Jack Stout

INTERFACE

# Federal Policies Promote Socialized Prehospital Care

**I can't think of a more boring** topic for this column than federal reimbursement policies for the ambulance industry. Boring to read; boring to write. I've been putting this off for over a year. But now a letter from *Interface* reader Charles Sundberg, Executive Director of Siouxland Health Services, Sioux City, Iowa, tells me the time has come. In the long run, this may be the most important series I'll ever write for *jems*.

As the title suggests, federal policies, mainly Medicare and Medicaid policies, actually promote the establishment of socialized (i.e. government-operated) prehospital care systems, and insulate those systems from private competition. These same federal policies spawn and sustain incredibly inefficient ambulance systems by helping to hide true system costs from the political light of day.

In poorer communities, Medicare and Medicaid reimbursement policies can actually prevent the development of paramedic capability, with disastrous effects upon patient outcome, and probably lengthening hospital stays for many who do survive.

These same policies severely inhibit the evolution of our nation's hodgepodge of mono-jurisdictional mini-systems into a network of powerfully efficient prehospital providers serving natural medical trade areas. Ill-conceived strategies to control federal spending for prehospital services actually *increase* America's total cost of prehospital care, probably increase hospital costs for many survivers, while institutionalizing a Rube Goldberg distorted approach to service delivery.

More than any other single factor, Medicare and Medicaid reimbursement policies have stifled the development of private paramedic services, giving an unfair and unintended advantage to socialized paramedic providers. And if the "freeze provisions" of the Deficit Reduction Act of 1984 (i.e. those designed to apply to "physicians and suppliers") are applied to paramedic providers, we may as well kiss the private paramedic industry goodbye. Mr. Sundberg said it nicely: "It appears that the private full time provider whose customary and prevailing charges are set in profile with minimal fee volunteer squads, etc. (and I would add, with heavily subsized government providers billing at token rates) takes it in the shorts again."

*What's the Problem?* Stripped of accounting mumbo-jumbo, the problem is this. A private paramedic provider's Medicare payment is set by a formula which takes into account the fees charged by other providers in the same region. If those "other providers" are fire departments or other government ambulance operations, they are usually heavily subsidized by local tax dollars, and their fees represent a fraction of their true production costs.

When Medicare payment levels are set for the region, unsubsidized providers are forced to live with payment levels far below fair production costs, while subsidized providers enjoy a windfall, receiving reimbursement levels which often exceed their own unsubsidized costs — ie. an effective "profit" from overlapping federal/local financial support.

The Medicaid program allows states to set their own ambulance reimbursement levels. Some rely upon Medicare's allowable charges, while others simply divide the available budget by the number of runs expected, not even pretending to consider fair production costs. Some states have actually "hard coded" ambulance fees into legislation, as though inflation shouldn't affect this industry and clinical progress would be free, or nonexistent. Many states have passed licensing laws requiring provision of emergency service without regard for the patient's ability to pay, and then set payment for indigent care at a fraction of the most efficient provider's production costs.

To survive, many private providers became practitioners of the cream-skimming arts, avoiding the upgrade to full paramedic capability, cultivating business that paid, and finding ways to leave the rest to others. The "others" in many, many cases were agencies of local government — fire departments and so-called "third services." A precious few dedicated and resourceful private providers managed to hang on without resorting to cream-skimming survival techniques. Some managed to capture the local tax subsidy for themselves, inadvertently adding fuel to the fires consuming their own unsubsidized neighbors. Some developed subscription programs. And some enjoyed markets rich enough to allow profits from some of the work to subsidize losses from serving lower income Medicare patients and the Medicaid-eligible population.

But throughout most of the U.S. the patterns were different. Mistaking the impact of these federal policies for a flaw in the character and motivation of the entire private ambulance industry, many cities and counties turned to socialized prehospital care. Soon government bureaucrats everywhere were licking their chops at the prospect of taking over an industry with such spectacular public relations potential. And they *did* take over in more than half of the major cities in the U.S.

Some communities got nothing at all. Where market conditions made it impossible for a private provider to overcome the effects of federal reimbursement policies, and where local government either refused to accept responsibility or was without financial ability to do so, the clinical progress of ambulance service stopped cold in the early 1970s, and there it remains to this day.

*How Did It Happen?* Prior to the mid-1960s the country was studded with deadly little "hospitals" — 10, 12, 15 beds. Physicians donated a day a month to indigent care. When indigent care was paid for at all, the funds usually came from the county, or private charities. Ambulance services were mostly provided by funeral homes, sometimes as a community service, sometimes as a "loss

leader" — the dead might become customers. In those days, an ambulance meant a ride — nothing more.

Then came the legislation that created the Medicare and Medicaid programs. Cost-plus rate setting on the hospital side, and a huge escalation of fee-for-service demand for both physician and hospital services, combined to create real problems of inflation and overutilization in the health care industry. But these problems were overshadowed by the benefits of improved access to health care for millions of people. The biggest benefit, however, has turned out to be the transition from mom-and-pop hospitals to a nationwide network of powerful institutions servicing natural medical trade areas. This change was a direct effect of the move *away* from local tax financing of health care services.

I'm told that it was only because of Walter Shaeffer's efforts that ambulance services were covered at all by the Medicare and Medicaid programs. In any case, the question then was whether ambulance companies would be treated like hospitals — whose reimbursement levels were set on a *cost-related* basis, or like physicians — whose reimbursements were set with regard to "prevailing rates."

In those days, the bookkeeping practices of most ambulance companies could barely satisfy IRS, much less a Medicare audit of costs. An industry of closely held small businesses, lots of cash transactions, relatives on the payroll, and ancillary businesses run from the same offices was hardly a candidate for treatment under Medicare's "Part A" (i.e. hospital) reimbursement program.

So we fell under *Part B* — the program of coverage for "physicians and suppliers." As Part B providers our reimbursements would be shackled to the prevailing rates of an industry in its clinical and technological infancy. As we entered the 1970s, the clinical lessons of Vietnam would bring an increasing demand for fast and reliable paramedic services. Already in the rescue business, some of the country's most aggressive fire departments seized the opportunity. Jacksonville, Fla., Houston, Texas, Los Angeles County (Calif.), and Seattle, Wash. became famous. With only a few exceptions, the private sector was forced to stand and watch.

*Rube Goldberg, Stand Aside.* What happened next could not have been predicted. Most government-operated paramedic services were loath to bill for services rendered, for several reasons. First, they didn't know how, especially when it came to the intricacies of third party reimbursement. Second, charging substantial fees for paramedic services would seriously undermine the angel-of-mercy public relations image.

Without a shread of supporting evidence, government providers argued that higher fees for paramedic service would cause patients and family members to avoid using paramedic services, even under the most serious symptomatic circumstances. At the same time, they argued that token fees might be necessary to inhibit system abuse — a sort of fine tuning of system demand based upon a hunch about the price-elasticity of paramedic services.

Two Rube Goldberg system designs emerged. Mostly on the West Coast, the *non-transporting paramedic rescue services* flourished. Even the average citizen sometimes questioned efficiency, as a private transporting ambulance, followed by a fire department paramedic rescue unit, sometimes followed by a pumper truck. . . all roared past on their way to the hospital. City attorneys sometimes wondered about the legal wisdom of call screening, treat/no transport health services delivery, and the routine handoff of patients to far less capable crews. But the PR was great, the total system cost was invisible, private transport providers often made out like bandits, and third party payers took the unsuspecting local taxpayers for a ride of their own.

***"Most government-operated paramedic services were loath to bill for services rendered."***

The alternative design was the *emergency-only transporting paramedic service*. There were lots of variations on this theme, but the basic idea was for government to somehow take over the entire emergency side of the ambulance industry — including transportation, leaving nonemergency work to the private sector. Cities installing these systems took more heat from private providers, and still had to deal with call screening and occasional abandonment of patients. But the PR benefits were just as great, and by transporting, additional income could be generated, giving the appearance of lower system costs.

The concept of the full service (i.e. emergency and nonemergency paramedic transportation) system was incompatible with these government paramedic services for several reasons. Firefighter paramedics and most civilian paramedics employed by government resisted transporting all but the most seriously ill or injured patients, preferring to rely upon private companies to transport nonemergency patients and sometimes even emergency patients believed not in need of paramedic care.

For the advocates of socialized prehospital care, the multi-tiered system was just what the doctor ordered. It required far less management skill than does a full service system. Labor liked its preservation of 24-hour shifts, permanent station assignments, and easy-going system status management practices. Many private providers, especially those with exclusive transport contracts with non-transporting rescue systems, were getting rich. Third party payers lent their silent support, as they watched local tax dollars offset their own financial obligations. And while the rest of the health care industry was shedding its umbilical attachment to local tax dollars, the multi-tiered ambulance system furnished the financial confusion to protect amazingly inefficient system structures. In simple terms, no one knew the *full cost* of these government-sponsored multi-tiered systems. No one.

*Financial Smokescreen.* As time passed, the older government paramedic services became increasingly expensive to maintain, partly because of normal inflation and increasing demand for service, but mostly due to the lack of effective incentives for cost containment in a socialized production setting. To help hide, or at least help justify, this growing inefficiency, government providers came to rely upon the financial confusion inherent in the multi-tiered system. That is, the *total ambulance system cost to the community* can be neither criticized nor compared, so long as that cost remains unknown. Similarly, if the *total cost* of service per transported emergency patient never appears on any patient invoice, the government-

operated systems may actually appear less expensive than more efficient systems whose total costs, including losses from uncollectables, are reflected in rates.

Government officials have sometimes argued that they are neither responsible for nor interested in the total ambulance system costs to the community. However, the presence of a government-sponsored multi-tiered system is itself the product of local political decision making, and the full financial consequences of such policies cannot be ignored by responsible public officials.

The truth is that, when equivalent clinical and response time performances are compared, and when total system costs are accounted for, a privately operated full-service paramedic system (single tiered) can literally blow the socks off any government-operated multi-tiered system. How is it, then, that multi-tiered systems persist? They persist because they are necessary to the survival of socialized paramedic services, and because Medicare and Medicaid reimbursement policies use token fee structures of socialized systems as an excuse to reimburse unsubsidized private providers at levels far below fair production costs.

The multi-tiered system provides the perfect financial smokescreen. By themselves, local tax subsidies of socialized paramedic services don't seem all that high, especially when compared with costs of police and fire protection services. By themselves, the token fees charged by government paramedic providers seem reasonable. By themselves, fees paid private transport providers in multi-tiered systems don't seem out of line. But added up, these costs often far exceed, even double, the total system costs of 100 percent paramedic full service systems operated by private firms — systems which equal or exceed the clinical and response time performance of multi-tiered systems in every way.

*What Can Be Done?* First, let's understand what has already been done. For years, federal reimbursement policies refused to recognize a distinction between basic life support (BLS) vs. advanced life support (ALS) ambulance services. If you were a private provider of sophisticated paramedic services, and found yourself surrounded by BLS providers sharing the same Medicare profile, the rates charged by your lower quality neighbors would severely depress your own reimbursement levels. If large numbers of your patients were lower income Medicare patients, and if you couldn't talk your own local government into subsidizing your operations, you would almost surely be forced to reduce your quality of care to the lower common denominator set by your BLS neighbors.

Then in 1981, Al Reichle, former chairman of the American Ambulance Association's (AAA) Legislative Committee, along with other AAA leaders, retained consultant Terry Schmidt to assist the association in attempting to resolve this and other reimbursement-related issues.

Their first major move was to request coverage of paramedic procedures, reasoning that if Medicare

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would pay for paramedic procedures *in addition* to basic transportation charges there would be no need to establish a separate profile for paramedic providers.

Federal officials said no. Frankly, I don't blame them. Controlling fee-for-service incentives to perform advanced procedures would probably be impossible in an industry where the work must be performed with great speed, in a remote location, and under the most adverse environmental conditions. Even if the prehospital care equivalent of "utilization review" was possible, I believe the constant pressure on paramedic personnel to justify every procedure to a committee of Monday morning medical quarterbacks would send our best people looking for other jobs.

While federal officials said no to the request for "coverage" of ALS procedures, they did agree to give paramedic providers the option of participating in a separate profile which would exclude BLS charges. Potentially, this was a great victory for private paramedic providers. If implemented properly, the separate profile for ALS providers would begin to unshackle our industry from its own clinical infancy.

That change, however right and potentially useful it might be, is still being implemented. Major problems remain to be ironed out. For example, our young industry has no useful system for accreditation which can be used to determine whether a given provider is a qualified provider of ALS service. There's also the problem of knowing when the ALS rate may be charged. When telephoned information indicates a *presumptive* need for ALS capability? Or only when the need for ALS is *retrospectively* determined by the actual delivery of a defined ALS procedure?

Does the federal government recommend call screening, as would be implied by a policy of prospective determination? and what about those cities which have decided to ban entirely the questionable practice of allowing BLS crews (about 100 hours of training in most states) to transport so called non-emergency patients? What about those numbers of nonemergency patients who need en route paramedic support (about three percent of nonemergency patients)? And won't retrospective determination, based upon whether an ALS procedure was actually rendered, create the same nasty fee-for-service incentives that the feds were, appropriately, trying to avoid?

There isn't space here to deal with this complex and important issue in greater depth. There are solutions to this problem, and they lie in the concept of accreditation. But an even greater problem remains entirely unaddressed — the unfairness of allowing an unsubsidized provider's reimbursement levels to be seriously reduced by the presence of subsidized providers within the same reimbursement profile. No other single factor hurts private paramedic providers more than being included in profiles with subsidized providers billing at token rates. No other factor does more to promote socialized prehospital care. In next month's *Interface* column, we'll discuss three different solutions to this problem, including collective legal action as a last ditch option. □