

Capital Area Rural Health ROUNDTABLE NOTES

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Rural Ambulance Economics

How low-volume and high-fixed costs affect rural providers.



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Rural EMS: Financing Preparedness

Schooled by popular media, Americans might think regional trauma and EMS systems are well established throughout the country. In truth, EMS is a fledgling development of the late 1960s and largely a locally financed enterprise, according to a panel of experts who addressed the Capitol Area Rural Health Roundtable May 8th.

Emergency service in many regions today still depends on a ‘wing and a prayer’ of grassroots organization supported by volunteers and vintage equipment. This is especially true in rural areas. The need to keep those organizations running and connected with medical help was the subject of the May forum, sponsored by George Mason University’s Center for Health Policy, Research & Ethics.

From Transport to Care

As EMS has evolved from a transportation concept to a health care function, rural EMS has lacked adequate financing and coordination with a medical provider, say its leaders.

“EMS is one of the newest parts of our healthcare system,” Jeff Michael told the Roundtable audience of some 90 association and government representatives. He is chief of the National Highway Traffic Safety Administration’s (NHTSA) EMS Division.

“In a schizophrenic way,” EMS lies at the intersection of several diverse institutions and disciplines, said Dia Gainor, President of the National Association of State EMS Directors (NASEMSD). Some operations are run by hospitals, others by fire departments, others are unincorporated volunteer groups, others are run by county or city governments. In rural areas, many are non-transporting agencies.

As a result, there is more diversity than

coherence to the field, and its development varies greatly from state to state, she said. While states such as Maryland have a statewide trauma system in place, others do not. Gainor’s state of Idaho relies on EMS organizations that are 70% volunteer.

90% of the EMS squads in North Dakota, are volunteer, said Neleen Eisinger, a legislative assistant to Senator Kent Conrad (D-ND), who also spoke at the forum. [*See related story, page 3*]

There is more diversity than coherence to the field.

In the rural U.S. not every EMS agency has a building, said West Virginia EMS director and Roundtable speaker, Mark King. “Sometimes the building is a barn.” Rural volunteers range from local factory workers to business people, to nurses, to volunteer firemen.

Low Volume, High Fixed Costs

Studies of rural EMS conducted since 1985 point out the same problems again and again, said King: Because of the low annual volume of calls and a thin tax base, it is difficult to finance the universally high fixed costs of an ambulance operation. Yet the need and demand for EMS in rural areas—where distance is critical and rates of occupational injury are high—is as great or greater than in urban areas, said NHTSA’s Michael. But one call a day, he said, can’t finance the operation.

King said **rural EMS’s second largest barrier is recruitment and retention.** Most organizations have time and resources only for training and responding to calls. There are few resources for recruitment or for supporting volunteers. Burnout rates

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are high because volunteers also work regular jobs and respond to emergencies that often involve people they know. In fact, **not enough attention is paid to the mental health needs of rural volunteers and workers**, said Idaho's Gainor.

A third major problem is the **lack of medical oversight** and immediate access to medical consultation. Rural physicians are in short supply and those in place work long hours, said Roundtable speakers. Receiving hospitals, facing their own staffing shortages or other problems, are known to divert ambulance crews elsewhere. In a rural area, "elsewhere" can be a considerable distance.

King also said training is a critical need in rural areas. Skill retention is challenging due to the low call volume, so training and practice are important. He said there is also a **critical need in many rural areas for management training**. "People are running agencies with no background in financing and with little understanding of accounting principles."

To overcome these deficits, he said **states must have a greater capacity to provide technical assistance**.

Medicare Fee Schedule

Because Medicare is the leading source of revenue for pre-hospital EMS in the country, the program's proposed new fee schedule for ambulance service will be critical for rural operations, according to Roundtable speaker Dan Manz. Through 1992-2000, he represented the National Association of State EMS Directors in a negotiated rulemaking process between industry and federal officials. The negotiations sought to reduce egregious payment disparities by putting ambulance services on a consistent, nation-wide schedule and by identifying various levels of service for payment.

The federal government published the proposed schedule for public comment last September, but implementation is on hold.

Manz predicted that the "win-win process" of the negotiations will be considerably undermined, however, by the fact that Medicare's overall payout is capped by a figure derived from 1998 funding levels, albeit with inflationary adjustments.

"Arguably, the amount of money that HCFA (Healthcare Financing Administration*) has today to pay for ambulance services is woefully deficient," said Manz.

A variety of estimates place the shortfall at \$1-\$1.3 billion, he said.

Conversions to Part-Pay

Rural costs are also going up, according to Roundtable speakers, as more and more agencies are finding they have to pay something to retain staff, especially for day-time hours. For example, 26 of 192 West Virginia agencies converted to part-pay in the last five years, said King.

Manz said the **financial impact of this national trend is not well documented**. Yet personnel can be 70 % of the cost for a fully paid, career-based department, so it "has huge budget implications."

King recommended a **"rural modifier" to the Medicare fee schedule for rural EMS providers**, akin to the payment enhancements made for rural clinics and the new, limited-service Critical Access Hospitals.

Call For New Payment Approach

In fact, a strategic planning document drawn up in 1996 by a large group of EMS industry and government experts introduces a new concept in rural emergency medical care. The ensuing report, **EMS Agenda for the Future, proposes reimbursing rural EMS providers for levels of preparedness, rather than just by the trip**, explained NHTSA's Jeff Michael.

Ambulance operations require an expensive vehicle (\$80,000-\$100,000), people, training, insurance, communications equipment—irrespective of how many runs are made. In rural areas, the "stand-

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* Recently renamed the Center for Medicare and Medicaid Services (CMS)

Local Initiatives, Federal Infusions

While EMS first grew out of local public safety work (police and fire), periodic infusions of federal money in the last 30 years have permitted some strategic planning and modernizations like the 911 system.

The EMS Systems Act of 1973, part of the Public Health Service Act, provided the largest national boost to date, with \$300 million going to local systems in 300 regions, over eight years.

In 1985, spurred by a National Academy of Science Report, Congress established a federal trauma division at the Health Resources and Services Administration that resulted in about \$15 million being invested between 1992 and 1995.

Last fall, at the urging of the trauma community, Congress appropriated \$3 million to begin patching and upgrading emergency medical and trauma services. \$300,000 of that is being directed to rural needs.

At the May 8th Capitol Area Rural Health Roundtable, legislative aide, Neleen Eisinger outlined additional legislation currently proposed by Senator Kent Conrad (D) of North Dakota to help rejuvenate and modernize rural EMS squads. The **Sustaining Access to Vital Emergency Medical Services Act of 2001** (S.587) would authorize \$50 million in grants for each of the next five years

See **Federal Infusions**, page 4

by” costs are higher, said Manz.

The current reimbursement models, devised in the 1960s, “only know how to buy a ride to the hospital,” said Manz. So “the set of **statutes and regulations Medicare operates under are not well aligned with the most contemporary thinking about EMS system development.**”

Speakers said there are many obstacles to moving from a transportation model to a financing system based on preparedness and the provision of emergency care:

For example, a “nagging thorn in the side of EMS providers,” according to NASEMSD’s Manz, has been the patient diagnostic condition codes under which ambulance services have had to justify a run when they file a claim. **Forced to file according to a guessed diagnosis**, rather than according to how the patient presents at the scene, ambulance companies have suffered inconsistent and high denial rates.

HIPAA Dilemma

Manz said a medical sub-committee involved in negotiating Medicare’s new fee schedule worked out EMS-related patient condition codes to replace the ICD-9 hospital-certain diagnoses. But the Health Insurance Portability and Accountability Act (**HIPAA**) **requires administrative simplifications that could foil use of the new EMS codes.** The new rules on simplification were published last October for full implementation in 2002, but claims “attachments” for ambulance and emergency departments are still being drafted.

In addition, HIPAA’s privacy provisions add new requirements for gaining patient permission in recording information. **Some privacy procedures can be “rather unreasonable, if not impossible for EMS,”** said NASEMSD president Dia Gainor. “The idiosyncrasies of EMS were not considered,” when they were written,” she said, inviting the audience to imagine application of privacy requirements to a

swift water rescue.

In rural areas it can also be difficult to ask volunteers to leave home in the middle of the night and then remain at the hospital to also do the paperwork required for compliance purposes, she said.

While the HIPAA privacy rules have been published, HHS Secretary Thompson has promised further review before their full implementation in April of 2003.

Uniform Data Problem

A major obstacle to a new payment paradigm for rural EMS providers is the lack of uniform national data on rural services, according to the Roundtable’s speakers. The new Medicare fee schedule increases Medicare’s payment for beneficiaries placed on board an ambulance at a

rural site, but the Healthcare Financing Administration still “has **no way to identify a low-volume provider in a rural area,**” said Manz. The extraordinary variation in EMS agencies and the complexity of their staffing arrangements also mean states collect data differently.

“If we’re ever going to craft effective policy to reimburse rural providers at something like reasonable cost, we’ve got to get more sophisticated with our information on where these guys are operating, how many calls they’re doing, and the environment they’re operating in,” said Manz.

Asked where the responsibility lies for developing and harmonizing such data, Roundtable speakers said rural EMS advocates have begun to organize nationally to build consensus and agree on definitions.

In December of 1999, they held a national conference to develop a set of rural recommendations for industry, state, and federal government, to mirror the 1996 Agenda for the Future. The conference report, **Strengthening Rural and Frontier EMS, is scheduled for publication this summer** by the National Rural Health Association.

“If we’re ever going to craft effective policy ...we’ve got to get more sophisticated with our information.”

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Federal Infusions *continued*

to meet rural personnel needs, especially for training and equipment.

The bill also adds EMS to the definition of “prudent layperson” to assure ambulance providers of “fair” reimbursement under Medicare and Medicaid, according to Eisinger. She said that rural EMS volunteer squads are shrinking while the numbers of rural elderly are growing. In North Dakota, for example, the average squad has gone from 30 to 12 volunteers in the past decade.

A companion bill to the Conrad measure (S. 587) has been introduced in the House by Representative Fred Upton (R) of Michigan.

Medicaid Policy

Few state Medicaid claims agencies have EMS-knowledgeable reviewers, said NASEMSD President, Dia Gainor. **The federal government could provide more EMS guidance to states on the Medicaid front**, she said. In Idaho, “our state personnel have seen the light on how [EMS-friendly policies] benefit the Medicaid program.” She said Idaho officials have broadened the basis for EMS claims to include evaluation of a Medicaid patient. Under a “treat and release” option for ambulance claims, for example, the state avoids unnecessary emergency department visits.

Rx For More Efficiency

Asked to discuss how rural EMS could achieve more efficiency, Roundtable speakers noted the problem of too many very small organizations clustered or “lined up on one road” in some places. “It’s the per-

fect opportunity for a marriage,” said Manz. But he added, “Do not underestimate the tradition and community pride at work.”

The need to combine and integrate such organizations into a local health care system is great, said West Virginia’s King. Many communities actually use EMS workers for public health support. But **“collaborative organizational experiments require a lot of technical assistance,”** he said, because they entail needs assessments, financial feasibility studies, and strategic planning.

In that sense, **the rural Critical Access Hospital Program “has been a stunning contribution” to integration efforts**, said Gainor. By offering state funds and technical assistance to promote rural hospital/EMS integration, “more people have come to the table than ever before” to talk for the first time about the basic need for front-line, emergency care, she said.

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