MBS MEDICAL BUSINESS SERVICES,LLC

BASIC REIMBURSEMENT FOR STAKEHOLDERS

Health care reimbursement is exceedingly complicated, and it is changing nearly every day.

EMS providers are a part of the larger health care system, just like hospitals, physicians, and other medical professionals.

All health care "payers" such as Medicare, Medicaid, and commercial insurers are facing increasing health care costs and working aggressively to control those costs. Reduced reimbursement is often a consequence of those efforts.

This document is intended to provide a very simple roadmap through the principles of EMS reimbursement to provide a basic working understanding for EMS stakeholders. It does, therefore, generalize.

EMS and most medical services are very different than other products and services. In those cases, the provider of that product or service sets its rates and costs, and the customer that uses the product or service is expected to pay the amounts billed.

EMS and medical reimbursement is very different.

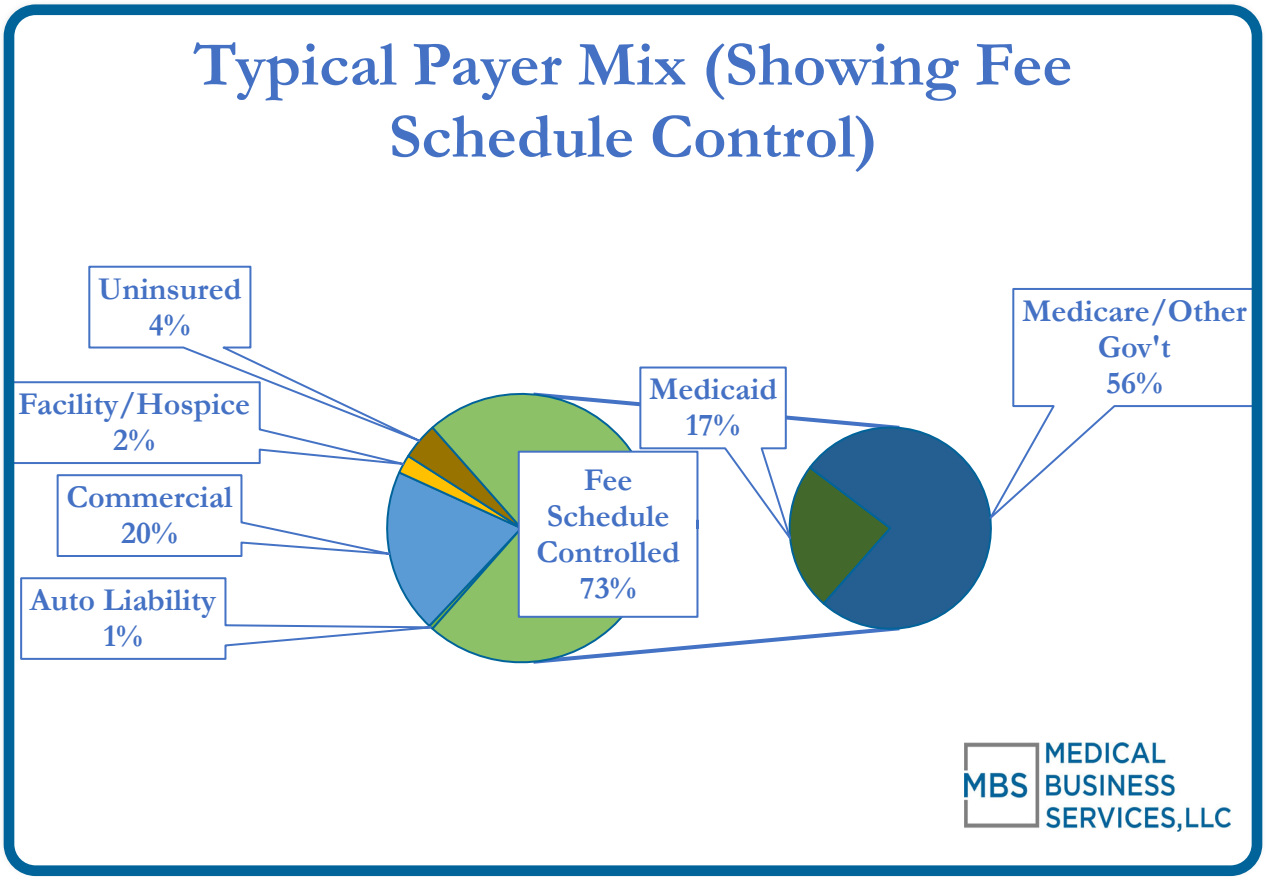
This summary outlines the reality that EMS reimbursement amounts are very often out of the control of the EMS agency. However, MBS believes that an informed EMS community may effectuate positive change and provides this and other information to inform EMS Stakeholders about those realities.

Payer Mix and Government Fee Schedules

Because of the very nature of EMS, it provides most of its services to two categories of patients. The first category are retirement-aged individuals who nearly always are insured by **Medicare**, which, as noted, is primarily age based. The second category is those of limited financial means, and that group is often insured by **Medicaid**, which is needs based.

> The actual return from any rate increase is limited by your **payer mix** and what the government has deemed that they will pay, as outlined in their **fee schedule.**

For that reason, the **Payer Mix** for most EMS providers includes a very large percentage of Medicare and Medicaid patients, most often exceeding 70% of all calls.



Medicare, Medicaid, and other smaller government programs establish **Fee Schedules**. Those fee schedules represent what the program will pay, regardless of the billed amount.

> As a result of government fee schedules, EMS providers have no control over their reimbursement amounts for more than 70% of their calls. The only way to change that reality is political or legislative.

Because Medicare is a federal program its **Fee Schedules** are established at the federal level by the Center for Medicare and Medicaid Services. Medicaid is a state program and, as such, its **Fee Schedules** are established at the state level by the state Medicaid agency.

Fee schedules aren't optional, and the patient can only be billed for bona fide cost sharing amounts, which are usually 20% of fee schedule for Medicare.

Simply put, the billed amount is essentially irrelevant for these programs as payments are controlled by **a Fee Schedule**. With limited exceptions Medicare patients may only be billed for 20% of fee schedule, and Medicaid patients cannot be billed for any amount at all.

The difference between the billed amount and the **Fee Schedule** amount is credited as an "adjustment". As a result, the total amount of charges "adjusted" is often surprisingly large. It is, in essence, the "cost" of treating patients insured by government programs.

Commercial Insurers – Cost Sharing

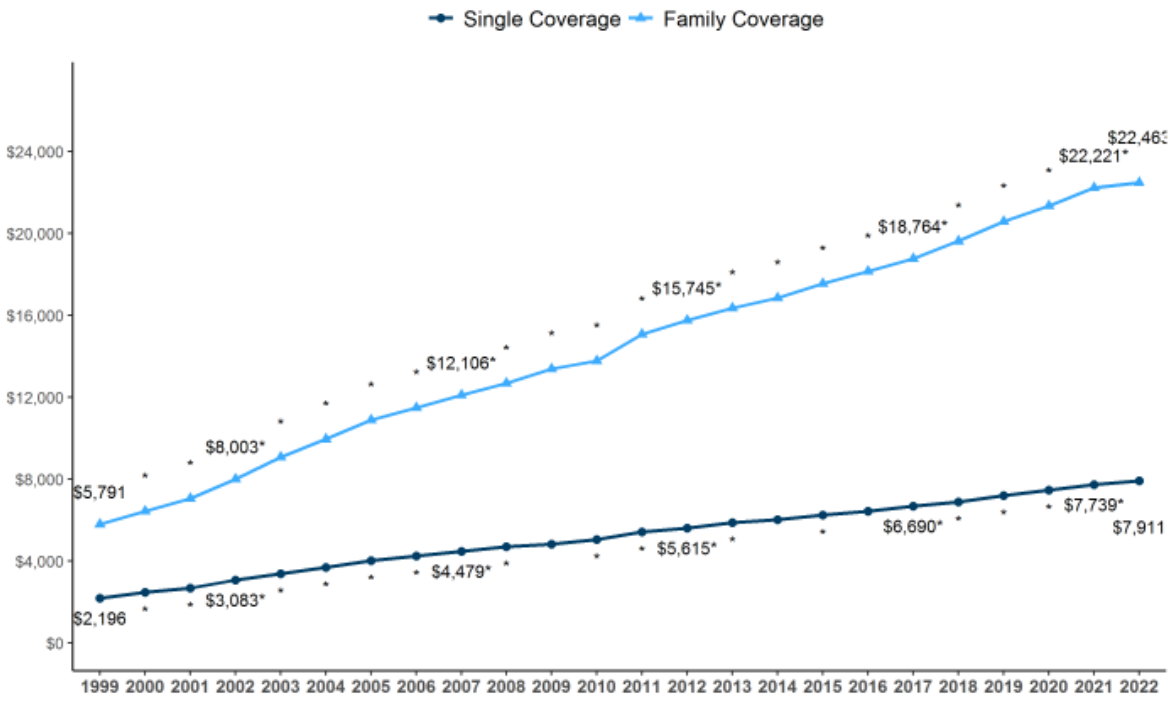
As noted above, most patients treated and transported by EMS are insured by Medicare, Medicaid, and other governmental programs.

EMS does also serve sick and injured patients that may be insured by their own health insurance policy or their employer's health insurance plans. Also, a small percentage of patients may have some benefits from an auto insurance policy or another specialized policy. **Payer Mix** indicates that *the percentage of EMS patients that are commercially insured is low, usually less than 25% of all patients.*

> Commercial Insurers reduce their payments using **cost sharing** and, increasingly through their own **network fee schedules.**

The dramatic rise in health care costs and the similarly dramatic rise in health care insurance premiums has had the effect of reducing payments by commercial insurers significantly.

Figure 1.12
Average Annual Premiums for Single and Family Coverage, 1999-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

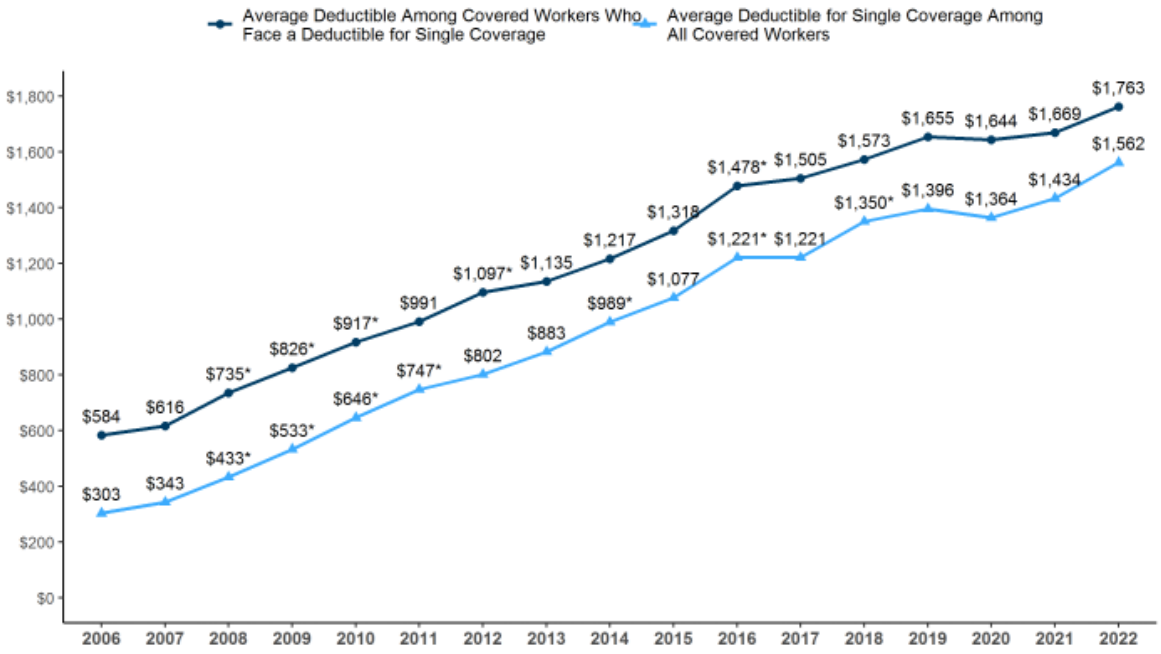
One of the primary methods to control health insurance premiums is to reduce actual payments by the health insurer and shift an increasing portion of billed amounts to the patient, termed **Cost Sharing**.

While one might conclude that commercial insurers would pay the entire billed amount, such is not the case.

Cost Sharing amounts may vary from a small percentage of the bill to the entire bill for a large deductible plan. These amounts are billed to patients after insurance has been paid.

Cost Sharing is not new. Regardless, amounts left to the patient through **Cost Sharing** have increased significantly. As premium costs rise so have **Cost Sharing** percentages, leaving patients liable for more of their health care costs.

Figure 7.10
Average General Annual Deductibles for Single Coverage, 2006-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

As a result of the increase in cost sharing, a significant and increasing percentage of EMS billed amounts are the responsibility of the patient, and, for those balances that go unpaid by the patient, are transferred to the taxpayer that funds the EMS entity.

Commercial Insurers – Provider Network Fee Schedules/Network Rates

In addition to increasing cost sharing amounts, commercial insurers have attempted to control costs in an additional and very important way.

The use of **provider networks** has expanded significantly to control quality and reduce costs. A provider network is a list of medical providers who have:

1. Met the insurer's credentialing requirements
2. Agreed to treat the insurer's patients
3. Agreed to accept the insurer's **fee schedule**, often called the **network rate,** or sometimes the **allowed amount**, which represent payments significantly less than billed amounts.
4. Agreed not to bill any balance to the insurer's patients

Provider Networks can and do make sense for many sectors of health care providers.

Many commercial insurance policies contain a provision indicating the if the insured patient chooses to visit an **in-network** provider that their liability will be reduced. If, on the other hand, if they choose to visit a provider that is **out of network** the insurer will only pay the **in-network** amount, leaving the patient with a larger liability.

As an example, a Cardiologist may consider joining an insurer's provider network. He or she may find that the additional business that would result from being included in the network outweighs the reductions in payments due to the insurers' **network rate** and may then **choose** to join the network. Also, if that provider finds that the reductions in payments don't outweigh the additional patients, he or she them may **choose** not to join the network and can **choose** to decline accepting those patients.

As for the patient in need of a Cardiologist, he or she can **choose** an in-network provider to save money or choose one out of network, knowing that they may owe more.

The common denominator is **choice.**

Few EMS providers choose to join networks because the discounts required would shift additional costs to the taxpayers that fund them.

MBS believes that efforts to reduce payments by commercial insurers by imposing network rates is unfair to the EMS entity, to the taxpayer, and to the patient.

The fairness of the method fails miserably when considering EMS. Obviously, EMS providers cannot decline to treat certain patients, and patients cannot choose their ambulance service.

The real-world result of application of network fee schedules to EMS is that insurance payments are reduced, patient liability is increased, and more costs passed to the taxpayer if the patient fails to pay their balance.

The unfairness of the method is represented in the letter below sent to a patient who had received 911 care. The letter informed the patient that he may wish to find an **in-network** EMS provider, and if he did not, that his liability would be greater if, in the future, he is treated by an **out of network** EMS provider.

Cigna
1640 Dallas Parkway
Plano, TX 75093

Cigna

April 2, 2022

[redacted]T 05403-6317

Please Read
This letter includes important information about changes to your plan's network.

Dear WILLIAM,

Starting April 1, 2022, [redacted]FIRE & RESCUE DEPT will no longer participate in your plan's network for the specialty listed below:

Specialty: AMBULANCE/TRANSPORTATION SERVICES

As of this date [redacted]FIRE & RESCUE DEPT will be out-of-network for this specialty.

What you need to know, and how we can help.

To continue receiving care at the in-network benefit level after April 1, 2022, you'll need to choose a new in-network provider. To do this, you can:

- **Call us** at the number on your ID card. We'll be happy to help you.
- **Use the myCigna app or cigna.com** to find in-network providers in your area.

If you choose a new provider, please tell your Primary Care Physician. This will help ensure a smooth transition in your care.

Why stay *in network*?

You get the most value from your plan, when you see in-network providers. When you go out-of-network, you are likely to pay more for the same services. That's because:

- In-network providers usually cost less. They agree to accept discounted rates and their services are covered at the in-network benefit level.
- Out-of-network providers usually cost more because they can charge you full price. That means your share of the costs is higher.
- If your plan doesn't cover out-of-network providers, you pay 100% of the cost.

Uninsured

While government program expansions have reduced the percentage of uninsured individuals, they still exist. A small percentage of EMS patients are uninsured. While these patients are billed, payment is rare.

No Transports

Medicare is a transportation benefit, and, as such, with a limited exception, if a patient is not transported there is no payment. Nearly all payers follow this reality. As a result, the costs of no transport are not billable nor paid.

MBS MEDICAL BUSINESS SERVICES,LLC

Southeastern Vermont Regional EMS Study

12/14/2022

	Atkinson	Danville	Hampstead	Newton	Plaistow	Sandown	Total	Mileage	%	Mileage Allowed	Primary Mileage Revenues	BLS Allowed	BLS Base Calls	BLS Primary Revenues
<none>	4	2	4	3	7	2	22	176	0.72%	$6.48	$1,140.48	$330.64	14.37	4,751.91
Blue Cross	44	25	62	32	98	53	314	2512	10.32%	$6.48	$16,277.76	$330.64	205.13	67,822.74
Collections	39	44	96	20	101	43	343	2744	11.28%	$0.00	$0.00	$0.00	224.07	0.00
Commercial	49	34	75	28	99	50	335	2680	11.01%	$6.48	$17,366.40	$330.64	218.84	72,358.65
Facility Contract	0	0	1	0	0	0	1	8	0.03%	$6.48	$51.84	$330.64	0.65	216.00
Hospice	0	1	3	0	1	1	6	48	0.20%	$6.48	$311.04	$330.64	3.92	1,295.98
Medicaid	21	41	86	35	112	14	309	2472	10.16%	$4.01	$9,912.72	$204.65	201.86	41,310.51
Medicare	187	86	303	101	281	109	1067	8536	35.08%	$6.48	$55,313.28	$330.64	697.04	230,467.71
Medicare Replacement	74	60	88	46	112	46	426	3408	14.00%	$6.48	$22,083.84	$330.64	278.29	92,014.29
MVA	7	3	8	1	15	3	37	296	1.22%	$6.48	$1,918.08	$330.64	24.17	7,991.85
Private	6	14	26	12	31	11	100	800	3.29%	$0.00	$0.00	$0.00	65.33	0.00
Tufts	3	3	14	4	10	4	38	304	1.25%	$6.48	$1,969.92	$330.64	24.82	8,207.85
Veterans	3	2	8	5	4	8	30	240	0.99%	$6.48	$1,555.20	$330.64	19.60	6,479.88
Work Comp	2	2	5		4	1	14	112	0.46%	$6.48	$725.76	$330.64	9.15	3,023.94
Grand Total	439	317	779	287	875	345	3042	24336	1		$128,626.32	0	1987.24	$535,941.30

MEDICAL BUSINESS SERVICES,LLC

Southeastern Vermont Regional EMS Study

12/14/2022

	ALS Allowed	ALS Base Calls	ALS Primary Revenues	Minumum Primary Revenues	Comparable Balance %	Total Charges	Balance Payments	Total Payments
<none>	$392.63	7.63	$2,995.04	$8,887.43	0.18%	$58,374.07	$105.07	$8,992.50
Blue Cross	$392.63	108.87	$42,747.34	$126,847.84	5.40%	$833,157.19	$44,990.49	$171,838.33
Collections	$0.00	118.93	$0.00	$0.00	0.00%	$910,104.82	$0.00	$0.00
Commercial	$392.63	116.16	$45,606.24	$135,331.30	1.50%	$888,877.89	$13,333.17	$148,664.47
Facility Contract	$392.63	0.35	$136.14	$403.97	0.00%	$2,653.37	$0.00	$403.97
Hospice	$392.63	2.08	$816.83	$2,423.84	0.00%	$15,920.20	$0.00	$2,423.84
Medicaid	$243.02	107.14	$26,037.33	$77,260.56	0.00%	$819,890.35	$0.00	$77,260.56
Medicare	$392.63	369.96	$145,259.29	$431,040.28	1.80%	$2,831,142.41	$50,960.56	$482,000.84
Medicare Replacement	$392.63	147.71	$57,994.81	$172,092.93	1.80%	$1,130,334.27	$20,346.02	$192,438.95
MVA	$392.63	12.83	$5,037.11	$14,947.04	6.50%	$98,174.57	$6,381.35	$21,328.39
Private	$0.00	34.67	$0.00	$0.00	1.48%	$265,336.68	$3,926.98	$3,926.98
Tufts	$392.63	13.18	$5,173.25	$15,351.01	1.50%	$100,827.94	$1,512.42	$16,863.43
Veterans	$392.63	10.40	$4,084.14	$12,119.22	0.00%	$79,601.01	$0.00	$12,119.22
Work Comp	$392.63	4.85	$1,905.93	$5,655.64	0.00%	$37,147.14	$0.00	$5,655.64
Grand Total		1054.76	$337,793.45	$1,002,361.06		$8,071,541.91	$141,556.06	$1,143,917.12

MEDICAL BUSINESS SERVICES,LLC

Southeastern Vermont Regional EMS Study
12/14/2022

	Atkinson	Danville	Hampstead	Newton	Plaistow	Sandown	Total	Mileage	Mileage Rate	Mileage Charge	BLS Rate	BLS Base Calls	BLS %
<none>	4	2	4	3	7	2	22	176	$85.00	$14,960.00	$1,800.00	14.37	65.326633%
Blue Cross	44	25	62	32	98	53	314	2512	$85.00	$213,520.00	$1,800.00	205.13	65.326633%
Collections	39	44	96	20	101	43	343	2744	$85.00	$233,240.00	$1,800.00	224.07	65.326633%
Commercial	49	34	75	28	99	50	335	2680	$85.00	$227,800.00	$1,800.00	218.84	65.326633%
Facility Contract	0	0	1	0	0	0	1	8	$85.00	$680.00	$1,800.00	0.65	65.326633%
Hospice	0	1	3	0	1	1	6	48	$85.00	$4,080.00	$1,800.00	3.92	65.326633%
Medicaid	21	41	86	35	112	14	309	2472	$85.00	$210,120.00	$1,800.00	201.86	65.326633%
Medicare	187	86	303	101	281	109	1067	8536	$85.00	$725,560.00	$1,800.00	697.04	65.326633%
Medicare Replacement	74	60	88	46	112	46	426	3408	$85.00	$289,680.00	$1,800.00	278.29	65.326633%
MVA	7	3	8	1	15	3	37	296	$85.00	$25,160.00	$1,800.00	24.17	65.326633%
Private	6	14	26	12	31	11	100	800	$85.00	$68,000.00	$1,800.00	65.33	65.326633%
Tufts	3	3	14	4	10	4	38	304	$85.00	$25,840.00	$1,800.00	24.82	65.326633%
Veterans	3	2	8	5	4	8	30	240	$85.00	$20,400.00	$1,800.00	19.60	65.326633%
Work Comp	2	2	5		4	1	14	112	$85.00	$9,520.00	$1,800.00	9.15	65.326633%
Grand Total	439	317	779	287	875	345	3042	24336	$85.00	$2,068,560.00	$1,800.00	1,987.24	65.326633%

MBS MEDICAL BUSINESS SERVICES,LLC

Southeastern Vermont Regional EMS Study
12/14/2022

	BLS Charges	ALS Rate	ALS Base Calls	ALS%	ALS Charges	Total Charges	Comparable Customer	Rough Indicated
<none>	$25,869.35	$2,300.00	7.63	34.673367%	$17,544.72	$58,374.07	26.00%	$15,177.26
Blue Cross	$369,226.13	$2,300.00	108.87	34.673367%	$250,411.06	$833,157.19	47.00%	$391,583.88
Collections	$403,326.63	$2,300.00	118.93	34.673367%	$273,538.19	$910,104.82	0.00%	$0.00
Commercial	$393,919.60	$2,300.00	116.16	34.673367%	$267,158.29	$888,877.89	55.00%	$488,882.84
Facility Contract	$1,175.88	$2,300.00	0.35	34.673367%	$797.49	$2,653.37	74.00%	$1,963.49
Hospice	$7,055.28	$2,300.00	2.08	34.673367%	$4,784.92	$15,920.20	74.00%	$11,780.95
Medicaid	$363,346.73	$2,300.00	107.14	34.673367%	$246,423.62	$819,890.35	9.00%	$73,790.13
Medicare	$1,254,663.32	$2,300.00	369.96	34.673367%	$850,919.10	$2,831,142.41	26.00%	$736,097.03
Medicare Replacement	$500,924.62	$2,300.00	147.71	34.673367%	$339,729.65	$1,130,334.27	26.00%	$293,886.91
MVA	$43,507.54	$2,300.00	12.83	34.673367%	$29,507.04	$98,174.57	70.00%	$68,722.20
Private	$117,587.94	$2,300.00	34.67	34.673367%	$79,748.74	$265,336.68	0.00%	$0.00
Tufts	$44,683.42	$2,300.00	13.18	34.673367%	$30,304.52	$100,827.94	47.00%	$47,389.13
Veterans	$35,276.38	$2,300.00	10.40	34.673367%	$23,924.62	$79,601.01	26.00%	$20,696.26
Work Comp	$16,462.31	$2,300.00	4.85	34.673367%	$11,164.82	$37,147.14	26.00%	$9,658.26
Grand Total	$3,577,025.13	$2,300.00	1054.76	34.673367%	$2,425,956.78	$8,071,541.91	36.14%	$2,159,628.33

MBS MEDICAL BUSINESS SERVICES,LLC

Southeastern Vermont Regional EMS Study

12/14/2022

HCPCS	Description	Medicare Fee Schedule (2022 Rural)	Medicare Payment	Medicaid Fee Schedule (7/22)	Medicaid Payment	Proposed Rates	Comparable Rates	Proposed Charges/Call	Comparable Charges/Call
A0427	ALS Level 1 Emergency	$490.79	$392.63	$243.02	$243.02	$2,300.00	$1,950.00		
A0433	ALS Level 2	$710.36	$568.29	$351.73	$351.73				
A0429	BLS Emergency	$413.30	$330.64	$204.65	$204.65	$1,800.00	$1,205.00		
A0426	ALS Level 1 Non-Emergency	$309.97	$247.98	N/A	N/A				
A0428	BLS Non-Emergency	$258.31	$206.65	N/A	N?A				
A0425	Ground Mileage	$8.10	$6.48	$4.01	$4.01	$85.00	$32.00		
A0434	Specialty Care Transport	$839.51	$839.51	$415.65	$415.65				
								$2,653.37	$2,116.09

Chris Knutsen

From: Nicole Vessal <nvessal@comstarbilling.com>
Sent: Tuesday, September 6, 2022 3:59 PM
To: Chris Knutsen
Cc: Rick Martin
Subject: RE: Plaistow Area Collection Projection

Hello Chief Knutsen,

Using the below rates and volume will yield approximately $1.4M.

In terms of your rates, Comstar generally does not provide recommendations. That is because rates are unique to each service as they are a function of costs. However, we can provide you with data from our current clients. Your base rates are in our top 10% for NH clients (they are not the highest). The mileage you provided is more than double our highest charging NH client. Please note that the above provided projection reflects your base rates but a mileage that mirrors one of our higher charging clients.

For planning purposes, we suggest you use a 5% fee for your billing service. This is based off of actual receipts collected.

Best,
Nicole

From: Chris Knutsen <cknutsen@plaistow.com>
Sent: Tuesday, September 6, 2022 1:03 PM
To: Nicole Vessal <nvessal@comstarbilling.com>
Subject: Plaistow Area Collection Projection

Nicole,

I have attached an 18-month payer matrix. This area remains to be fairly consistent with ambulance transports. Looking at the 18—month data, it appears that there would be around 2,028 transports annually.

A three year average for billable transports is
BLS Rate: 66% 1338 transports
ALS Rate: 34% 690 transports
Based on a total of 2,028 transports

Charge rates using flat rate billing
ALS: $2300 base
BLS: $1800 base

Milage: $85 per loaded mile
I would probably use a 8-mile average transport distance

I am also looking at suggestions for billing rates. A comprehensive budget is not complete, but looking around 1.9-2 million annual operating expense.

Thank you again for helping me with this information.

Have a great day,

Chief Knutsen

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8 Turcotte Memorial Drive
Rowley, MA 01969
Ph: (978) 356-3344 Fax: (978) 356-2721
Web: http://www.comstarbilling.com