PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL

Your Voice In EMS

Senators Vulakovich and Ward:

I am David Jones, President of the Pennsylvania Emergency Health Services Council (PEHSC), I am a practicing paramedic and I currently serve as the EMS Manager for the Pennsylvania State University in State College.

The Pennsylvania Emergency Health Services Council serves the Commonwealth as the state advisory board to the Pennsylvania Department of Health on all aspects of emergency health care. This mission is defined in the state EMS Act (Act 37 of 2009) and was also found in the previous Act from 1985 (Act 45).

Today, we wish to share with you our concerns on behalf of the EMS community in Pennsylvania and to offer a system-wide solution for your consideration.

The EMS community is not unlike the fire service with our unique set of challenges. The significant changes to our system tend to be linked heavily in societal changes. EMS Agencies are now involved in responses to acts of terrorism, increased gun violence, increased drug overdoses and the violent reactions associated with the treatment of these patients. We are also seeing new and re-emerging infectious diseases, such as Ebola and Measles, both of which have generated hours of education. We have also seen increased use of the EMS system for primary health care complaints rather than the emergent situations from the past. These types of calls comingled with our daily volume of medical and trauma patients has made EMS an integral part of both healthcare and public safety, each and every day. It is important to state the obvious . . . this is not the EMS system from the 1990's. This is a changed system that now requires a new model to financially support it.

We offer some global EMS concerns for your consideration. These concerns are not new but we wish to be on record supporting efforts to:

Correct the direct pay issue by the insurers.

Secure cost based reimbursements from the PA Medical Assistance Program.

Create incentives to promote volunteerism.

Secure reimbursements for patient treatment without transportation to the hospital.

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Secure a payment mechanism to support Community EMS Services (Community Paramedicine). – which is a national effort to expand local EMS resources to realize cost savings to the healthcare system. This program has been funded in Minnesota, through their Medicaid program.

Alleviate the financial burden for the background check process via waiver or designated funding for both EMS and Fire Services

However, our main message today is to share our concerns about the financial condition of the Commonwealth's EMS system, in total. We doubt anyone here would argue that we are in the midst of a financial crisis. For many years we have been concerned about dwindling reimbursements however this crisis scenario has now played out and we impacted by the long term effects of these reimbursements.

Let me demonstrate with some basic trend data, from the 1990's to today. Some additional information is attached to this testimony.

- Declining per trip reimbursement
    - Medicare fee schedule implemented in 2006 which eliminated itemized billing (including loss of ECG monitor charges $75.00 and O2 charges - $25.00)
- Implementation and increasing per trip co-payments ($50 - $175 per trip) has contributed to lower collection of payments as many patients simply cannot or will not pay their co-payment.
- Unlike other health care providers, EMS has no ability to collect co-pay at the time of service
- High deductibles ($1,000 - $6,600) has contributed to lower collection of payments as many patients simply cannot or will not pay their deductible amounts.
- Increasing number of patients who do not have any health insurance leads to decreased collection and lower revenue
- Most large insurance companies have elected to reduce EMS reimbursement by adopting Medicare payment policies. This has significantly EMS payments from 100% of charges to the Medicare rate or a percentage of Medicare like 125%.
- Average collection percentages (total billed vs total paid) has decreased dramatically from ~70% to ~40% for most EMS services

- Dramatic reduction of volunteers which has led to hiring compensated staff and a significant increase in operating costs
- Enhanced training requirements
- Enhanced regulations and new medical technologies increasing system costs
- Increased Cost of Readiness: Most EMS services face significant readiness costs as units and stations must be staffed 24 hours a day waiting for next emergency response.

The Bottom Line: Increased costs and reduced revenue has led to decreased reserves and significant financial losses for many ambulance services. Many EMS services have either consolidated with other local services or closed due to financial or staffing shortfalls.

It is important to remember the unique services that EMS provides. We act as the medical safety net for our communities. We cannot limit our readiness time like other caregivers who determine their operating hours and can schedule patients. We must be ready to respond 24 hours a day 7 days a week. Further, our growth over time has reduced the number of 100% volunteer agencies so the low overhead benefits by such a model are no longer common in most communities.

You may ask, what are the long term effects of the current financial constraints? The long term effects include restricted growth in clinical care; poor retention of seasoned field providers; extended response times in communities where small populations do not support a community ambulance or demand for service exceeds the system capacity, just to name a few. I am sure several of you have already heard from constituents who are echoing these trends in your home districts.

Today, we would like to offer some thoughts to support a solution.

We believe that another funding mechanism for direct support to the EMS agencies would assist in our efforts to maintain our clinical edge, our knowledgeable providers and our services to all areas of the commonwealth.

It is not an easy to make a determination as to how much money is needed to meet current and future needs. Since 1985 with the passage of Act 45 the system has spent hours planning expenditures in an effort to offset what eventually happened, the loss of significant direct support to EMS Agencies. Simply, the EMS Operating Fund (EMSOF) as created in Act 45 no longer funds the EMS agency to the level that it was intended. The 2013 Legislative Budget and Finance Committee (LBFC) study shows that a significant portion of funding from EMSOF supports needed administration functions.

The Study reports, "Pennsylvania's statewide EMS system no longer receives direct funding support from the General Fund. The EMS program received a separate line-item EMS appropriation until FY 1989-90. This appropriation peaked at $1.9 million in FY 1985-86. In its final year, the amount of this appropriation was $1.4 million. Since that time, General Fund monies have been available to the EMS program only from the Department of Health's (DOH) General Government Operations (GGO) appropriation and are used only for the administrative and operational costs of the Bureau of Emergency Medical Services. Members of the EMS community have often questioned the absence of General Fund monies for EMS program purposes. Although not stated in Act 2009-37 or its predecessor statute, Act 1985-45, or related legislative discussion at the time of their respective passages, many persons believed that EMSOF monies were to supplement rather than replace General Fund support of the statewide EMS system."

We can argue that cost savings can be found in the EMSOF distribution but at the end of the day it still cannot support the agency level with needed education and equipment as intended. We have included some citations to the end of our testimony from the LBFC report to fully demonstrate our concerns. Simply stated, the EMSOF from 1985 is depleted, and the infusion of federal monies has also returned to a level similar to the amounts dispersed in 2006.

The lack of system wide funding will impact patient care.

We are requesting your consideration of a new funding source for identified system wide needs and for direct support to the ambulance services.

The LBFC Study suggested that the General Assembly consider options to "bolster" the EMSOF revenue. We, of course, are willing to consider that as an option as well as another General Budget line item. But we are seeking a long term solution. We hope that you will consider the suggested proposal by the Pennsylvania Fire and Emergency Services Institute (PFESI) for the 1/2% increase in tax on foreign homeowners and vehicle insurance as an appropriate source of funding for the EMS and Fire concerns. We will need more detailed information regarding this option to be certain the funding would be sufficient for future generations. We are hopeful that you will be able to secure information so we can have meaningful dialogue about the in the near future.

If this option, or any comprehensive funding option is deemed suitable, we are committed to properly identifying the specific uses for the funding. On behalf of the Pennsylvania Emergency

Health Services Council (PEHSC), we are offering to establish a special committee to provide funding recommendations to the committee so that any questions about the need or use of the funds can be easily answered and supported by goals and a strategy.

Citations from the 2013 LBFC Study

- **The amount deposited into the EMSOF from fines on traffic violations and fees on ARD admissions has fallen from $15.1 million in FY 2007-08 to $13.3 million in FY 2011-12.**

- **The year-end balance in the EMSOF has declined from $23.0 million in FY 2005-06 to $14.6 million in FY 2011-12. The balance is projected to decline further to only $2.6 million in FY 2016-17.**

- **Funding for the Commonwealth's EMS system has been declining in recent years, from $11.3 million in FY 2007-08 to $10.0 million in FY 2011-12. This decline has been driven primarily by a decline in the revenues generated by the fines on traffic violations and fees on ARD admissions which are deposited into the Emergency Medical Services Operating Fund.**

- **Although the percentage of EMSOF funds used for pre-hospital provider equipment (PPE) has decreased from 23.5 percent to 14.6 percent since FY 1997- 98, the impact of this decrease may not be particularly significant because EMSOF funds comprise only a small fraction of ambulance company revenues.**

An Illustration of Common EMS Revenue Sources

Billing (Only eligible for reimbursement when patient is transported)

- Average per trip charge - $1,000.00
- Average cost per call - $600.00
- Average per trip reimbursement - $450.00
- Medicare policy limits payment for transports only
- Can bill for Base Rate and loaded mileage ONLY
- However, 20% - 30% of EMS calls result in no transport – limited revenue

- Subscription Drive
- Donation Drive
- Grants
  - EMSOF
  - Federal and State
- Subsidy (Municipal)
- Loans - 2% Loan Program for capital items

Type of Service	*Medicare Rates PA Urban Areas*	*DPA/Medicaid* *(RATE HAS REMAINED THE SAME FOR 15 YEARS)*
Basic Life Support (BLS) - Non-Emergency	$ 211.39	$ 120.00
Basic Life Support (BLS) - Emergency	$ 338.22	$ 120.00
Advanced Life Support (ALS) - Non-Emergency	$ 253.67	$ 200.00
Advanced Life Support (ALS) - Emergency	$ 401.63	$ 200.00
Advanced Life Support (ALS) - Critical Care	$ 581.32	$ 200.00
Specialty Care Transport (SCT)	$ 687.81	$ 200.00
Loaded Miles Only	$ 7.16	$ 2.00 > 20 miles