by Jack Stout

Let's Dump The "Prevailing Rate" Approach

(And Instead Do Something Smart)

Before I begin, I must repeat a conversation I recently overheard while hanging out with friends. However, it just wouldn't be right for me to name the speaker. Besides, the speaker's identity isn't important to the story (it was Harvey Allison.) It is true that we were in a bar and that Harv *did* have one too many. Not one too many drinks — rather, one too many irritating experiences struggling to obtain his Medicare reimbursement.

A bunch of us management types were engaged in social drinking when this new guy, a street paramedic recently demoted to a management position, complained that the more he read about Medicare reimbursement for ambulance services, the less he understood it. Harv volunteered an explanation.

"It's not really that complicated once you grasp the basic concepts," said Harv. "First, we send in our statements to the Medicare intermediary. The Medicare intermediary is a private company hired by the federal government to mismanage the program. Anyway, when we send in our bills, they're placed on a conveyer belt which sorts them at random into three equal piles. The piles are labeled 'Accepted,' 'Rejected,' and 'Lost.' " The new guy appeared skeptical, but Harv was not offended.

"Next," Harv continued, "all the bills from the accepted pile are dumped into this great big hopper that feeds into the 'charged screen.' They call it that because it's electrically charged — 9,000 volts. At least I think it's 9,000. Maybe it's 8,000. Anyway, it's one or the other." Harv was warming up. "Now," he warned, "here comes the technical part, so pay close attention.

"Going through the screen, all the big bills get zapped, but the teeny-tiny bills slip right through and drop into this old gray computer. The old gray computer checks out all the teeny-tiny bills to figure the 'prevailing rate,' and then multiplies that by the cube root of its logarithm to establish the 'allowable charge.' Then the computer breaks down. You with me so far?" The new guy nodded to indicate he was on track. I was busy taking notes for this month's "Interface" article.

"Finally," Harv concluded, "when a bill does make it through the charged screen and into the old gray computer, the intermediary pays us either 50 percent of the allowable charge; or 80 percent of the allowable charge; or the 75th percentile of the prevailing rate; or our own company's 'customary charge'; or nothing at all. . .whichever is less. That's how it works." Deep in our hearts, we knew Harv's explanation wasn't exactly correct, but it *was* close enough.

In last month's "Interface" column, I promised to explain how the prevailing rate approach to Medicare payment for primary emergency ambulance services actually encourages proliferation of inefficient production methods, rewards our industry's least efficient providers, and strangles our industry's best-managed firms. I also promised to present a practical alternative, which when implemented, will promote bona fide cost-containment by encouraging and rewarding efficient production of quality EMS.

Brief Background

Readers requiring a more in-depth background concerning the effects of federal policies on the EMS industry are encouraged to refer to three previous "Interface" articles dealing with that subject: "Federal Policies Promote Socialized Prehospital Care — Part 1", October 1984 *JEMS*; same title — Part 2, December 1984 *JEMS*; and "What the Feds Should Know," May 1986 *JEMS*.

The following brief overview of current Medicare policies is taken from the financial chapter written by this author for inclusion in an EMS resource manual soon to be released by the American College of Emergency Physicians (ACEP).

Ambulance services are eligible for Medicare reimbursement as "Part B" providers. In contrast, hospitals are "Part A" providers and are therefore reimbursed on an entirely different basis. As is the case with other Part B providers (e.g., most private-practice physicians, suppliers of durable medical equipment, etc.), the level of reimbursement for ambulance services is determined by a complex formula and limited by prevailing rates. At the time of this writing, Medicare will pay 80 percent of the allowed charges for ambulance services. Basically, allowed charges are established for each provider as the lowest of three amounts — (a) The actual charge listed on the Medicare claim form; (b) The provider's customary charge (i.e., the amount most often billed for the

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service during the 12-month period prior to the current fiscal year); or, (c) The prevailing charge in the area defined as the 75th percentile of the customary charges for all providers within the geographic area during the preceding 12-month "base period."

The preceding sentence begins with the word "basically" because there also exists an array of special rules, exceptions and provisions intended for inflation control and other purposes which modify the "basic" provisions in individual situations. Many of these policies were designed to deal with problems associated with reimbursement of services *other than* prehospital care services.

These regulations and their interpretations have been altered for better or for worse several times during recent years, and additional changes are currently being studied by the Health Care Financing Administration (HCFA). *Note:* By far the best access to current information on these issues is via membership and participation in the American Ambulance Association (AAA).

Miscellaneous Comments

Interpretation of applicable Medicare regulations differs considerably from region to region. Until recently, the prevailing rates for both advanced life support (ALS) and basic life support (BLS) providers were lumped together, allowing potential windfall compensation for BLS providers while providing inadequate compensation for ALS providers. Futhermore, while the option of switching to an all-inclusive ALS charge has been approved (to avoid financial incentives to perform unnecessary procedures), as of this writing many ALS providers continue to bill on a "laundry list" basis.

Even now, Medicare's prevailing rate calculations make no distinction between primary emergency service providers subject to stringent response-time requirements and firms subject to no response-time requirements, even though the reasonable cost of producing reliable response-time performance is obviously much higher than that needed to produce less reliable service. Equally troublesome is the fact that the prevailing rates, as of this writing, also make no distinction between heavily subsidized providers and unsubsidized or less heavily subsidized providers, even though the per-transport subsidies of some providers actually exceed the total charges of some unsubsidized providers offering equal or better service.

Some observers (among them this author) believe that the prevailing rate approach can never be a positive economic force in the prehospital care industry, regardless of how extensively or creatively the regulations are tuned.*

Summary of Problems

The economic logic underlying the prevailing rate approach assumes that retail competition exists in the market and is economically effective. This is simply not the case in the EMS industry. Emergency victims pinned under a car or experiencing cardiac arrest are very poor shoppers indeed. Dialing 9-1-1 in most communities brings an ambulance service selected by local government — not by the consumer. In the technical terminology of microeconomics, the retail-market transaction is all messed up.

Although retail competition has had plenty of opportunity to prove its worth in our industry, there are no examples in which retail competition (i.e., competition *within* the EMS market as opposed to *for* the EMS market) has evolved high quality service at a reasonable cost. In the EMS industry, the economic forces of retail competition simply don't work.

The Medicare program is a major buyer of ambulance services. Like it or not, and intentional or not, Medicare policies greatly affect every aspect of our industry's structure. Under present policies, its major effects are:

1. Where primary emergency providers are limited by the same prevailing charge level as firms having no responsibility to provide geographic coverage and reliable response-time performance, Medicare reimbursement allows excessive profits by "cream-skimming" firms, and unfair losses by even the most efficient providers of primary emergency service. Thus, "cream-skimming" firms are encouraged to inflate their fee schedules more rapidly than necessary, while even well-managed private providers of primary emergency service are literally squeezed out of the market, often to be replaced by less efficient government operations.

2. Where providers of primary emergency services having little or no local tax subsidy (i.e., usually private firms) are limited by the same prevailing charge level as organizations enjoying generous subsidy injections (i.e., usually government operations), the fee schedules (and operating costs) of subsidized providers tend to rise with the prevailing rate level. This occurs even where subsidies alone are more than sufficient to completely fund the costs of an efficient operation. At the same time, the higher fee structures of less subsidized firms give political advantage to subsidized providers whose actual cost-effectiveness may be dismal in comparison with the firms they replace.

Combined, the above effects have: Protected the market positions of less efficient organizations, including some with productivity so low as to boggle the mind; retarded the expansion of well-managed firms; slowed development of superior system designs and better production strategies; and preserved the present proliferation of mono-jurisdictional mini-systems too small to approach even modest economies of scale.

HCFA is concerned about rising Medicare costs of ambulance service, and rightly so. However, HCFA's recent efforts to control its ambulance service costs only exacerbate these larger adverse effects. (See last month's "Interface" column on the "Inflation-Indexed Charge.") To the limited extent federal EMS expenditures may actually have been contained, the shifting of federal EMS costs to local government budgets has more than offset the savings.

For example, Joe Phillips, EMS director for the state of Tennessee and chairman of the ASTM task group on EMS finance, reported that unreimbursed annual EMS expenditures by Tennessee counties had already grown to nearly 18 million dollars by fiscal year 1985-86, and now constitutes the largest category of public health ex-

Special Note: Thanks to ACEP for permission to reprint the above background material.

penditure by non-urban Tennessee counties. Additional equally illustrative examples are readily available from throughout the United States. Given Medicare's powerful influence on the structure and performance of the entire EMS industry, the full effects of reimbursement policy can no longer be ignored.

So What Shall We Do?

First, let's abandon the prevailing rate approach as a means for reimbursing primary providers of emergency ambulance services. The latest idea for trying to make a bad idea work is to keep the basic concept using two prevailing rates: one for subsidized providers and another for unsubsidized providers. Another idea along the same line is to separate providers into government vs. private "prevailing rate" groups. Neither is the answer.

Few primary providers are completely unsubsidized, and the budgets of even fewer are completely tax supported. The fee-for-service income/subsidy mixture among primary providers has an infinite range. Futhermore, the government vs. private distinction is all but irrelevant since both lightly subsidized and heavily subsidized providers of both types exist throughout our industry.

However, the biggest problem with the prevailing rate approach is the unavoidable fact that, in the unique economic environment of the EMS industry, the prevailing rate concept can never be made a positive economic force for recognizing and promoting more efficient production methods and superior management practices.

Design Criteria for a New Reimbursement Method.

Medicare's impact upon our industry cannot be made neutral. Intentional or not, that which Medicare policy rewards (e.g., organizations, production methods, system designs, etc.) will tend to displace that which Medicare policy ignores or, in some cases, inadvertently punishes. As we have seen, current Medicare reimbursement policies inadvertently reward less efficient producers and promote false economies. New Medicare policies must be deliberately designed to reverse those effects.

Specifically, new reimbursement policies must of course be designed to contain Medicare costs. But they must also be designed to strengthen the market positions of more efficient producers, allow and even promote superior economies of scale, and eliminate the false economy of shifting to local governments more than a dollar in new costs for each Medicare dollar saved. The approach presented below can simultaneously accomplish all of these objectives.

Stout's Proposal for Medicare Reimbursement

We begin by removing from the Medicare intermediaries all responsibilities for establishing rates of payment for prehospital EMS and medical transportation. All ambulance service providers, public and private, wishing to participate in the Medicare program will apply to a single national entity contracted by HCFA to issue EMS provider numbers and, in accordance with rate-setting policies discussed below, to establish rates of payment for every authorized firm. For purposes of this discussion, we'll refer to this entity as the "National EMS Rate-setting Organization" (NEMSRO).

In carrying out its work, NEMSRO will employ two different rate-setting methods — one applicable to primary providers of emergency transportation and another to firms which specialize in the provision of routine transfer services, interfacility transports, and elective or backup EMS transport. There are three very important reasons for distinguishing these two types of firms:

1. Primary providers of emergency service must incorporate within their budgets the fixed costs of maintaining both geographic and peak-period demand coverage. Other firms are not required to incur these expenses. Therefore, a reimbursement policy appropriate for either type of firm would be unfair or a windfall for the other type of firm.

2. Local tax subsidies, where they exist, are almost universally intended to support the provision of primary emergency services. Thus, a reimbursement policy appropriate for primary emergency providers must somehow cope with the issue of subsidy, while a reimbursement policy for other types of firms need not address subsidy at all.

3. In most communities (and it should be the case in every community) primary emergency-service providers are not allowed to refuse transport of uninsured indigent patients, to concentrate their coverage in more lucrative neighborhoods, or to refer less financially desirable business to their competitors. Thus, the percentage of unavoidable bad debt experienced by primary providers is generally higher than that of other providers. A reimbursement policy fair to either type of firm would be unfair or a windfall to the other type of firm.

Reimbursement Rate for Non-Primary Providers

The methods of rate-setting and reimbursement for *non-primary* providers will be essentially the same as the current prevailing rate method, except that a single, nationwide schedule of prevailing rates will be employed, rather than the multiple regional schedules which currently govern reimbursement levels.

Firms wishing to participate in Medicare reimbursement for routine transport services, interfacility transports, and elective or backup emergency ambulance services must submit the same information and documentation required under current policies, but their respective Medicare reimbursements will be limited by a single, nationwide prevailing rate schedule, adjusted up or down to account for cost-of-living differences among the market areas. (An already available cost-of-living index will be employed for this purpose.)

Primary emergency providers who also sell routine transport services, interfacility transfers, and/or backup emergency services outside their own primary areas will be eligible for reimbursement for these non-primary services under the same reimbursement policies (and limited by the same prevailing rate schedule) as that which applies to non-primary providers.

Maximum Allowable Charge for Primary Emergency Service

Only firms submitting proof that they are certified by one or more local governments as having responsibility for provision of primary emergency services will be eligible to participate in reimbursement for delivery of primary emergency services.

To prevent abuse of this program and to avoid financing poor economies of scale and duplicating

coverage costs, only one primary provider per geographic area may be designated by each local government. That is, each local government may designate one or more "primary providers" to serve its jurisdiction, but if multiple providers are designated, each must be assigned primary responsibility for covering a non-overlapping geographic zone.

Having identified the primary providers and the areas they serve, the next task is to set reimbursement rates for primary emergency service (i.e., 9-1-1 EMS calls or equivalent). *The goal is to establish a maximum allowable charge sufficient to fund the costs of efficient production of quality emergency service and good response-time reliablity.* Such a maximum allowable charge, adjusted up or down to account for cost-of-living differences, will limit reimbursement for all primary emergency services rendered by all primary emergency providers throughout the U.S.

Three basic approaches are available for determining the cost of *efficiently produced* primary emergency service of excellent quality and response-time reliability: the negotiation approach; the competitive cost approach; and the actual cost approach. I recommend a combination of all three.

The first step is to identify EMS markets currently receiving good clinical and response-time performance from their primary emergency ambulance service providers. Initial identification can be accomplished by survey method, followed by on-site inspection and verification.

From among the markets known to be receiving excellent primary emergency services, those experiencing the lowest overall costs (i.e., combined fee-for-service and subsidy income) would then be indentified. Again, the field can be initially narrowed by a follow-up survey, subject to verification by on-site inspection and/or external audit as appropriate. In markets meeting this definition where subsidy levels are zero, true cost to the public can be most easily determined. Where subsidies exist in combination with fee-for-service income, adjustments must be made to determine the true cost to the public (i.e., users and taxpayers).

The essential point is that we must identify the reasonable cost of *efficiently producing* primary emergency ambulance services of good quality and response-time performance. Having estimated such costs within a reasonably accurate range, NEMSRO officials will then negotiate with industry representatives (e.g., the American Ambulance Association) to definitively establish the maximum allowable charge for primary emergency services furnished by eligible primary providers. (To hold down administrative costs, this process can be conducted at three-year intervals, indexing interim adjustments to a percentage of an appropriate inflation index.)

Establishing Each Provider's Rate of Reimbursement

Now that we have established the maximum allowable charge for primary emergency services and have calculated regional adjustments based upon cost-of-living factors, the last step is to determine each eligible provider's individual reimbursement rate. The policy will provide that each provider's individual reimbursement will be 80 percent of the lesser of: the actual charge; or, the maximum allowable charge for that region, less the estimated per-transport local tax subsidy received by that provider. (The remaining 20 percent will be billed to the consumer as per current policy.)

The deduction of subsidies from the maximum allowable charge is extremely important to the long-term economic effects of reimbursement policy. For example, if a provider is already receiving greater subsidy per patient served than a more efficient provider requires to do the entire job without subsidy, then Medicare payments in addition to the subsidy would merely serve to finance and preserve an inefficient operation or, in some cases, politically imposed but economically impractical primary service areas (e.g., our present nationwide network of mono-jurisdictional mini-systems).

To the extent that any provider's *combined* income from local tax subsidy and fee-for-service payments exceeds the level needed for efficient service delivery, a change is in order — i.e., a change of production method, a change of management, a change of provider, or a change in the boundaries of the primary service area. The reimbursement policy recommended here would do much to expose inefficient operations and much to encourage positive change.

To estimate the amount of each provider's subsidy per patient served, each eligible provider will be required to submit (to NEMSRO) audited accounting information certifying the amount of subsidy received, verified by the chief financial officer of the subsidizing local government, and certified by the providers' own chief executive officer. Willful submission of false information would constitute criminal fraud.

There isn't space here to spell out all the details of applying the subsidy offsets to individual provider's rates. Certain forms of "in kind" subsidy (as opposed to cash support) should not be included. For example, the provision of non-transporting first responder services by local government should not reduce Medicare reimbursement to the transport provider. Similarly, government-financed costs of external regulation, medical quality control, 9-1-1 services, and certain communications infrastructure costs should also be excluded from offset calculations. (This is part of the reason for establishing NEMSRO — such specialized knowledge can never be maintained by every intermediary.)

Finally, in extremely rural areas which cannot be economically serviced as satellite operations of neighboring urban systems, the policy will provide that NEMSRO may disregard that portion of the subsidy which is necessary to finance a better level of service than that which could otherwise be produced by an efficient provider billing at the regionally adjusted maximum allowable charge level. Even so, Medicare reimbursement would still not exceed 80 percent of the regionally adjusted maximum allowable charge. (I do not recommend a similar allowance to offset uncollectible losses due to higher percentages of low income residents, as such a policy would serve to divert attention from the better solution — i.e., fixing the Medicaid problem.)

Management of Payments

Actual Medicare payments for both primary emergency and other types of service will continue to be

managed by the Medicare intermediaries. However, in managing reimbursements, the Medicare intermediaries will strictly abide by provider eligibility determinations and authorized rates of payment supplied directly by NEMSRO.

Political Realities

Could this program actually work? Is it economically feasible? Is it administratively practical? Would it effectively contain Medicare costs in the long run while ending the false economies and cost-shifting effects of the current policies? Would it actually encourage and reward better productivity while promoting change in less well-managed organizations? To all of these questions, the answer is yes. It's just common sense.

But there's another question: Is the program I've described *politically* feasible? I think so. Who stands to benefit? Mainly patients, taxpayers, and efficient providers of primary emergency services. Who stands to lose? Mainly inefficient (or profit-crazed) providers of primary emergency services. In this case, I think the good guys can win. It's not always so.

A Scary Option

Finally, the reader should know about yet another alternative to the program I've described — an alternative that has been recently kicked around by some HCFA officials. The general idea is to divide the U.S. into ambulance service trade areas and to periodically award by bid competition the Medicare ambulance service contract to a single provider in each designated area. (Presumably, Veterans Administration contract work would be automatically included, perhaps Medicaid as well.)

As president of the firm which has successfully managed more large-scale awards of EMS contracts than any other organization, I believe I am qualified to evaluate this option. If the market areas are properly defined; if other buyers of ambulance services (e.g., other third-party payers, HMOs, IPAs, etc.) are included in a "group purchase" program for each market area; if the "supply side" of our industry is given the time, means, and incentive to prepare for such massive competition; if regulation is provided to guarantee that uninsured residents cannot be ripped off by the monopoly provider on which they would almost surely be forced to depend; if the quality of care standards, bidder qualifications, performance security provisions, competitive bid variables, bid evaluation process, etc., are all done correctly. . . the concept could work. You see why it's scary!

Here's what won't work: The prevailing rate approach can never work well as the basis for reimbursing primary emergency providers. And if we as an industry continue playing defense by opposing further changes to the present payment method, eventually that won't work either. We cannot rely upon the federal government to understand our industry sufficiently to solve this problem. We must assume a pro-active leadership role. This article is my contribution. Now let's see yours. □