The EMS Subsidy/Price Tradeoff

NTERFACE

by Jack L. Stout

During a coffee break someone asked the question, "What is the most practical little tip you can give us, something we can take back home and use right away?" I was conducting a management workshop for members of the Michigan Ambulance Association, probably boring them to death with the endless details that distinguish high performance EMS systems from run-of-themill operations. The question was a good one. The answer is the subject of this article - the best little management "trick of the trade" I've stumbled across this year.

In the past I've struggled with trying to explain to elected officials the relationship between EMS subsidies and EMS prices. On first thought, the solution seems simple — when subsidies go down, prices go up. And, in general, that's true. The difficulty comes in trying to explain how a given price structure will actually be affected by a change in level of local tax support. Until a few months ago, I had never quite succeeded in developing an easily understood way of displaying the subsidy/price tradeoff. Now I've got it, and you can use it too.

Why It's So Important There are two good reasons to



regularly remind local elected officials and the local press of the relationship between EMS subsidies and EMS prices. The first is to protect against unfair and uninformed criticism. For example, during recent mayoral elections in a city served by one of our industry's most costeffective EMS systems, a candidate suggested the public would benefit by a government takeover of EMS operations. With government takeover and an annual subsidy of only \$2 million, user fees could be lowered by 50 percent, according to the candidate.

The numbers weren't wrong. They should, however, have raised another question. Since the privately operated system was receiving no subsidy at all, and since its entire annual budget (funded from fee-for-service income) was only \$2.5 million, why wouldn't a \$2 million subsidy injection produce considerably more than a 50 percent drop in user fees? The truth is that a \$2 million subsidy of the privately operated system would produce approximately an 85 percent reduction in rates, not the 50 percent promised for the government takeover. Put another way, \$2 million in subsidy plus 50 percent of the current system's fee-for-service income would fund new system costs three-quarters of a million dollars *higher* than the total cost of the privately operated system. For what purpose would the windfall funding be used?

The privately operated, all-ALS, full-service system had been operating for years at levels of productivity nearly triple those typical of government-operated services. The quality of clinical performance and response-time reliability was literally second to none on the national scale, with well-above average wages and benefits. The system was clearly a public service bargain, but its managers had neglected to periodically make clear that its rates were high because the subsidy is low — not because the system is inefficient.

In EMS systems serving multiple jurisdictions, offering a range of subsidy/price options to each jurisdiction eliminates the need for uniform subsidy levels among participating jurisdictions. That is, affluent communities able to afford high subsidy levels can opt for a higher subsidy/ price ratio. At the same time and within the same EMS system, less affluent communities can obtain identical service simply by selecting a lower subsidy/price ratio. Neither jurisdiction is subsidizing the other, but both communities benefit from the improved economies of scale by creating a single larger system.

Presenting the Choices

For years I've tried to display these relationships and to present the funding policy options by a variety of methods, none completely satisfactory. The solution came when I was working on converting Fort Worth's MedStar system into what will eventually become a countywide system.

Our firm originally developed the

MedStar system to serve the city of Fort Worth. (See "Failsafe Franchise Model," Interface, October 1985 *JEMS*.) After its first two years of operation, a favorable editorial in the Fort Worth *Star-Telegram* called for the expansion of MedStar to a county-wide service area.

To facilitate multi-jurisdictional financing, the decision was made to convert the system from the "failsafe franchise model" to the more flexible and more stable "public utility model" structure. (See Interface, February, March, and May 1985 [EMS.] However, the problem of displaying the subsidy/price tradeoff again reared its head; then-current annual subsidies among the various jurisdictions ranged from zero to just over \$3 per capita per year. We had to find a better way to display and explain the funding choices available under the expanded MedStar system. The "Uniform Subsidy/Price Option Schedule" furnished the solution.

To establish the expanded system, we converted Fort Worth's Ambulance Authority into a multi-jurisdictional legal entity by way of an "Interlocal Cooperation Agreement." (Every state has passed some form of an interlocal cooperation act allowing these local partnerships.) Next, we converted the business structure to a public utility model form and developed a "Uniform EMS Ordinance" to ensure uniform quality of care throughout the MedStar service area.

The final step was to offer opportunity for membership to the various jurisdictions. To join the MedStar system, each local government must approve the Interlocal Cooperation Agreement; adopt the Uniform EMS Ordinance; and select a funding schedule from the Uniform Subsidy/ Price Option Schedule.

For example, while the city of Fort Worth chooses to subsidize paramedic services at a rate of about \$3 per capita per year, Haltom City chooses not to subsidize paramedic services at all. (As MedStar members, both cities are entitled to receive identical levels of service.) Thus, the average bill for an emergency paramedic service originating in Fort Worth will be less than \$300, while the average bill for the same service in Haltom City may go as high as \$385. The differences in price are entirely due to the difference in levels





of subsidy. And as the schedule shows, should any city wish to offer a paramedic service free to the users, an annual subsidy of \$14 per capita will achieve that effect.

Building Your Own Subsidy/Price Schedule

The subsidy/price matrix is the

same for every system, but where the option line actually appears on the matrix, and its slope, depends upon several factors. If your system is small, you may not enjoy the economies of scale in larger systems. If that is the case, the entire option line may be elevated (*i.e.*, more expensive across the board). On the other hand, in larger systems better economies of scale should allow the option line to be lower (*i.e.*, cheaper).

Lower standards of care or less



stringent response-time standards should obviously result in a drop in the subsidy/price option line. Less capable management and less efficient production strategies (*e.g.*, multi-tiered systems and other forms of the ''specialized production strategy'') will, of course, raise the option line. For many heavily subsidized urban systems using specialized production strategies, the zerosubsidy rate will easily approach \$1,000 per patient transport.

Potential collection rates affect the slope of the option line. That is, at higher levels of subsidy, losses from uncollectibles have little influence upon user-free structures. As the percentage of funding from subsidy increases, collection potential increasingly impacts the option line slope. For example, at a 50 percent unadjusted collection rate (see "Comparing Ambulance Rates," July 1985 *IEMS*), for every \$1 drop in level of subsidy, \$2 must be generated in additional fee-for-service billings. In contrast, at an unadjusted collection rate of 70 percent, the required increase in receivables generated is only \$1.43 for each subsidy dollar lost. Thus the optional line slope is easier to climb where collection rates are better.

Many factors affect collection potential, e.g., prevailing Medicare rates, Medicaid payment levels and eligibility policies, the local economy, and the effectiveness with which accounts receivable are managed. In the Fort Worth area, collection potential is well below average; thus, the option line slope is comparatively steep. Fort Worth's local economy is depressed by the decline in oil prices and related factors, and a provision in the Texas Constitution makes bad debt collection particularly difficult. Thus, in most EMS markets, less slope is required than in MedStar's environment. (For example, the subsidy/price option line for the ambulance system we recently developed for Pinellas County, Fla., enjoys a gentle slope, starting at about \$210 at the zero-subsidy level.)

Comparisons Are Revealing

Now that you understand the relationship between EMS subsidies and EMS prices, you might wish to develop a subsidy/price option schedule for your own paramedic service. Remember to base calculations only upon frequency of patient transport — not calls. But be prepared for a shock, and keep the shredder handy.