

# Comparing Ambulance Rates

*Editor's Note: Italicized items are elaborated on in "Definitions," beginning on page 50.*

**A typical day** at the typewriter, a deadline closing fast. The end is in sight; maybe I won't have to work tonight. The phone rings. "Mr. Stout, I'm a reporter. I'm doing an article on ambulance rates, and I understand you know something about the subject. Would you mind answering a couple of questions?" Two hours later, the reporter is saying, "thanks I'm glad I took the time, and we'll both be working late."

Usually such calls mean that an ambulance company is under attack for charging "unreasonable rates." A reporter is assigned to investigate, and if that reporter is smart, he invariably discovers that what looks like a simple issue is in fact as complex an assignment as a reporter ever encounters. Some back off . . . others start digging. That's when my phone rings. Somehow, they find me.

Whether or not I have the time, I take it. Confusion over rates is the camouflage that protects *socialized prehospital care systems* and the *cream-skimming companies* that thrive on their table scraps. Confusion over rates is the mortal enemy of the best private providers of *primary emergency services*.

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*Jack Stout, chairman of The Fourth Party, has been at the forefront of innovation in the design and implementation of EMS systems for the past dozen years.*

*If you have a question, a problem or a solution related to the public/private interface in prehospital care, address your letter to "Interface," jems, P.O. Box 1026, Solana Beach, CA 92075.*

If your company has primary emergency service responsibilities, this one's for you. Save this *jems* issue, and when your rates come under scrutiny, which they surely will, give this article to reporters, elected officials and others who are often unfamiliar with the financial nuts and bolts of the industry, but who must nonetheless try to deal with the controversial subject of ambulance service charges. It may help convert confusion and unfair criticism into understanding and appreciation (it may also save me some time on the phone).

## What's Too High?

Were Bill Leonard's rates too high when his long-established and respected ambulance company (MSI) went bankrupt? City officials in Eugene, Oregon, thought they might be, and refused to allow requested rate increases. The city demanded an audit by a top notch accounting firm. The audit turned out to be a financial autopsy. It showed that neither wages nor profits were excessive. No kidding. It showed that the company was going broke. But it couldn't show whether the unsubsidized company's services to the community were worth what the company was charging. No analysis of costs, however well done, can do that.

Evaluating the rates of a primary emergency provider is a lot like appraising a house. The market value of a house is best determined by actual offers, or if offers aren't available, by the "comparable sales approach." That is, what are similar homes in similar areas selling for?

The "cost depreciation approach" to appraisal, based upon construction costs and/or last purchase price, may be quite misleading. Construction costs of a poorly designed home can easily

exceed market value, just as total production costs in some government-operated ambulance services approach \$1,000 per patient transported. In both cases, the question is, what is it worth — not, what did it cost?

In the case of ambulance rates, the issue is . . . do similar communities get similar services for less money? Could our community get a better deal by switching to another provider, or to another type of system? There are only two ways to find the answers — conduct a bid competition designed to attract offers from the most competitive firms in the industry, or compare rates charged in other communities for comparable services delivered under comparable circumstances.

Rates are "too high" if the same quality of service can be obtained at a significantly lower cost. But if the best in the business can't do the same job more efficiently, then the rates can't be "too high." Perhaps the quality of service is "too high" — i.e., higher than the community wants to pay, but that's a different issue — a clinical and political issue having nothing to do with efficiency or profit margins.

## Factors Affecting Production Costs

*Clinical Sophistication.* Everything else being equal, more clinically sophisticated services cost more to produce than less clinically sophisticated services. In terms of clinical value, *advanced life support* (ALS) is so far ahead of *basic life support* (BLS) that comparison of costs is almost meaningless. But even among certified paramedic providers, the range of true clinical capability is panoramic. In California, each county sets its own standards for "paramedic" service. Even

where statewide standards do exist, the differences in clinical performance of equally licensed providers are so many that rates should not be compared without considering relative clinical quality. Many "certified paramedic providers" actually operate only a few paramedic units, while the firm's other ambulances operate at a much lower level of clinical capability.

*Response Time Reliability.* Everything else being equal, good response time performance costs more to produce than bad response time performance. It

is harder and more costly to furnish every neighborhood with equal response times than to shirk the more remote or difficult areas, while racking up impressive-looking statistics by concentrating upon the easier-to-serve neighborhoods. It costs more to get to 90 percent of the patients in less than eight minutes than to get to the "average" patient in less than five minutes.

*Transport Volumes.* Everything else being equal, the company with higher transport volumes can charge lower rates than the one with lower transport

volumes (i.e., a bigger number to divide the budget by). Low transport volumes, for the size of the company, can result from many causes, such as low population density, government regulations restricting emergency ambulances from running non-emergency calls, telephone call screening as in many government services, or competition by cream skimmers. Whatever the cause, lower transport volumes hurt economies of scale. (Don't confuse "calls" or "runs" with "transports." Be sure of your terminology.) *continued*

## What to Look for in a Billing System

By Judith H. Jameson

Billing systems aren't as difficult to compare as ambulance systems and rates (thank goodness!), but, as in any comparison it's important to know not only how much you're paying, but also what you get in return. The simplest billing system takes information from run tickets, sends out bills, posts payments, and sends unpaid accounts to a collection agency. A good billing system integrates policies, procedures, and information processing to do a better job of billing and to assist in meeting the ambulance company's overall objectives. Here's what to look for in a billing system:

### Accounts Receivable Management

- Provides sufficient flexibility for tailoring the handling of accounts to type of account or its financial classification (e.g. number and frequency of statements, primary and secondary insurance forms, statement messages).
- Organizes information on a patient basis but permits separate financial classifications and responsible parties for different services. (Patients are served better through improved coordination of their accounts, missing information can be obtained from earlier accounts, addresses are more current, potential abuse of service can be identified early and preventive action taken.)
- Manages third-party billing, keeps track of accounts which need claim forms printed, automatically sets up required claim forms when financial classification is changed, reports accounts with insufficient information to print claims. Policies should support comprehensive third-party billing (e.g. city employees, multiple patients, subscription members) to reduce unnecessary cost shifting.
- Provides flexible cycles, ad hoc statements, data mailers or folded statements, zip code sorts.
- Provides complete, fast account accessibility for look up purposes including patient-based organization of information; availability of complete infor-

mation (original charges, history details, third-party billings, origin and destination, and diagnosis); supports a professional, helpful staff in responding to inquiries from the public and other organizations.

- Incorporates narrative notes for any account to facilitate special handling.
- Identifies subscription program members so correct account handling is insured.
- Handles DRG transports, special contracts, special charges, easily.
- Supports efficient and professional personal contacts between billing staff and hospital (information-sharing), medics (obtaining and maintaining complete information, fulfilling special handling requests), and others.
- Permits ease of transition between different functions such as look up and data entry e.g. running multiple jobs on the same terminal.
- Furnishes good working reports including summaries of posting, follow-up reports by financial classification or account type and age of account, automated bank deposits, credit balance reports, accounts transferred to collection agencies. Reports should be easy to generate according to user-specified criteria.

### Revenue and Financial Reporting

- Reports charges by financial classification, type of service provided, and location of service, for planning, budgeting, and rate setting.
- Reports aging for separate financial classifications.
- Identifies and reports accounts receivable (AR) sent to collection agencies so that an accurate picture of "good" ARs and "bad" ARs is furnished.
- Provides transaction reports for managers and auditors including revenue and statistics by procedure code, financial classification, cash reporting and furnishes straight-forward reconciliation within the billing system (charges, receipts, adjust-

ments) and to bank statements and the general ledger.

### Support of Patient Care and Monitoring

- Frees field personnel from competing objectives — clinical vs. collections.
- Obtains information that was unavailable at the time of service.
- Discourages potential abuse of services through consistent collection policies, billing selected "no transport," identifying potential abusers for physician review.
- Provides statistical information on diagnoses managed; procedures, drugs and supplies used; by medic and/or diagnostic group.
- Interfaces billing and dispatch data for a complete service record.

### Interface with Other Functions/Data Bases

- Checks patients for subscription memberships.
- Identifies, using dispatch data, transports with missing run tickets.
- Feeds general ledger.
- Provides word processing and mail merge.
- Provides optional capabilities of accounts payable, spreadsheet, inventory maintenance, and others.

### Expansion Capabilities

- Provides for additional services or geographical areas to be added as completely separate accounts receivables functions or as a subdivision of the main services (reporting as subtotals).
- Expands to larger hardware easily.
- Includes electronic billing capability.
- Provides adaptability to changing circumstances without additional set-up expenses such as adding procedure codes, changing insurance codes, changing fees, adding new financial classifications or account types. □

## INTERFACE

*Geographic Difficulty of Providing Coverage.* Everything else being equal, some communities are simply harder to cover than others. For example, the geography and street systems of Syracuse, New York and Santa Ana, California are such that good response time performance is fairly easy to achieve. Kansas City, Missouri, in contrast, is much more difficult to cover.

Communities that are more or less round or square, are encircled or crisscrossed by freeways, have little traffic congestion, and few rivers or other barriers to movement are easier and cheaper to cover. Elongated communities, with few good freeways and more traffic problems, sliced by rivers, and perhaps studded with island communities served by other providers (e.g. a description of Kansas City, MO), are far more difficult and costly to serve.

*Population Density Per Square Mile.* Ambulance transportation and medical services are provided to individuals, but "coverage" must be provided to a geographic area. If the provider's

customer base is scattered over a large geographic territory, the cost of providing adequate response times will be higher than if those same customers were concentrated within a smaller area, all else being equal. It doesn't matter why a company's customers are spread out — i.e., low population density in a rural area or the presence of multiple providers drawing customers from

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### *"The range of control center sophistication is wide and growing."*

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the same geographic market. The effect will be the same — higher costs (per transport) of providing coverage to the company's service area. Cream skimmers have the same effect upon efficiency as does low population density — i.e. the primary provider has fewer customers per square mile, but no reduction in geographic coverage responsibility.

*Selective vs. Full Service Responsibilities.* Providers allowed to refuse services to individual patients and

neighborhoods, as well as providers who are exempt from responsibility for calls referred to others, should enjoy much lower costs than a provider who has accepted full service responsibilities. This lighter responsibility should be reflected in much lower rates, all else being equal.

*Quality of Dispatch.* Clinical sophistication on the streets is not always reflected in the dispatch system. A dispatch system which employs medically trained dispatchers using clinically-oriented telephone and dispatch protocols, with computers capable of maintaining medical records and special instructions for handling individual patients with known medical problems, will cost more than one using 9-1-1 complaint takers or other emergency dispatchers whose primary function is to assign a unit to each call. The range of control center sophistication in this industry is wide and growing.

*Disaster Readiness.* The disaster capabilities of ambulance systems vary widely, but these differences may easily escape notice during rate comparisons. Greater on-line and reserve paramedic production capacity, extra channel capacity and greater redundancy built

## Definitions

*These definitions relate to the italicized terms, and are in order of their respective first appearances in the article.*

*Socialized Prehospital Care Systems.* The "prehospital care system" includes all elements (organizations, equipment, communications, financing, personnel, etc.) involved in the delivery of the emergency and nonemergency ambulance and rescue services in a community. These services include dispatching, first responders, non-transporting rescue units (if any), and both emergency and non-emergency ambulance services. A "socialized" prehospital care system is one in which non-transporting rescue services or emergency ambulance services are entirely or mainly provided by a department of local government, usually a fire department or so-called third emergency service. An "EMS" system is part of the prehospital care system, but the wisdom of managing EMS as an isolated component is a topic of dispute among industry experts. Many EMS systems, but only a few prehospital care systems, are completely socialized. Services rendered by private companies under contract to local

government are not considered "socialized."

*Cream Skimming Company.* This term refers to any ambulance company which is allowed to market and provide services selectively to improve profitability. This "selection" process may involve: avoiding, referring, or discouraging business in low income or difficult-to-serve neighborhoods; performing emergency work strictly at marginal cost by referring calls to others when no surplus capacity exists; specializing in non-emergency transfer work where costs are lower while collections are higher; deliberately moving into markets where incumbent providers have already taken the heat for raising Medicare reimbursement levels; contracting to provide basic transportation for the patients of non-transporting rescue services (i.e. where much of the cost is born by local government while 100 percent of fee-for-service revenues go to the private provider); and even the practicing of refusing service to patients who appear unable to pay. Some cream skimmers are cream skimmers by choice, while others are forced into the role by the policies of local

government.

*Primary Emergency Services.* A company with "primary emergency service" responsibilities has assumed legal responsibility for furnishing emergency ambulance services throughout a defined geographic area, and is externally monitored and held accountable for the delivery of that service. Such a provider has no other providers with whom the blame for poor service can be shared. The interests of primary emergency service providers may sometimes conflict with those of companies allowed to compete in the same market on a selective "cream skimming" basis. In general, the production costs, service responsibilities, and managerial complexity of delivering primary emergency services (reliably) are far beyond those required of a cream skimming organization.

*Primary Service Area.* That area for which a primary emergency provider is held responsible. Some prehospital care systems are so poorly designed that entire communities have no legally responsible primary emergency provider, or are

into communications systems, a larger inventory of certain equipment and supplies on every ambulance a central inventory specifically geared to handle the large scale disaster, uniformity of vehicles and field equipment and compatibility with the neighboring providers in case crews have to use each other's equipment . . . these and other measures of disaster readiness cost more to maintain than the hope it won't happen.

**System Stability.** This issue is subtle but important. Some wonderfully efficient and high performance providers operate within systems which could collapse overnight. Other prehospital care systems are designed to withstand major breach of contract, provider bankruptcy, political, financial and labor problems without service interruption, deterioration or the need for emergency appropriations. But such stability costs more to maintain than a Pollyanna attitude.

**Regional Cost of Living.** This is the factor that is most often considered when rates are compared, and while it is significant, it has far less impact upon costs and prices than do the other factors discussed here.

### Why Not Just Bid?

Sometimes bidding is the right option. But bidding is complex, traumatic, expensive and involves real risks. If the quality of existing service is questionable or if the cost is clearly out of line, then bidding is the way to go. But if the present service is clinically sound, bidding risks wasting the cost of an expensive provider turnover, traumatizing the labor force and possibly reducing quality of service.

Unfortunately, most ambulance service bids conducted by local governments are so poorly designed that they fail to attract the industry's most qualified firms, and bid specifications are so poorly written that apples-to-apples comparisons are often impossible. Without participation by the industry's best firms . . . without apples-to-apples comparison of offerings, bidding cannot identify the best possible deal.

### Comparing Apples With Elephants

Comparing the rates charged by a heavily subsidized government provider (e.g., a fire department rescue service) with those of an unsubsidized provider

of primary emergency services is, unless several adjustments are made, unfair, useless, and misleading. Comparing a cream skimmer's rates with those of a primary emergency service provider is just as meaningless.

Fair and useful comparison of ambulance rates requires comparability of clinical sophistication, response time, reliability, economies of scale, degree of difficulty in providing coverage, level of subsidy, and a number of other production factors and financial realities which are external to the company providing the service, but which powerfully impact production costs and rate structures.

No two providers deliver precisely the same degree of production difficulty or identical financial environments. the same degree of production or identical financial environments. Independently conducted rate comparisons (i.e., conducted by someone other than the ambulance company) can be extremely useful and productive, if the comparisons are apples-to-apples, and if allowances are made for the inevitable differences.

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served by multiple organizations — no one of which is held accountable for emergency service coverage. To have a primary service area, a provider must be legally responsible for maintaining good clinical and response time performance throughout the area, and must be legally designated as the area's exclusive or primary provider. It is not enough for a provider to merely claim responsibility. Thus, many ambulance companies have no primary service area, and many areas are assigned to no primary emergency provider.

**Advanced Life Support (ALS).** This term has many different meanings, depending upon who is using the term and the context. As used here, ALS refers to paramedic level services — not to basic life support services (BLS) or the intermediate levels of licensure available in many states (I.V. technician, EMT-D, etc.) In most states, paramedics have an initial investment in training that is more than 10 times that required for BLS certification. In terms of equipment and clinical capability, paramedic units are usually so far superior to BLS units that comparisons listing similarities are shorter than those listing differences. Even so, some paramedic services are far more advanced in practice than others. Finally, don't assume that paramedic skills are too exotic or impractical for rural areas and everyday transport service. The average initial train-

ing investment of a paramedic (about 1,000 hours) is still less than many states require of licensed barbers and beauticians (about 1,500 hours). As clinical progress continues and more becomes known that can be effectively applied in the prehospital setting, paramedic training requirements will advance accordingly, and the systems which cannot support paramedic services, as well as paramedic services unable to keep the pace, will widen the already profound gap in clinical capability.

**Basic Life Support (BLS).** The meaning of BLS is somewhat more uniform than the meaning of ALS, although some states do require a slightly higher level of capability for "basic" certification than do others. Normally, however, BLS certification requires about 100 hours of training. One well-known school advertises a concentrated two-week course leading to California certification. The additional costs (over BLS costs) of providing paramedic services differ depending upon the type of system involved. In general, the cost of producing paramedic services is less than double that of producing BLS services under otherwise identical conditions, but the clinical value of paramedic services is many, many times that of BLS services.

**Third-Party Payers.** This term refers to both government and private programs which pay the cost of health care services. Under Medicare, ambulance services are

treated as "Part B" providers — like physicians. Under "Part B," rates are set with regard to the "prevailing rate." Hospitals (i.e. "Part A" providers) come under a completely different set of reimbursement rules. In general, current third-party reimbursement practices encourage socialization of the prehospital care industry, complicate rate comparisons, and help to obscure differences in efficiency among systems and providers.

**First Responder Program.** This term refers to programs established in many communities wherein personnel trained and equipped at or near the BLS level are regularly dispatched, simultaneously with ambulance units, to initiate basic procedures until the ambulance crew arrives, and to provide additional manpower to assist the ambulance crew when it does arrive. Some of the most successful first responder programs are built around fire department resources, but others have been developed using volunteers as well as police department personnel. The marginal cost of an efficient first responder program is quite low — on the order of 25 dollars per run (which may be added to ambulance billings, although few third-party payers allow reimbursement). Even so, a good first responder program can save lives — if it is coupled with a reliable paramedic emergency service. There are few, if any, public services that do so much good for so little cost as a good first responder program.

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## Higher Costs or Higher Prices?

What factors make the rates of one ambulance company higher than those of another, even if both companies are equally well-managed, equally efficient, and have equal profit margins? Two kinds of factors, external to the provider, affect price structures in any ambulance system: factors which influence provider costs, and factors in the local economic environment which influence how those costs get translated into prices. Remember, in this industry high costs may not be reflected in high prices, and low prices are the favorite camouflage of the least efficient systems.

## The Economic Environment

The above list describes those aspects of the work being performed which make production costs higher or lower for any given company. That is, if all those factors are equal, then any difference in production costs are probably attributable to differences in the efficiency of the companies being compared.

But equality of production costs (per transport) doesn't translate into equal rates for services rendered. In many prehospital care systems, production costs are partially financed by fee-for-service revenues. To fairly compare the rates of two providers, one must consider and adjust for all of the above production factors, plus this continuing list of economic realities external to the provider.

*Level of Local Subsidy (direct and indirect).* A group of insurance adjusters recently complained by letter to the Ft. Wayne, Indiana City Council that rates charged by the city's ambulance authority are much higher than those charged by other Indiana providers, and therefore "excessive and unreasonable."

The authority's rates are based upon costs, and those costs are almost entirely determined by competitive bidding. Ft. Wayne residents benefit from what is probably Indiana's most clinically advanced ambulance service and one of the nation's most efficient systems.

The adjuster's letter noted the city's low level of subsidy, and lamented the city's intention to phase out the subsidy entirely. What the adjusters want is lower prices — not necessarily lower true costs. The Ft. Wayne system is

already one of the nation's most efficient systems, so there are only two ways of lowering rates — reduce the quality of service (now set by an arm of the Ft. Wayne Medical Society) or increase the city's subsidy, so that local taxpayers will help cover the insurance companies' financial obligations.

Many local governments do just that, especially those operating socialized systems that are so inefficient that an actual cost bill could be material for "Saturday Night Live." For example, a recent internal study of system costs in a medium-sized, socialized California system showed that the city would have to charge \$763.44 per transport just to break even, given current costs, transport volumes, and collections. And as socialized systems go, this one is efficient.

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It should be no surprise that *third party payers*, including the federal government, enjoy the free ride at the expense of the taxpayer. Powerful unions representing government workers obviously oppose the installation of more efficient systems, while supporting the local subsidies needed to hold prices to a fraction of real production costs. And any metropolitan resident is bound to be confused when the unsubsidized bill of an efficient private provider is higher than that of a heavily subsidized, but far less efficient government service.

If all else is equal, rates go up as subsidy goes down. But keep in mind that a dollar of subsidy cannot be replaced by a dollar in billed revenues. Losses from uncollectibles must be added. A rule of thumb that won't be far off is that it takes about a dollar and a half in billed revenues to equal a dollar of lost subsidy.

Today, the typical local government directly subsidizes ambulance services to the tune of about four dollars per capita per year. Some pay far more and get terrible service; some pay far less, even nothing at all, and get superb service. Higher subsidy does not mean better service, and no subsidy does not

mean poor service. *The only effect of ambulance subsidies is to reduce prices below costs.* Keep in mind, however, that the accounting systems of many local governments are not structured to show the full cost of ambulance service subsidies.

*Rate Structure Hocus-Focus.* Some providers brag about "low base rates," while charging for a long laundry list of add-on items. Others include most of the bill in a larger base rate, while charging nothing or modest amounts for mileage, oxygen and other items. Different billing practices are, from time to time, encouraged or discouraged by third-party reimbursement procedures. Some providers deliberately use their rate structure to create the appearance of lower prices. Don't try to compare base rates or rate structures at all. Instead, compare "average total bills."

*Medicaid Treatment.* Medicaid, the program intended to pay for health care services for the poor, is administered by the states. Each state determines its own coverage and its own reimbursement level. In many states, Medicaid payment levels are far below the lowest possible costs of producing the most basic ambulance services, while other states pay more reasonable rates, and pay on a wider range of patients. When comparing rates of providers working in different states, adjustment should be made to account for these important differences. If all else is equal, rates charged by the provider forced to live with low Medicaid reimbursement levels should be higher than those of a company enjoying fairer Medicaid treatment.

*Medicare Treatment.* Even though Medicare is a federal program, payment levels and reimbursement practices vary enormously, depending upon the company administering the program (i.e. the "carrier"), the makeup of providers in the region, and the duration a provider has been in business.

Medicare reimbursement levels for ambulance services are unique to each region. Sometimes these regions are as small as a county; sometimes as large as a state. In any case, payment levels are affected by the rates charged by all the providers in the region (i.e. the "prevailing rate"). If a company shares a region with heavily subsidized providers billing at token rates, with cream skimmers, or with companies offering a lower quality of service, the allowable Medicare payment levels will be well below that company's actual production costs, creating greater losses from uncollectibles.

In comparing rates of companies operating in different geographic areas,

adjustments should be made to account for differences in respective Medicare payment levels. If all else is equal, the company with a fairer Medicare arrangement should have lower ambulance rates, since less cost shifting is required. Don't be confused by "cost shifting" arguments suggesting that local government is somehow responsible for bad debt in the ambulance industry. Including bad debt costs in price structures is *not* shifting. Every industry has such costs. "Cost shifting" occurs when a third-party payer (e.g. Medicare or Medicaid) manages to get by, paying less than the cost of services provided – thereby "shifting" part of its own financial obligation onto the shoulders of other paying customers. Cost shifting has nothing to do with ordinary bad debt. A local government which refuses to cover bad debts of ambulance customers is not guilty of "cost shifting."

**Socio-economic Mix.** If all else is equal, a company serving a well-heeled community can afford lower rates than one serving an economically depressed area, unless of course the Medicaid program covering the depressed area is extremely liberal – a condition I have never seen. Poor people are often uninsured and cannot pay their ambulance bills, especially if they get hit with multi-thousand dollar hospital bills at the same time. Those losses from uncollectibles become a "cost" and must be added to rates.

Don't be sidetracked by arguments that customers who pay should not be charged the costs of serving those who can't pay. People who can't pay back bank loans raise the interest costs for those who do. Every department store includes in its prices the cost of inventory lost to shoplifting and bad debt. In every other industry, customers who pay cover the costs of those who don't, one way or another.

Perhaps it is wrong for the federal and state governments to allow costs of serving Medicaid and Medicare recipients to be partially included in the bills of others (i.e. true cost shifting), or to shove the problem onto the shoulders of local government. But if so, the fault lies with federal and state policy – not with the ambulance industry, and not with local government.

**Outside Sales.** Some prehospital care systems are designed to benefit from improved economies of scale by using off-peak emergency production capacity to furnish additional services at low marginal costs, and by spreading overhead costs over greater production volumes by selling services outside the company's primary service area.

Such "outside services" include non-

emergency transfer work, special events coverage, long distance transfer work, interhospital transport of patients needing sophisticated en route support, and other related services. All else being equal, a company which is prohibited (by ordinance, contract, or location) from engaging in such work cannot be expected to achieve the efficiency of a company which enjoys such superior economies of scale. (Also note that the collection rate for nonemergency work is often much higher than that for emergency work in the same community.)

**On-Scene Collections.** This controversial issue can affect rates. Skilled paramedics don't usually enjoy asking patients or families for payment. Cash transactions under unsupervised and highly stressful circumstances are ethically questionable at best. Paramedic crews make expensive bill collectors. And several highly sophisticated and unsubsidized systems have proven that it is possible to survive without resorting to on-scene collections.

But on-scene collection practices probably do reduce losses from uncollectibles to some extent. If all else is equal, the company which uses on-scene collections should have lower losses from uncollectibles and therefore lower rates. A provider who refuses service without payment in advance has a 100 percent collection rate and should charge much lower fees. (My own opinion is that the slight financial advantage of on-scene collections does not justify the harm done by such practices.)

**First Responder Program.** A good first responder program can save both lives and money. Without such a program, a primary provider must often tie up two or more ambulance crews at a single scene when only one would be necessary with a good first responder program in place. If all else is equal, and even if the marginal costs of the first responder program are included in ambulance rates, a company backed by a good first responder program should have slightly lower rates than one forced to work without such a program.

**Medical Accountability.** Some systems are expertly, independently, and closely monitored by qualified physicians, but many are not. (Every system claims it is adequately monitored.) A reasonably large system can be adequately monitored at a cost of about three dollars per transport. If all else is equal (but how would you know?), a company which is poorly monitored should have lower rates than one that is adequately monitored, assuming the costs of monitoring are included in rates rather than covered by a regulatory agency.

## Psychological Screening of EMT Applicants

The Psychological Resources test battery consists of five well validated psychological test instruments which provide a substantial amount of information about the applicant's fitness for EMT work. At \$50.00 per case, an agency head or his representative receives a detailed but easy to read report describing the applicant's strengths, weaknesses, intelligence, and psychological fitness for the position. Rapid turnaround and on site administration by agency personnel permit the use of our services in most hiring situations. This battery has withstood federal court supervision and meets EEOC guidelines.

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Circle #73 on Reader Service Card

## INTERFACE

The sidebar article by Alan Jameson shows by way of example how the factors discussed above are used to compare the rates of two very different paramedic providers. Space limitations do not permit a quantitative analysis, but the relative values of the two "deals" are discussed.

Keep in mind that all else is never equal, and that expert judgment is required to estimate the various adjustments. The fact that one company's rates are higher or lower than another's, by itself, says nothing about the relative efficiency of the two providers or whether the community enjoying the lower rates is getting a better deal.

The least effective ambulance service may sell for the highest prices. Some of America's most expensive and inefficient systems lie hidden behind the lowest rate structures. The most efficient providers of superb ambulance services are often subjected to severe and unfair criticism, while far less capable organizations are showered with unwarranted praise.

This article would not be complete

without discussing fee-for-service billings as a means of financing ambulance services. Like anything else, fee-for-service financing has advantages and disadvantages, and can be accomplished with expertise and compassion, or with incompetence and greed.

I recently argued with a well-known ambulance industry financial consultant about the purposes of an effective ambulance rate setting, billing and collection system. He argued for a single purpose — raising money. I argued that, to a primary emergency provider, rates, billings, and collection procedures have several additional and equally important purposes. If you intend to compare ambulance rates, you should compare billing and collection procedures as well. Consider these points:

1) Rate schedules should be structured to minimize patients' out-of-pocket costs by maximizing the portion of the bill paid by third-party payers. Even when average total bills are equal, different ways of constructing the charges can make a difference in out-of-pocket cost to the patient.

2) Rate structures and collection procedures should discourage abuse of 9-1-1 lines or other emergency numbers.

When emergency transportation is cheaper than other forms of transportation, or when the provider has a reputation for easy-going collection practices, abuse of the emergency system is encouraged. In fact, every paramedic knows of lonely people who regularly fake emergency need merely to get some attention. Understandable, but eventually deadly to someone else.

3) Billing procedures should make it simple and convenient for patients to recover from their insurance companies. Where feasible, third-party payers should be billed directly by the provider, eliminating paperwork for the patient. (In contrast to the Ft. Wayne insurance adjusters, Blue Cross/Blue Shield of Oklahoma recently negotiated a true cost-containing arrangement with Tulsa's Ambulance Authority. In exchange for a reduced rate and assistance in controlling unnecessary use of services, the authority is allowed a direct terminal-to-terminal computer connection. Except for persons with Medicare supplement insurance, and a few older plans now being phased out, no one insured by the company will ever see an ambulance bill from Tulsa Authority.)

4) Collection procedures should be designed to identify as early as possible those patients who needed the service but who are uninsured and for whom payment of the ambulance bill would truly present an unreasonable financial hardship. Such patients should not be made to feel embarrassed, but should be allowed to make special arrangements or, if appropriate, told to forget their ambulance bill. A city councilman once demanded to know why 30 to 40 percent of the patients get off the financial hook. My answer: a few of them are just too slick for us, some fall through the cracks of America's health care financing systems, and you wouldn't take a dime from the rest if you knew the situation. A good billing system is humane.

5) A good billing service works just as hard to collect from those who abuse the system or can afford to pay as it does to identify those whose debts should be forgiven. Cost-based rates and serious collection practices are far safer and more humane than call screening, refusal to transport, or patient hand-offs to less capable crews (standard practice in many social systems). An effective approach to patient accounts management sometimes requires spending more to collect a bill than the amount of the bill — if that's what it takes to make the point.

6) Any ambulance service system with rates approaching full production



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costs should offer a program (usually called a subscription program) which allows the elderly and persons with chronic disabilities to pay an annual fee to cover the uninsured portions of medically necessary ambulance service for an entire year. Many third-party payers still think of ambulance service as a fast ride to the hospital, and allow payment accordingly. Star wars communication systems, eight-minute maximum response times, vehicles and equipment costing over \$100,000 per rig, salaries of skilled and professional paramedics, maintenance programs rivaling aircraft industry standards . . . it's a new pre-hospital care industry, but not all third-party payers have noticed, and some still hope local government will continue paying this costs. Until reimbursement levels line up with fair production costs, elderly people on fixed incomes need the safety valve provided by a subscription program. (Note: the subject of subscription programs is riddled with numerous legal and financial complications, some quite subtle. Space does not permit full treatment of this subject here.)

7) Finally, the data base of a good patient accounts management system is

also the foundation of the medical record keeping system and the problem-solving statistical analyses of demand patterns used to improve response time performance and improve efficiency. This same data base is sometimes used to analyze costs and revenues by geographical district, or to answer other questions of interest to elected officials (e.g. Losses from Medicaid underpayments now account for 100 percent of Kansas City's ambulance subsidy.). The sidebar article by Judy Jameson lists some of the features of an automated patient accounts management system tailored to this industry.

8) Oh, yes — a good patient accounts management system also raises money. Ambulance rates should be regulated. Emergency patients need it because they have no opportunity to quality/price shop. Non-emergency patients need it because many are sick and old, playing a limited role in venter selection. (It is not uncommon for cream skimmers to pay nursing home employees to send business their way.)

The reputable private company needs it to defend against unfair criticism, and to assure customers that its rates are reasonable even if quality is high and

subsidy low. Policy makers need it to learn the true effects of subsidy, the impact of cream skimmers, and the truth about efficiency. The entire industry of private providers of primary emergency services needs it to strip the camouflage off its heavily subsidized government competitors. The taxpayer needs it to learn what is really being done with his money.

But cost-based analysis won't do the job, and bidding isn't always the answer. What we need is objective and expert rate comparisons. Hopelessly oversimplified and self-serving comparisons such as that done by the above-mentioned insurance adjusters are not what is needed. But if ambulance rates charged in every community were fairly compared with those similar communities receiving similar services, and if adjustments were properly made to account for differences in subsidies, demographics, and the other factors discussed here, our industry's finest organizations would be allowed to grow and prosper, while the rest would change or die. That's the secret of the American way of doing business, and government agencies should not be exempt. □

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