770	80%	$ 41,416	
BLS-E (A0429)	42%	$ 463	$ 363.29	9,572	$ 4,432,315	$ 3,477,412	80%	$ 2,781,930	
ALS1-NE (A0426)	1%	$ 405	$ 272.48	2,281	$ 923,805	$ 621,527	80%	$ 497,222	
ALS1-E (A0427)	55%	$ 579	$ 431.42	12,535	$ 7,252,124	$ 5,407,850	80%	$ 4,326,280	
ALS2 (A0433)	1%	$ 811	$ 624.43	228	$ 184,817	$ 142,370	80%	$ 113,896	
SCT (A0434)	0%	$ 926	$ 737.96	-	$ -	$ -	80%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 9.26	$ 6.91	113,955	$ 1,055,223	$ 787,429	80%	$ 629,943	
							TOTAL	$ 8,390,688	
Payor: Medicaid (4%)	**Est. % of Transports**	**Charges**	**Medicaid Approved Charge**	**Est. Medicaid Transport Volume**	**Total Charges**	**Total Medicaid Approved Charges**	**Medicaid Allowable**	**Total Medicaid Cash Receipts**	
BLS-NE (A0428)	1%	$ 348	$ 100	23	$ 7,994	$ 2,300	100%	$ 2,300	
BLS-E (A0429)	42%	$ 463	$ 100	957	$ 443,139	$ 95,700	100%	$ 95,700	
ALS1-NE (A0426)	1%	$ 405	$ 100	23	$ 9,315	$ 2,300	100%	$ 2,300	
ALS1-E (A0427)	55%	$ 579	$ 100	1,253	$ 724,923	$ 125,300	100%	$ 125,300	
ALS2 (A0433)	1%	$ 811	$ 100	23	$ 18,644	$ 2,300	100%	$ 2,300	
SCT (A0434)	0%	$ 926	$ 100	-	$ -	$ -	100%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 9.26	$ -	11,395	$ 105,518	$ -	0%	$ -	
							TOTAL	$ 227,900	
Payor: Commercial/Auto (28%)	**Est. % of Transports**	**Charges**	**Est. Ins. Approved Charge**	**Est. Commercial/Auto Volume**	**Total Charges**	**Total Insurance Approved Charges**	**Insurance Allowable**	**Total Insurance Cash Receipts**	
BLS-NE (A0428)	1%	$ 348	$ 249.64	160	$ 55,608	$ 39,942	100%	$ 39,942	
BLS-E (A0429)	42%	$ 463	$ 332.60	6,701	$ 3,102,898	$ 2,228,768	100%	$ 2,228,768	
ALS1-NE (A0426)	1%	$ 405	$ 290.91	160	$ 64,800	$ 46,545	100%	$ 46,545	
ALS1-E (A0427)	55%	$ 579	$ 415.56	8,774	$ 5,076,198	$ 3,646,162	100%	$ 3,646,162	
ALS2 (A0433)	1%	$ 811	$ 582.24	160	$ 129,696	$ 93,159	100%	$ 93,159	
SCT (A0434)	0%	$ 926	$ 665.20	-	$ -	$ -	100%	$ -	
Loaded Miles (A0425) (Average/Trip)	5	$ 9.26	$ 6.65	79,770	$ 738,670	$ 530,576	100%	$ 530,576	
							TOTAL	$ 6,685,163	

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%	$ 348	179		$ 62,370		10%	$ 6,237
BLS-E (A0429)	42%	$ 463	7,537		$ 3,490,055		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%	$ 926	-		$ -		10%	$ -
Loaded Miles (A0425) (Average/Trip)	5	$ 9.26	79,770		$ 738,670		10%	$ 73,867
							TOTAL	$ 1,021,954
GRAND TOTALS - CHARGES/APPROVED CHARGES					$ 34,624,464	$ 17,301,410		

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

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

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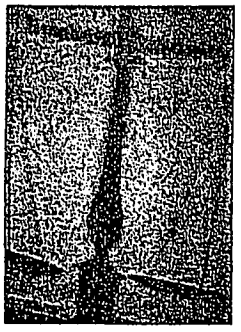
Appendix E
EMS Rate Setting Article



LEGAL CONSULT

INCISIVE ANALYSIS OF EMS LEGAL TOPICS

How Should Your Ambulance Service Set Its Rates?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Help OSHA Revise Its Emergency-Response Regulations

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

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

Wait to Respond to AMR, IAFC Advises Fire Departments

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

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