# EMS Pricing / Revenue / Billing

The Business of EMS

## Determining EMS Charges

- County Mandates
- Historical
- Contracted / Negotiated
- Cost-Based
- Fee Schedule
  - (PPS) Prospective Payment System

## Determining EMS Pricing

- Understanding Cost
- Items Impacting Cost
  - Personnel
  - Non-Personnel (Supplies, Repair, etc.)
  - Capital - Depreciation
  - Subsidies
  - Allocations (A&G)
- Identifying what your agency determines to be cost

## Formulas in Determining Cost

- Total Cost / Annual Transports = Cost per Call

  $500,000 / 2000 = $250.00

- Cost per Transport / Collection = Retail Cost

  $250.00 / .60 = $416.67

  (The price the service needs to charge to operate without a subsidy)

## Subsidy

- Often provided by County to offset the user's fee
  - A tool to manage or reduce the fee charged
- Local Government often ask:
  - How to lower the subsidy ?
    - » This often comes a cost of either services or charges
  - How do you evaluate the effect?
    - » Calculate: subsidy dollar decrease / collection rate

      $1.00 / .60 = $1.66

## Determining Ambulance Fee Schedule

- Program / Service Cost
- Subsidy
- Payer Mix
- Goals of the Program

## Payer Mix

- Medicare
- Medicaid
- Commercial
- Managed Care
- Self-Pay

## Revenue Considerations

- Collections
  - In-House
  - Out-Source
- Accounts Receivable : A/R
  - 90 - 120 days
- Cash Flow
  - Impact

## Medicare

- Typically, the largest payor source for EMS (Healthcare)
- Often represents 60 - 70 percent of patient revenue source
- Part A
- Part B

## Medicare Part A & B

- Part A
- Cost-Based
  - Paid based on cost of services
  - Determined to be cost that are usual and customary
- Hospital Based Services

- Part B
- Fee-Schedule
  - Currently determined for each service provider / county
  - Based on Charges/ Cost
- Proposed Fee Schedule for all Providers - April 1, 2002

## Current Medicare Reimbursement Methodology

- Based on historical billing / cost
- Assignment
  - Services agrees to accept Medicare's payment based off Medicare's determined allowable charge.
  - Medicare reimburses 80 percent of allowable charge.
  - Service may bill patient for remaining 20 percent.
  - The service must write-off (contractual allowance) the amount above the allowable charge.

## Medicare Calculation

Ambulance Fee: $400.00

Medicare Allowable: $150.00

Medicare Payment: $150.00 x .8 = $120.00

Patient Responsibility: $30.00 ($150.00 x .2)

Contractual Allowance: $250.00

## Proposed Medicare Fee Schedule

- Part of Balanced Budget Act of 1997
- Effective April 1, 2002
- Mandated for a more uniformed payment structure
  - Moves all services to a part B structure
  - Prospective Payment System
- Requires Mandatory Assignment
- Transition Period 1st year
  - (80% Reasonable Cost; 20% fee structure)

## Proposed Medicare Fee Schedule

- Provides for In-County Mileage Reimbursement
  - $5.00 per loaded mile
- Provides for Rural modifiers for Mileage
  - 1 - 17 miles : 1.5 times urban
  - 18 - 50 miles: 1.25 times urban
  - Over 50 miles: pays urban

## Medicare Fee Schedule

- Fee Schedule Divides Payment into classifications

| Level of Service | RVU | Fee $ |
|---|---|---|
| BLS | 1.0 | $157.52 |
| BLS – Emergency | 1.6 | $252.03 |
| ALS 1 | 1.2 | $189.02 |
| ALS 2 | 2.75 | $433.18 |
| Paramedic Intercept | 1.75 | $275.66 |

## *Definitions of Level of Service*

- **BLS Basic Life Support (BLS):** Where medically necessary, the provision of basic life support(BLS) services as defined in the National EMS Education and Practice Blueprint for the EMT-Basic including the establishment of a peripheral intravenous (IV) line.
- **ALS1 Advanced Life Support, Level 1 (ALS1):** Where medically necessary, the provision of an assessment by an advanced life support (ALS) provider and/or the provision of one or more ALS interventions.
  - An ALS provider is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education.
  - An ALS intervention is defined as a procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

## *Definitions of Level of Service*

- **ALS2 Advanced Life Support, Level 2 (ALS2):** Where medically necessary, the administration of at least three different medications and/or the provision of one or more of the following
  - » ALS procedures: Manual defibrillation/cardioversion, Endotracheal intubation, Central venous line, Cardiac pacing, Chest decompression, Surgical airway, Intraosseous line.
- **PI Paramedic Intercept (PI):** These services are defined in 42 CFR 410.40. They are ALS services provided by an entity that does not provide the ambulance transport . Under limited circumstances, these services can receive Medicare payment.

## Calculating Medicare Fee Schedule Payment

- Payment will adjusted to reflect the differing costs of business based on geographic location
  - Geographic Practice Cost Index (GPCI)
    - » applied to 70 percent of the base rate payment for ground
    - » will not apply to mileage
    - » Updated every three years (January 1, 2001)
    - » North Carolina : GPCI .924 (www.hcfa.gov/medicare/amb.data.txt)
- Calculate the base rate for the fee schedule:
  (unadjusted base rate x .70 x GPCI) + (unadjusted base rate x .30) = adjusted base rate
- Calculate Reimbursement Rate for First Year
  (adjusted base rate x .80) + ( current allowable rate x .20)

# Calculating Medicare Fee Schedule Payment

- Calculate the base rate for the fee schedule:
  (unadjusted base rate x .70 x GPCI) + (unadjusted base rate x .30) = adjusted base rate

  ($157.52 x .70 x .924) + ($157.52 x .30) = $149.14
  $101.883 + $47.256

- Calculate Reimbursement Rate for First Year
  (adjusted base rate x .80) + ( current allowable rate x .20)

  ( $149.14 x .8) + ($100.00 x .20) = $199.31
  $119.312 + $80.00

# Other Carriers

- Medicaid
  - Administered by the State
  - Stringent guidelines for meeting "Medical Necessity"
  - Typically, 10 percent of transports
  - 1999 - 2000 NC Average Payment per Trip:
    - » High: $106.04
    - » Low: $ 58.88

# Other Carriers

- Commercial
  - Third party
  - Managed Care
  - Contracted Services
  - Typically, represents 10 - 17 percent
  - Usually, best payers
    - » 80 - 90 percent of charges
    - » 90 percent collection rate

- Self-Pay
  - Lowest reimbursement
    - » 20 percent collection
  - Individuals without a carrier
  - Signs wavier on insurance claims
  - Typically, represents 15 - 20 percent

## Putting It Together

## Wrap Up

- Understanding Cost
  - "How Cost is Determined"
- Fundamentals of revenue
  - How payers and collections impact pricing
- Medicare
  - PPS