



# Ground Ambulance & Patient Billing Advisory Committee

Rural and Volunteer Ambulance Service



# Gary Wingrove FACPE, CP-C

- The Paramedic Foundation – President
- National Rural Health Association – Government Affairs Committee
- National Rural Health Resource Center – Advisor

This generalized description introduces the committee and public to the uniqueness of rural ambulance services. It will inform the GAPB's work going forward. It is one person's thoughts, observations, and ideas.

# Goals

- Describe a specific rural volunteer agency
- Issues with staffing and billing
- Describe rural ambulance deserts
- Costs of operations
- CAH reimbursements for ambulance
- Recommendations

# Typical Volunteer Ambulance Agency

- The staff are volunteers that have other full-time jobs in the community
- The staff volunteer for ambulance duty when they are not working their primary job
- Some agencies have call schedules, while others do an “all call page” to get the available people to the ambulance garage and complete the call
- Some volunteers go to great lengths in order to support their families and also serve the community

# Take a vacation!

- Choose Rapid City, ND

# Driving options

- Mount Rushmore National Memorial – 30 minutes
- Custer State Park – 35 minutes
- Crazy Horse Memorial – 50 minutes
- Badlands National Park – 54 minutes
- Wind Cave National Park – 60 minutes
- Black Hills National Forest – 60 minutes
- Minuteman Missile National Historic Site – 64 minutes
- Jewel Cave National Monument – 64 minutes
- Devil's Tower National Monument – 90 minutes

# Choose Devil's Tower National Monument

- 6 miles from Hulett (pop ~300)
- Park has park ranger EMTs (no ALS) and does not transport
- Close Encounters of the third kind
- Hulett EMS has you covered
  - 1 EMT-Intermediate, 2 AEMTs, 2 EMTs (tech)





# Hulett EMS

- Jason Perry
  - President/Director - unpaid
  - Volunteer





# Jason Perry

- Full-time job: Mandaree, ND – Indian Reservation
  - 7 days, paid 24 hours
  - 3 weeks at home
- Was Intermediate EMT
- CP/IBSC
- Completed Paramedic school
- Balancing jobs, retirement, etc.

# Jason Perry Recap

- In order to volunteer as a paramedic and agency director Jason drives 300 miles to work as a full-time paramedic
- Works one week, has three weeks off to volunteer

# About Hulett EMS 2023

- In 2022 Hulett completed 189 ambulance runs
- The next closest ambulance is 37 miles away in Sundance, WY (CAH-operated ambulance)
- No staff schedule
  - All call paging
  - One paramedic is available 24x7
- Annual budget ~\$101,000
- The last ambulance purchased was a used ambulance that cost \$97,000

# About Hulett EMS 2023

- Based at the fire department (no fee)
- Dispatched by the sheriff (no fee)
- To purchase new ambulances:
  - Community “pie party” to raise 50%
  - Finance 50%
- Uses a professional billing company

# About Hulett EMS 2023

- Closest trauma center
  - Rapid City Level II - 94 miles
  - Billings – miles 318 miles (5-6 hours) fly if an airplane can fly, 35 minutes to pick up in Hulett
- STEMI center
  - Gillette, SD – 141 miles (2 hours) has cath lab but no open heart,
  - Rapid City for an open heart– drive 110 miles
- Stroke
  - Rapid City – time window fly 4.5-hour window from onset of symptoms fly, otherwise drive

# A Consensus Panel Approach to Estimating the Start-Up and Annual Service Costs for Rural Ambulance Agencies

Disclaimer: This study was led by Yvonne Jonk at the Maine Rural Health Research Center at the University of Southern Maine, of which I served as an advisory member of the Expert Panel

	Tier 1	Tier 2	Tier 3
<b>Primary On Duty Ambulance Units</b>	1	2	3
<b>Service Area Population</b>	Less than 8,000	8-15,000	15-22,000
<b>Responses per year*</b>	Less than 800	800 - 1499	1500 - 2200
<b>Responses per day</b>	$\leq 2$	Between 2 - 4	$\geq 4$



# Cost to provide one ambulance on duty 24 x 7

Total Annual Costs (Depreciation + Variable)	\$883,429
Administrative Costs (9% of Annual Budget)	\$79,509
Grand Total Annual Budget	\$962,937

# Cost by tier

	Tier 1 (<800 Responses/Year)		Tier 2 (800 1499 Responses/Year)		Tier 3 (1500 2200 Responses/Year)	
	Start-up Costs	Annual Costs	Start-up Costs	Annual Costs	Start-up Costs	Annual Costs
	Fixed Costs	Depre-ciation	Fixed Costs	Depre-ciation	Fixed Costs	Depre-ciation
	1 Primary Ambulance		2 Ambu-lances		3 Ambu-lances	
Ambulance and Medical Equipment *						
Primary Ambulance and Equipment	233,736	23,374	467,471	46,747	701,207	70,121
Secondary Ambulance Back up	208,736	20,874	208,736	20,874	208,736	20,874
Additional Ambulance Back up	183,736	18,374	183,736	18,374	183,736	18,374
Chief/Supervisor Unit	57,500	5,750	57,500	5,750	57,500	5,750
Total Vehicle & Equipment Costs	683,707	68,371	917,442	91,744	1,151,178	115,118
Building **	1,725,000	57,500	1,725,000	57,500	1,725,000	57,500
Technology ***	91,200	17,829	115,847	22,452	140,494	27,076
Variable Costs: Ambulance Crews						
Salary & Benefits (n 24x7, 1 on call, 1 transport; 1 chief)	1-24x7 c./rew	726,713	2-24x7 crews	1,203,257	3-24x7 crews	1,679,801
Training (Initial & re certification, CE)		13,017		22,591		30,543
Total Fixed & Annual Costs						
Fixed, Annual Depreciation + Variable	2,500,787	883,429	2,759,402	1,397,544	3,018,018	1,910,038
Administrative Costs						
Other Administrative (9% of budget)		79,509		125,779		171,903
Grand Total Annual Budget						
Depreciation + Variable + Administrative		962,937		1,523,323		2,081,941

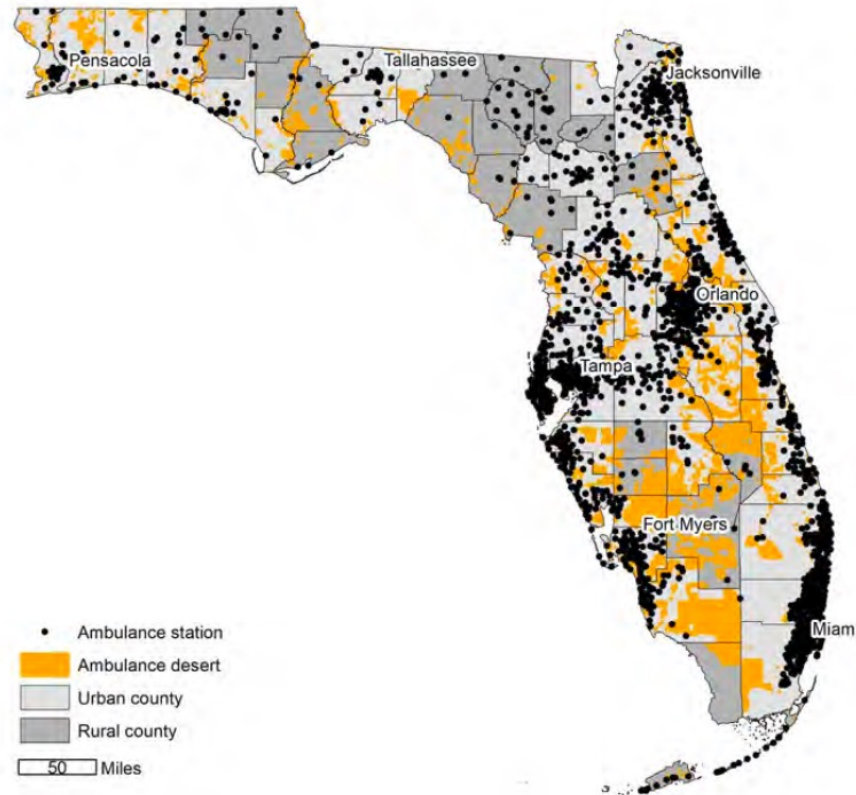
# Breakeven by tier

	Tier 1 (<800 Responses/Year)		Tier 2 (800-1499 Responses/Year)		Tier 3 (1500-2200 Responses/Year)	
Range of Responses	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
	0	799	800	1499	1500	2200
Annual Budget	\$962,937		\$1,523,323		\$2,081,941	
Distribution of Responses	Annual No. of Responses	Cost per Response	Annual No. of Responses	Cost per Response	Annual No. of Responses	Cost per Response
	25	38,517				
	50	19,259	800	1,904	1500	1,388
	100	9,629	900	1,693	1600	1,301
	200	4,815	1000	1,523	1700	1,225
	300	3,210	1100	1,385	1800	1,157
	400	2,407	1200	1,269	1900	1,096
	500	1,926	1300	1,172	2000	1,041
	600	1,605	1400	1,088	2100	991
	700	1,376	1499	1,016	2200	946
	799	1,205				

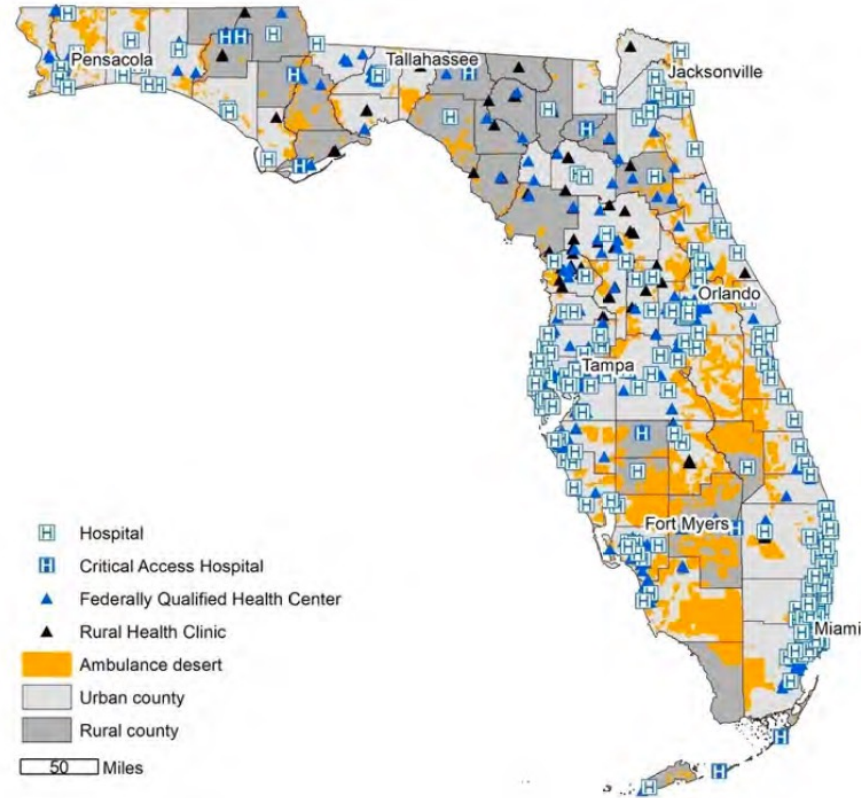
# Ambulance Deserts

- Federal Office of Rural Health Policy funded project completed by the Maine Rural Health Research Center
- In the clearance process and subject to modification

### Ambulance Locations and Deserts



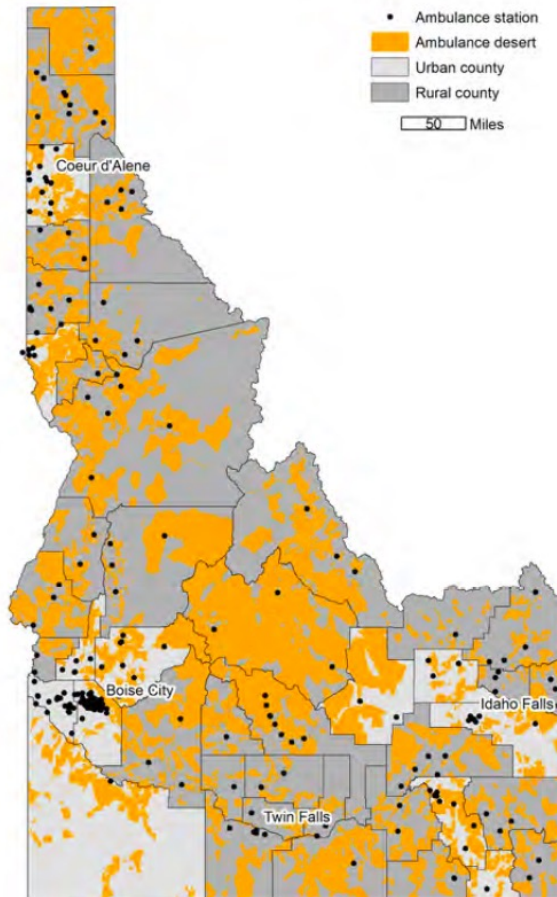
### Health Care Facilities and Ambulance Deserts



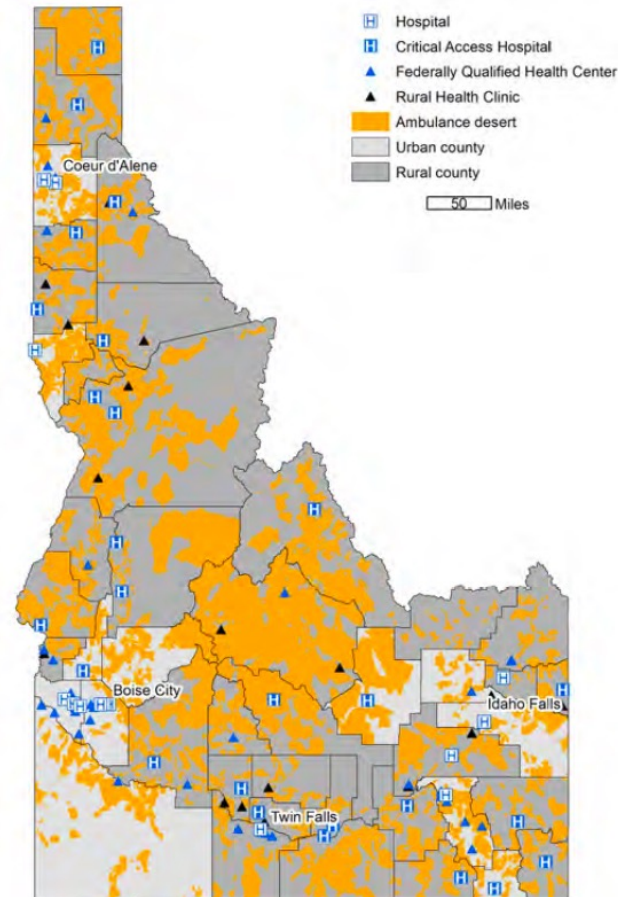
Ambulance stations	Ambulance desert population		Rural county ambulance desert population		
	n	% of state pop.	n	% of rural county pop.	% of total desert pop.
1,826	199,176	0.9%	29,031	4.2%	14.6%

Data sources: Florida Health; Esri; US Census Bureau; Health Resources & Services Administration; USDA Economic Research Service.

### Ambulance Locations and Deserts



### Health Care Facilities and Ambulance Deserts

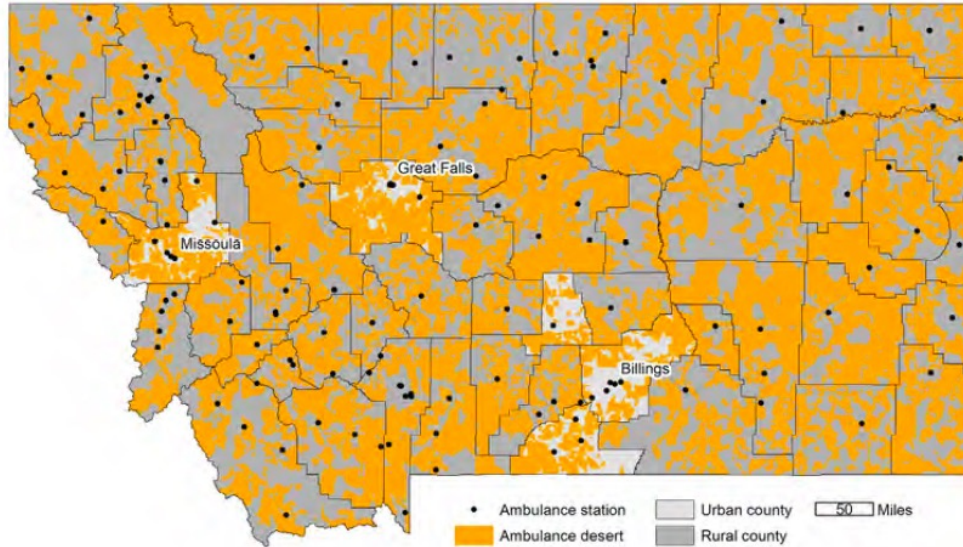


Ambulance stations	Ambulance desert population		Rural county ambulance desert population		
	n	% of state pop.	n	% of rural county pop.	% of total desert pop.
21	84,254	4.6%	57,428	9.6%	68.2%

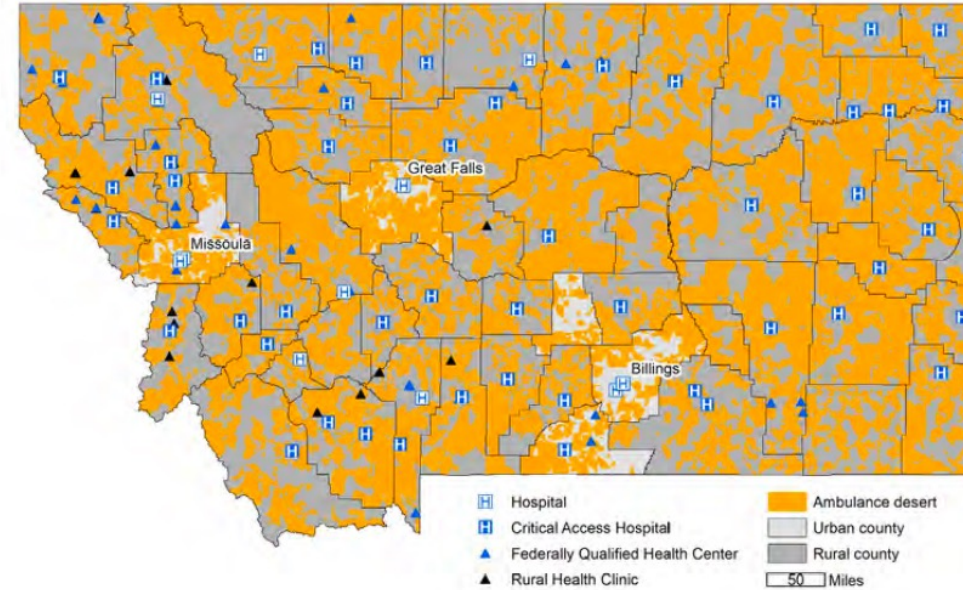
ta sources: Idaho Department of Health & Welfare, Bureau of Emergency Medical Services and Preparedness; Esri; US Census Bureau; Health Resources & Services Administration; USDA Economic Research Service.



## Ambulance Locations and Deserts



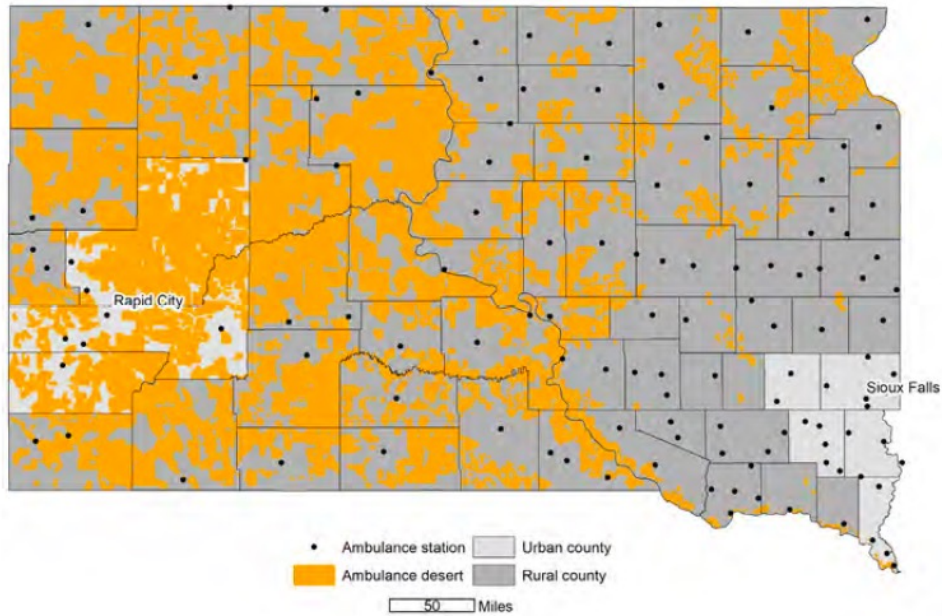
## Health Care Facilities and Ambulance Deserts



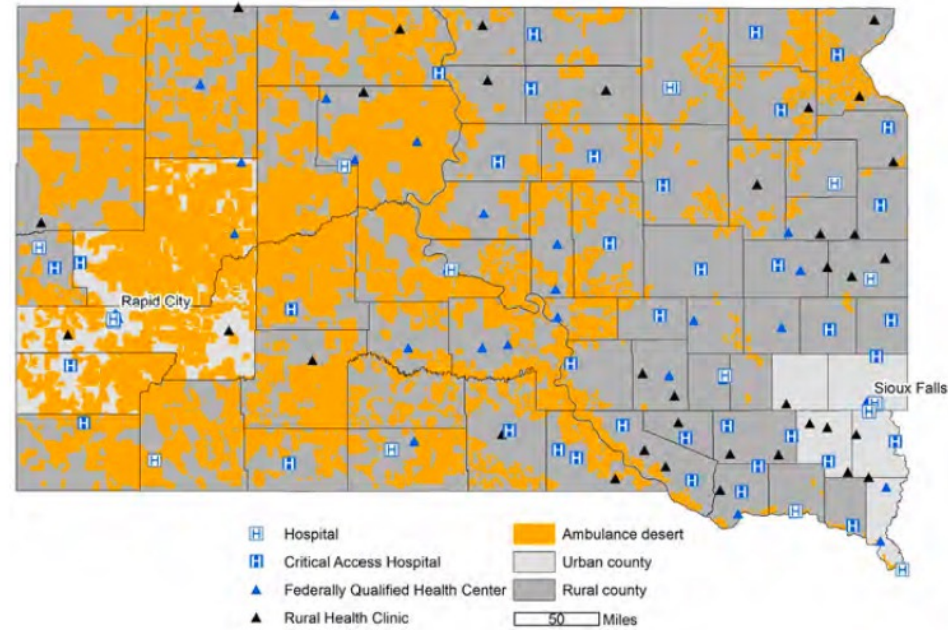
Ambulance stations		Ambulance desert population		Rural county ambulance desert population	
n		n	% of state pop.	n	% of rural county pop.
218		140,365	12.9%	112,824	80.4%

Data sources: Montana Bureau of Emergency Medical Services; Esri; US Census Bureau; Health Resources & Services Administration; USDA Economic Research Service.

Ambulance Locations and Deserts



Health Care Facilities and Ambulance Deserts



Ambulance stations	Ambulance desert population		Rural county ambulance desert population		
n	n	% of state pop.	n	% of rural county pop.	% of total desert pop.
124	58,688	6.7%	43,944	9.9%	74.9%

Data sources: South Dakota Department of Health; Esri; US Census Bureau; Health Resources & Services Administration; USDA Economic Research Service.



# How can the government help?

Rural ambulance services have unique needs. Good policies within and without the GAPB process are needed.

- Transparency
- Good policy
- Cost reporting adaptations
- Need CAH-like cost-based payment option
- How REH affects ambulances – other influencing factors
- Note: Higher rural costs are not variable in nature, they are fixed.

# Let's talk transparency

- Transparency must not be limited to the ambulance service
- Insurers and Medicare must be transparent in their policies and communication with their members and beneficiaries
- Insurers should be transparent with ambulance services

# Insurer transparency

- Insurers should be transparent and publicly disclose how they compute usual and customary charges - including if and how they compute urban ambulance differently than rural and super-rural ambulance services
- Insurers should publicly disclose whether the contract rates they offer to rural and super-rural ambulance services include the actual cost of operating a full-time ambulance service or a volunteer model

# Survey

- A survey in 2 rural states
- On average insurance and self-payments need to be 150% of Medicare in urban areas
- On average insurance and self-payments need to be 250% of Medicare in rural areas
- Medicare's rural and super rural add-ons are not a proxy



# Medicare policy

- Ambulance has no pathway for payment for new innovations
- There is no 340-B-like ambulance program
- Innovations in other parts of the Medicare program have introduced skyrocketing ambulance costs that are ignored in innovation policy

# Medicare's Ambulance Cost Collection

- Regardless of what is collected in the cost collection system, Medicare must compute rural and super-rural ambulance rates in a **paid** model. Set the floor under the model for any costs that are less than in a paid model
- In other words, a payment “floor” of the costs of one full-time ambulance as described by Maine or others

# Medicare cost-based option

- Medicare could work with the federal Office of Rural Health Policy and Congress to create a cost-based rural and super-rural ambulance payment model that mirrors the CAH cost-based payment model
- Medicare must better consider how new policies affect ambulance cost and work with Congress to affect change
  - New REH model does not consider the increased costs and decreased ambulance coverage. Cost-based ambulance payments must be included
  - [NRHA advocates](#) adding \$750,000 per ambulance service for increased costs to serve REHs

# Ambulance Cost Changes

- Medicare must develop a method that recognizes the increased cost of new technology and drugs that are not reflected in an inflation update
  - Other suppliers and providers have mechanisms for new technology since 2002 to be recognized and paid for
  - Ambulance services are embracing and adapting to new technology such as:
    - Ultrasound
    - Monitor innovation/introduction of mechanical CPR devices
    - New brand name drugs