

**Testimony of the  
Ambulance Association of  
Pennsylvania**

**Before the  
House Veterans Affairs and  
Emergency Preparedness  
Committee**

**House Bill 2252**

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**Presented by Barry Albertson, Jr.  
and Heather Sharar**

Mr. Chairman, and distinguished Members of the Committee, my name is Barry Albertson, President of the Ambulance Association of Pennsylvania (AAP). The AAP is a statewide advocacy organization that represents, and is the collective voice, for over two hundred and thirty ambulance services in Pennsylvania. Our membership is diverse and includes volunteer, non-profit, for-profit, municipal, air medical, hospital and fire based ambulance services that perform a large majority of the emergency and non-emergency ambulance transportation in the Commonwealth. Additionally, I am the Executive Director of an ambulance service that is the primary emergency medical service provider in six communities in Monroe and Northampton counties. Joining with me today is Mrs. Heather Sharar, Executive Director of the Ambulance Association of Pennsylvania.

Let me begin by reviewing the current landscape in the General Assembly relative to the “any willing provider” issue that House Bill 2252 addresses and “direct reimbursement”. After the release of the bipartisan Senate Resolution 60 Commission Report, and specifically Recommendation 14, *“Permit Direct Reimbursement to EMS and Fire Agencies”*, there was a flurry of activity by the General Assembly with the introduction of ten separate Bills in both the House and Senate addressing the ability to contract for services, the prompt payment of clean claims and direct and/or joint payment for services rendered by ambulance

providers. At the time of this hearing today and as we near the end of the 2005-2006 Session of the General Assembly, only one Bill has received a public hearing (House Bill 1224 in the spring of 2005) and none of these Bills have seen movement or left committee. The implication of an explicit recommendation by a bipartisan Senate Commission Report and the introduction of ten separate pieces of legislation appear to validate the issue of direct reimbursement for ambulance services. Subsequently, one must ponder the question why no Bill has left its assigned Committee?

Since the implementation of the National Medicare Ambulance Fee Schedule, the environment for emergency medical services in this Commonwealth from a "911 System", and a reimbursement perspective, continues to deteriorate. Like most reimbursement for health care providers we are a rate-controlled industry, and those rates or levels of reimbursement fall well short of the cost of providing those services. This reimbursement ceiling does not fully address the costs associated with the requisite expenses incurred in the area of maintaining readiness. Ambulance services in the Commonwealth face mandatory assignment from most insurers. Federal and state funded health care programs (Medicare and Medicaid) have defined benefits for their beneficiaries that result in fixed reimbursement for the provider community. Additionally, auto insurance and Workman's compensation reimbursements are also tied to the federal program rates through legislation (i.e. Act 6 of 1990 and Act 68 of 1998) and the substantial financial loss of Medicaid and Medicare crossover payments

for Medicaid recipients. Other third party insurers including the four “non-profit“ insurers (Highmark, Capital Blue Cross, Independence Blue Cross, Northeast Blue Cross) permit “open” contracting in some cases but with advertised but unrealized negotiable rate structures. In layman’s terms, this translates into an automatic loss of reimbursement or “contractual allowance” from our charges before we start an ambulance and respond to your constituent’s request for service. A rate-controlled industry also limits the ability of ambulance services to compensate for inflation or recoup increases in fixed costs analogous with, personnel costs due to an ever dwindling workforce, increased insurance premiums and workman’s compensation cost relative to the daily risks encountered by the Commonwealth’s EMTs and paramedics and the recent daily rising exorbitant fuel costs associated with the volatility of the world’s oil market.

Ambulance services, through the AAP, have attempted to seek redress by lobbying the General Assembly for legislative relief over the last five years, or as recently settled in western Pennsylvania, file suit against the largest insurer in the Commonwealth with billions of dollars in reserve seeking legal relief for the mere ability to contract and provide services to our communities. The woeful reimbursement rates paid and “unjust enrichment” by the Commonwealth’s contracted Medicaid Managed Care Organization Plans have prompted another recently filed class action lawsuit in western Pennsylvania to address the financial strains that many ambulance services have suffered in recent years.

## **Why is the EMS landscape so bleak?**

Ambulance services in Pennsylvania are struggling with a number of issues revolving around recognition, recruitment, retention and reimbursement. At the core of these issues is woeful reimbursement.

EMS is a critical component of the Commonwealth's emergency and trauma care system, providing response, treatment and medical transportation to millions of sick, injured and convalescing Pennsylvanian's each year. We impact the health care system daily improving morbidity and mortality from illness and traumatic injury. The timely delivery of quality prehospital medicine has been proven to improve patient outcome, lessening potential long-term disability and reducing hospital inpatient days subsequently saving the system countless health care dollars. Unlike our emergency medicine colleagues in the sterile, stable environment of the hospital, we are subject to the most arduous and complex situations imaginable in which many of our patient's lives hang in the balance. This is a duty that few in this room would want. With this noble mission, EMS still does not enjoy the same recognition as police and fire with the Administration, General Assembly, local government or general public as an essential vital public service. Lack of recognition translates into a lack of funding. Very few communities directly subsidize or provide any financial support to sustain their community ambulance service. Additionally, although EMS is responsible for the majority of emergency responses daily compared to the fire service, it still has

not received consideration for parity in funding with the fire service in Commonwealth grant programs or homeland security funding. In conjunction with the funding crisis at the provider community level, if additional financial support is not soon found for the Emergency Medical Services Operating Fund (EMSOF), the funding for the infrastructure administration of the “EMS System” in Pennsylvania will face critical shortfalls.

Furthermore, EMS has an evolving role as an integral component of the overall health care delivery system and along with the hospital emergency department, is viewed as part of the “healthcare safety net” for twelve million Pennsylvanians. We face new challenges and missions in public health, disaster response, weapons of mass destruction and emergency preparedness, yet we receive no funding or reimbursement directed toward public health care, as an essential resource in disasters and emergency management, or in our preparation and training as a homeland security resource.

Consequently, the fiscal viability of many ambulance services is in question due to the insufficient revenue obtained from fees for service and subscription and/or membership programs. This translates in to non-livable wages for our career staff, the inability to fund capital improvements to replace equipment and vehicles or the ability provide for new technology and training to meet the health care needs of our communities today and in the future. As I stated previously, inadequate reimbursement and funding is at the core of these

issues. From an operational perspective it is not hard to comprehend that if the provider community does not have adequate reimbursement to afford livable wages for their staff, we will not have personnel to place on our ambulances. If ambulance services do not have adequate funding, they will not be able to improve equipment and provide the technology required by current regulation and standards of care for adequate prehospital care. Limited staff and equipment translates into fewer ambulances in our communities and an access problem for 911 emergency responses. This access issue is non-discriminatory. It affects everyone from the insured to the un-insured, from the wealthy to the indigent and the young and old. Fewer personnel and ambulances result in longer response times and longer response times correlates into increased morbidity and mortality. I am not predicting a future event; this is occurring today in many communities across the Commonwealth, and if not corrected, will lead to the demise of our current EMS System.

Now that I have covered the mission, funding and rate controlled reimbursement of today's EMS, allow me to illustrate the cost of operations for an ambulance service. The cost of providing EMS includes the direct costs of each emergency or non-emergency response, as well as the readiness costs associated with maintaining the capability to respond quickly 24 hours a day, 7 days a week. It is important to understand that the bulk of operational costs to maintain an ambulance service are not incurred in the actual delivery of services, but in maintaining this constant "state of readiness". Medicare, Medicaid and

other third-party insurers do not adequately reimburse these costs. Additionally, these insurers routinely pay only when a patient is transported limiting the flexibility of EMS providing the most appropriate care for each patient and potentially wasting health care dollars while adding to the overcrowding of Pennsylvania's emergency rooms.

The cost of readiness may be simply explained that, unlike other healthcare providers who may have the ability to schedule their services or staff accordingly to see a number of patients, ambulance services must staff and prepare daily based on the presumption that a certain number of people will require our services today. This presumptive equation must also factor in the number of patients that we provide care for who do not have healthcare insurance or lack the necessary financial resources to pay for this care. Ambulance services in Pennsylvania are required by law to respond to calls for emergency assistance when dispatched to do so under 28 Pa Code § 1005.10(e)(4), and like hospital emergency departments, are not immune to the costs of uncompensated care. However, unlike hospitals and their emergency departments, ambulance services have never been the benefit of receiving “quick fixes” using the Commonwealth’s Tobacco Settlement Funds or adjustments in the Medicare fees for service to compensate for the financial impact of uncompensated care.

With all this considered, let me return to the reason for this hearing today. The ability for “any willing provider” to contract with third party insurers would be welcome, but the ability to contract and negotiate a fee commensurate with the cost actually associated with providing that service is paramount to the future financial viability of ambulance services in this Commonwealth.

The AAP would like to thank the prime sponsor of this bill, Representative O’Neil for his continued interest and support of the 911 EMS System in Pennsylvania. With all due respect to Representative O’Neil, House Bill 2252 has some inherent flaws that we would offer suggestions for amendment to make the Bill whole. The basis for the Bill is discrimination against any willing provider of volunteer ambulance services. As defined in this Bill, the definition of “volunteer ambulance service” would itself discriminate against the ability for municipal, for-profit, hospital based and air-medical services that provide emergency service or 911 response. The EMS System in the Commonwealth is made up of entities with different corporate structures. Emergency or “911 response” is provided by volunteers, non-profit, for-profit, municipal, fire based, hospital based and air medical services. Additionally, language should be added regarding negotiated payment levels clarifying what a fair negotiated payment would be. These rates need to be developed with sensitivity to the distinct differences between the delivery of EMS in the various geographic regions of the Commonwealth (i.e. urban, suburban and rural). In our rate controlled reimbursement climate, even Medicare reimbursement was acknowledged by the

recently released National Academy of Science, Institute of Medicine Report: “EMS at the Crossroads” to be far below the cost of providing such services.

The AAP acknowledges the hard work and effort that this Committee has devoted to EMS System development and subsequent elevation in recognition for the thousands of EMS providers across the Commonwealth. This recognition of the value that the EMS system provides to the residents and visitors of the Commonwealth is the responsibility of all the stakeholders of the system. In order for this to occur, the effort must start with you, our elected leaders, to create that environment for positive change. Your leadership role in the funding and reimbursement of the EMS system can be achieved through passage of meaningful any willing provider, direct pay legislation and other identified legislative initiatives. However, understanding the political climate in Harrisburg we realize this is a difficult undertaking, but one that can be achieved.

At a minimum, the General Assembly should take the lead in assisting the ambulance provider community in opening a meaningful dialogue with the Commonwealth’s insurance industry to assist them in promoting contracting to control health care costs but at a negotiated rate that covers the cost of providing those services. Without legislation or meaningful dialogue with the insurance industry, the Commonwealth’s ambulance providers face a bleak financial future that will directly impact the provider community’s ability to respond to you or your constituent’s requests for life saving services.

On behalf of the members of the Ambulance Association of Pennsylvania,  
I again thank you for the opportunity to comment on this important legislation.  
We will be happy to answer any questions the Committee members may have.