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INTERFACE

Socialized Prehospital Care Part 2

Last month we showed how it has come to pass that Medicare and Medicaid policies work to insulate government-operated paramedic systems from private competition in two powerful ways. First, when Medicare and Medicaid reimbursement policies were initially established, the ambulance industry was in its clinical infancy. By tying reimbursement levels to the "prevailing rates" which existed prior to the development of paramedic service, federal policy made it extremely difficult, sometimes impossible, for even the best private providers to keep up with the industry's rapid technological evolution. The inadvertent but direct effect was to provide advocates of socialized paramedic service with their most effective argument—i.e. that the private sector was unable to keep pace.

Second, by treating ambulance companies as "Part B providers," federal policymakers were able to use the token charges of heavily subsidized government paramedic providers as an excuse to reimburse unsubsidized private providers at levels far below fair production costs. This further weakened the private paramedic industry, but more importantly, helped to hide from both the consumer and the taxpayer the incredible inefficiency of government-sponsored multi-tiered systems —systems whose *total costs to the community* are never exposed by either a total system budget or by a full cost fee structure.

We concluded last month by agreeing with federal officials as to their reluctance to allow itemized fee-for-service coverage of individual ALS procedures, and I supported the plan to free ALS providers from being shackled to the prevailing rates of companies offering inferior service. However, shackling the largely unsubsidized *private* paramedic industry to the prevailing (token) rates of the heavily subsidized *socialized* paramedic industry is no less damaging and unfair to consumers, taxpayers, and private providers of paramedic service. No other issue is as crucial to the future of this industry.

Problems With Prevailing Rate Concept. Before we can responsibly start developing solutions, we must have a more complete understanding of the problems. We have said that the current problem has two parts: first, it is unfair to set the reimbursement levels of a high performance provider to reflect the charges of lower quality providers; second, it is unfair to use the subsidized token rates of government providers as an excuse to lower the reimbursement levels of unsubsidized private providers.

The simple solution might seem to be creation of separate profiles for unsubsidized paramedic providers. But that solution just begs the question: What is a "paramedic provider."

There is no ambulance industry equivalent to the Joint Commission on Accreditation of Hospitals (JCAH) to develop industry-wide standards and to rate individual providers. (See April 1984 *jems,* p. 20.) But even if such standards did exist, it is still questionable whether the prevailing rate concept would be useful. For example, consider two unsubsidized paramedic providers offering clinically identical services, one of which is the primary emergency provider in a town requiring (by local ordinance) stringent response time performance, while the other provides paramedic transportation to a non-transporting fire department rescue service, and is under much less stringent response time requirements.

Even if these two providers are equally efficient in producing paramedic unit hours, the unit hour utilization ratio (i.e. the ratio of patient transports per unit hour) should be much higher in the case of the provider working under less demanding response time standards. In simple terms, it costs more to produce better response time performance. The concept of accreditation, though useful and necessary, does not by itself solve the problems of the prevailing rate method.

Currently, Medicare is trying to address the problem of differences in quality by allowing ALS providers the option of participating in separate profiles. But no attempt has been made to distinguish subsidized vs. unsubsidized providers, nor are primary emergency providers distinguished from companies who may rely upon others to handle peak load demand.

In practice, fair application of the prevailing rate concept in this industry presents even more complications than the simple examples above suggest. Merely dividing the providers into subsidized vs. unsubsidized categories isn't enough. Actual provider subsidies cover the whole range from zero to 100 percent. Some providers serve multiple jurisdictions, some of which subsidize while others do not. If service levels are equal, rates charged in the jurisdiction which chooses to subsidize should logically be less than rates charged for unsubsidized services in the other jurisdiction. Thus, a multi-jurisdictional provider's Medicare and Medicaid reimbursement levels should differ in each jurisdiction served, depending upon local subsidy levels.

In the short run, much can be done to reduce the damage inflicted upon our industry by current federal reimbursement policies. Later in this article, I'll propose stopgap solutions to the immediate problem. But in the long run, we must realize that the prevailing rate approach is no longer a fair or effective method of setting reimbursement levels in this industry.

Who Loses? Where a private paramedic provider is forced to share a prevailing rate profile with heavily subsidized government providers billing at token rates, the losers are patients covered by Medicare and paramedics whose wages and benefits reflect the financial stress caused by unfair reimbursement practices. The private provider would like to "accept assignment" of the Medicare Part B payment, meaning that Medicare would pay the provider 80 percent of Medicare's "approved charge," and the provider would

then bill the patient or the patient's coinsurance company only the remaining 20 percent (assuming any deductible has already been paid). Accepting assignment is both easier for the provider and easier on the patient.

The problem develops when Medicare's "approved charge" has been severely depressed by the presence of heavily subsidized providers sharing the same profile. In such cases, while the government providers may be receiving reimbursement levels that are actually in excess of their own unsubsidized costs, the unsubsidized private provider who accepts assignment will receive total reimbursement far below his actual costs.

The private provider has a choice: he can bill the patient directly at his own full rate (i.e. not accept assignment); or he can accept assignment and find some way to live with the losses. If he bills the patient directly at full cost, Medicare will reimburse the patient only a fraction of out-of-pocket expenses. For many medicare recipients, the unreimbursed ambulance costs constitute a real financial hardship—a hardship resulting purely from the fact that neighboring communities, in which the patient doesn't live and in which the provider doesn't operate, happen to bill below cost. And because hardly anyone understands all this, the provider is often accused of price gouging and profiteering.

On the other hand, should the provider elect to accept assignment, he'll have to somehow shift the losses or go broke. He has two primary options. He can raise his rates still further, passing some of the losses onto private paying patients and helping to eventually boost the Medicare profile a little. ("Eventually" because Medicare carriers, or "intermediaries" collect billing data for 12 months, then wait 6 more months to recognize a new prevailing rate.) Or he can hold down costs. Since labor is the biggest cost of providing paramedic services, paramedic wages and benefits suffer the most.

In practice, private paramedic providers usually accept assignment on some patients, but bill directly those who seem able to pay the full tab. Increasingly, subscription programs are being offered as a way to ease the pain of rate adjustments between the time rates are raised and the time those increases are reflected in profile adjustments. (I urge great caution in setting up subscription programs; there are a variety of laws which can easily be violated, and unless your subscription contract is properly written, you may risk being required to pay back any funds you collect from Medicare for services rendered to your subscribers.)

Medicaid is handled so many different ways that there isn't space here to deal with this important issue in depth. But to give you an idea of the size of the problem, consider that according to Dr. Richard Biery, Director of Health for Kansas City, Missouri, Medicaid losses alone account for Kansas City's entire annual subsidy of nearly $1 million (about one quarter of the entire ambulance system budget).

So, who loses as a result of these unfair reimbursement practices? Local taxpayers where socialized systems have replaced private paramedic providers; Medicare recipients where private providers cannot accept assignment; and private sector paramedics where assignment must be accepted for humanitarian reasons. Everyone loses when reliable paramedic services are unavailable in communities too poor to support socialized service, and in which quality private services cannot survive due to heavily subsidized prevailing rates of neighboring cities.

"Everyone loses when reliable services are unavailable in communities too poor to support socialized service. . ."

First of all, don't expect much support from government providers. Without the advantages of local tax subsidy and the appearance of efficiency promoted by token fee structures, government providers will eventually have to compete fairly for the right to remain in business. Only a handful could hope to stand the test.

What is ultimately needed is new legislation which will end our industry's Part B status. Such legislation should be designed to avoid adverse fee-for-service incentives, avoid dependence upon call screening to determine coverage, recognize industry-wide accreditation levels, distinguish between the fair cost of providing community-wide service with good response time performance vs. the sale of services on an elective basis with a focus on the profitable elements of the market (i.e. the difference between full service and cream skimming).

Such new programs should reward efficiency, encourage better economic scales, and promote rather than retard clinical progress in prehospital care. It should also begin to pave the way toward an end to fee-for-service financing of ambulance services, by allowing or even encouraging carriers to enter into full service prepaid contracts in areas served by providers capable of full service delivery within a given market area.

Eventually, these changes will be made. Barring some unforeseen calamity, I expect to live to see them. But I don't expect it soon. In the meantime, we've got to institute stopgap measures. Perhaps you weren't even aware of how close the private paramedic industry recently came to disaster. Charles Sundberg, whose letter to Interface prompted me to write this short series, was aware. Mr. Sundberg was concerned that the "freeze provisions" of the Deficit Reduction Act of 1984 might be applied to ambulance providers. He supplied a copy of correspondence from his Medicare carrier that seemed to indicate that such provisions might in fact apply.

If the freeze provisions were applied to ambulance providers, as they are being applied to physicians, here's what would happen. You would have to choose between being a "participating provider" vs. a "non-participating provider." If you decided to "participate," you would sign a contract agreeing to accept assignment on all services provided to Medicare recipients, except under certain defined circumstances where you were, in effect, acting as a subcontractor to an HMO or other approved health benefit plan. As a "participating provider," your Medicare payments would be frozen at July 1 levels, but you could raise your rates to affect your profile next time around.

Ambulance providers sharing profiles with heavily subsidized government operations, as well as companies surrounded by volunteer

organizations billing at token levels, could obviously not afford to sign a participation agreement. Accepting assignment on large numbers of Medicare patients with payment levels far below actual production costs would put many providers out of business before they could live to see a profile adjustment.

But here's the kicker. If the freeze provisions did apply to ambulance providers, and if you refused to sign a participation contract, your payments would still be frozen at the July 1 level, and if you increased your charges to Medicare patients, you might be subject to civil penalties (up to $2000 per violation), plus getting kicked out of the Medicare program for up to five years. That's not all, Medicare would also refuse to recognize any increase in charges for non-participating providers when figuring out the new prevailing rates in October of 1985 and 1986!

You can sort of see why Mr. Sundberg was nervous. If those freeze provisions had been applied to ambulance providers, some of our highest quality and most efficient firms would have been required to choose between "participating" (a quick and merciful financial death) vs. not participating, and dying painfully and slowly over two or three fiscal years. Fortunately, as of this writing, the folks at Health Care Financing Administration (HCFA) have decided not to apply the freeze provisions to ambulance providers. Whew! That was a close one.

Three Partial Solutions

We won't deal here with long term solutions requiring major policy changes. For now, let's consider what could be done without a major policy shift—that is, without changing our industry's Part B status.

1. *Establish optional national profile for paramedic providers.* I am listing this first because I believe it is the most practical and would have the best long term consequences. I am suggesting the establishment of a separate national profile for paramedic providers. Participation in the national profile would be optional. Criteria for participation in the national profile would be certification as a paramedic provider (using national accreditation procedures, when available), use of an all-inclusive rate rather than itemized add-ons for ALS procedures, and annual submission of CPA audited and certified information regarding subsidies received from state and local government, including an independent and professional estimate of the per-call impact of that subsidy upon the rates charged for services included within the national profile.

Allowable charges would be set in much the same way as they are currently being set for ALS providers who participate in the recently established regional ALS profiles, except that prior to determining the prevailing rate, the effects of local tax subsidy would be factored out. The "adjusted prevailing rate" would, then, be used to calculate allowable charges for unsubsidized providers, and for subsidized providers, the actual amount of their own subsidies would be used to reduce each subsidized provider's own allowable charge by an accurate amount.

". . . the prevailing rates would no longer be boosted by the higher rates of unsubsidized providers."

Obviously, there are numerous administrative details necessary for implementation. But the intent is to end the unfair and inequitable practice of averaging effects of local tax subsidy over all providers within a profile, whether subsidized or not.

Obviously, only providers who are unsubsidized or who are subsidized at very low levels would elect to participate in the national profile. Even so, by removing these providers from regional profiles, the prevailing rates of the remaining providers would no longer be boosted by the higher rates of unsubsidized providers. According to Alan Jameson, unsubsidized providers have for years been running interference for subsidized providers. That is, subsidized providers have waited for their unsubsidized neighbors to take the heat for setting higher rates. Later, when prevailing rate profiles have been raised by the unsubsidized provider, the subsidized neighbors follow suit by raising their own rates just enough to secure maximum available Medicare reimbursement. *Establishing the national profile as* suggested would end this incentive for subsidized providers to follow the rising prevailing rate regardless of need.

A provider of both ALS and BLS services would be allowed to participate both in local BLS profiles and in the national ALS profile. An all-paramedic full service provider offering both emergency and nonemergency paramedic service would also be allowed to participate in both profiles, just as some of my own clients now participate in both ALS and BLS profiles, even though all units are always ALS capable. It might also be necessary to consider regional cost of living adjustments in setting allowable charges for national profile participants.

2. *Pressure Medicaid to adopt Medicare payments.* By most standards, we are a small and poorly funded industry. Without the support of heavily subsidized providers, we have little clout. We should tackle the problem of Medicare reimbursement first, because we can tackle it together. Then, if we succeed, it will be worth our while to deal with the Medicaid programs one by one.

Some Medicaid programs already recognize Medicare payment levels. In those states, solving the Medicare problem solves the Medicaid problem automatically, at least the problem of ridiculously low Medicaid reimbursement levels. In states where licensing laws require the delivery of emergency service without regard to the patient's ability to pay, it may well be illegal for the state to set its own reimbursement below fair cost of service delivery. Even so, establishing fair Medicare reimbursement levels paves the way to establishing fair Medicaid reimbursement levels. Start with Medicare.

3. *It's unfair, but is it illegal?* It is the responsibility of federal officials and Medicare's contracted intermediaries to administer the Medicare program. We may assume that Congress intended the program to be administered fairly and equitably. The use of prevailing rate profiles in determining reimbursement levels for Part B providers is an administrative *method*—a tool. If, in the case of *this* industry, it is the wrong tool, it should be replaced or modified.

Clearly it is unfair to tell an efficient but unsubsidized private provider that he must be reimbursed at levels far below reasonable production costs simply because other providers sharing his profile

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happen to receive subsidies. Just as clear, it is unfair to tell a Medicare recipient that he or she must pay large out-of-pocket costs, simply because politicians in other communities—perhaps far wealthier communities—choose to bill for ambulance service at token levels.

The damaging effects of mixing subsidized and unsubsidized billings in the same profile, without adjustment, are *not* the result of the subsidization itself, but are instead the result of an HCFA decision to employ formulas which, inadvertently but no less certainly, produce damaging and unfair results.

Few would argue that the present system is unfair to unsubsidized private providers and the patients they serve. But to what extent are federal officials legally obliged to correct the unfairness caused by their own policies and regulations? Can it be successfully argued that HCFA cannot deal with this unfairness without a change in the law itself? Frankly, these are complex questions to which no one has a certain answer.

From the standpoint of national health policy, this issue is peanuts. Compared with Medicare's hospital costs, the dollars involved are miniscule. And as I have already stated, there is good reason to believe that any apparent federal savings from using one provider's subsidy as an excuse to underpay another provider may well be false economies.

But while these issues may seem small from one perspective, they are of enormous importance to our industry. I believe the time has come for collective action aimed directly and persistently at solving this problem. Ideally, such action would be led by the American Ambulance Association, and ideally the approach would involve cooperation with HCFA officials along the lines I have suggested, or along any other lines that would solve the problem.

However, providers with something at stake in this issue may well constitute a minority within the AAA. In fact, some AAA members may actually prefer the status quo, e.g. companies holding transport contracts with non-transporting government rescue services who don't even participate in the area profile. Furthermore, I am told that preliminary discussions with HCFA officials some time ago did not indicate an active interest in this matter on their part.

For this reason, the ideal approach may not be feasible. Rather, it may be necessary for a smaller group of providers, sharing a common interest in this issue, to undertake a commitment to pursue this issue until a solution has been found, starting with new conversations with HCFA officials, but with a reluctant willingness to pursue collective legal and/or legislative action, should cooperation fail. Although well hidden by a jungle of administrative, financial and political complexities, the truth is that the future of the entire prehospital care industry is being profoundly influenced by little-understood administrative policies. I recommend organized and committed action now. And I implore HCFA officials to understand and assist. □

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