House Veterans and Emergency Preparedness Committee

Pennsylvania's Emergency Medical Services Crisis

March 1, 2022

Chairwoman Boback, Chairman Sainato and members of the House Veterans Affairs and Emergency Preparedness Committee, my name is Donald DeReamus and I am a Board Member and Legislative Chair of the Ambulance Association of Pennsylvania (AAP). Accompanying me today is my legislative co-chair Charles Cressley. Heather Sharar, our Executive Director sends her apologies for being unable to attend due to personal reasons.

Let me open by offering our sincere gratitude to General Assembly and the Governor for Act 10 of 2022 creating a $25 million grant program for Pennsylvania EMS Agencies. These funds are critical at this moment however, this is analogous to a band-aid applied to a trauma patient when multiple tourniquets are needed.

Emergency Medical Services (EMS) serves as an essential component of Pennsylvania's health care system. We are the only healthcare provider mandated by law to respond as dispatched to a request for service. In 2021, the EMS system in Pennsylvania was comprised of 1,259 agencies that responded to 2,447,932 calls for service, an average of 6,706 call per day. The overwhelming majority of these calls for services were emergency responses to incident scenes. A non-viable EMS System impacts 911 emergency response, the movement of critically ill patients between acute care and specialty care hospitals and the movement of patients between hospitals, skilled nursing facilities and other medical care. Any failure in the System directly impacts morbidity and mortality.

For several decades, we have known that the funding model for EMS was inadequate, and now, unsustainable. The crisis in our EMS System predates the pandemic. Preliminary survey data shows 53% of respondents (n=290) reported a budget deficit since 2018, with most reporting multiple years. Thanks too many factors, now exacerbated by the impact of COVID-19 on transport volume, costs, staffing and more, these financial struggles have become dire. EMS agencies across the Commonwealth have shut down or forced to alter their level of service. Our organizations and clinicians are on the brink, just months, weeks or even days from insolvency.

The below cost reimbursement rates from Medicare, Medical Assistance and the constant non-negotiated rates with insurance companies put pressure on how we operate and our ability to survive. The reality is that EMS is a business, like it or not, and like any business, income must at least equal or exceed costs for us to remain solvent.

For the remaining time I will provide members information on the assistance needed from the General Assembly, the Administration and County and local municipal leaders. I hope you gain a true understanding of the gravity of the issues facing our state's EMS System as they are momentous; on a daily basis we hear reports of poor patient outcomes in many areas of the Commonwealth that are directly related to the lack of EMS resources statewide. Your commitment during this legislative session, along with the EMS Provider Community and other stakeholders will determine our future and will have a direct effect on for the wellbeing and lives of all of the residents and visitors in the Commonwealth.

Funding – Why We Need Funding for The Cost of Readiness

The costs of maintaining an EMS service are based on a need to maintain a readiness to respond, which is expensive. EMS statue and regulation in the Commonwealth requires an EMS Agency to staff a unit 24/7/365. Staffed ambulances sitting in the station awaiting a call, or returning unloaded from a call or transport, only generate cost. Ambulances that respond on fire calls, public assists, standbys, and other non-patient responses also only generate cost. The lower the utilization rate of that ambulance translates into a higher cost of service "just to be ready to respond." These costs are amplified in rural areas with longer transport times and smaller EMS Agencies with minimal call volume. Rural areas also require twice the number of staffed ambulances to perform the same number of calls as their urban counterparts (*see* Chart 1- *PA DOH Bureau of EMS*).

Since 2008, the Borough, Township and Third Class City Codes have stated that these units of local government *"shall be responsible for ensuring that fire and emergency medical services are provided within the borough by the means and to the extent determined by the…………,* ***including the appropriate financial and administrative assistance for these services"***.

Preliminary survey data reported that that 60% of EMS Agencies received a municipal subsidy or contribution (n=294) but 48% (n=176) also report these subsidies provided less than 20% of that Agencies' budget.

There is a novel EMS Grant Program in Pike County that is leveraging local municipal funds with matching County funds returned to the local municipality to assist them in the provision of EMS in their communities. This EMS Grant Program has garnered participation from every municipality in the County and may be a model for the rest of the Commonwealth.

EMS Agencies need a universal sustainable funding mechanism to cover the cost of readiness and operations in general.

Proposals

- **Pass SB 698 (Baker)** – gives Counties the ability to form public safety authorities to include EMS, amend to remove fire. There is a co-sponsor memo in the House **HCO2657 (Guenst)** that is a companion bill House
- **Develop Legislation for a universal county-municipal funding match mechanism for EMS administered by the County with funds returned to the municipality through a grant for the provision of EMS as designated by the municipality**

Funding – Why We Need Changes in EMS Reimbursement

The principal mechanism for an EMS Agency to generate revenue is through reimbursement for treatment and transportation, either emergency or non-emergency.

The AAP surveyed our members on "Fully Loaded Costs" in 2020 (n=104). Fully Loaded Costs are an accounting of the minimum reimbursement required per transport for an EMS Agency to break even. The data returned a high amount of $2300.00/call to the lowest of $174.00/call.

The mean cost was $662.34 with a median cost of $545.87. (*See* Chart 2-AAP Fully Load Cost Survey 2020)

Compared to the median current reimbursement rates, and in consideration of a patient transport of ten miles, it is calculated that Medicaid currently reimburses 44% of our costs and Medicare reimburses 67% of our costs. Since the passage of the Patient Protection and Affordable Care Act, commercial insurers have mirrored Medicare rates into their fee schedules. All other insurers (i.e., Workers' Compensation, Auto Insurance) also pay a percentage based on Medicare. (*See* Chart 3-Ambulance Rate Schedule)

The National Emergency Medical Services Advisory Committee (NEMSAC) report on *EMS Funding and Reimbursement*, December 2, 2016, stated that:

> *"Based upon a subtotal of the payer mix data above, **ambulance providers receive below-cost reimbursement for 72% of all transports**—the charity care delivered to the uninsured and the **under-compensated care resulting from below-cost Medicare and Medicaid reimbursement.** Therefore, uncompensated care, if left unaddressed, threatens the financial stability of the entire EMS safety net."*

Additionally, that study cited uncompensated or charity care in EMS nationally:

> *"The NEMSAC estimates the current magnitude of **uncompensated care** delivered by the nation's ground ambulance services as follows:*
>
> ***$ 1.542 billion Charity Care***
>
> ***$ 1.327 billion Under-compensated Care***
>
> ***$ 2.869 billion Total EMS System Uncompensated Care in U.S.***
>
> *The amount of uncompensated care absorbed by ambulance services is extensive. The $2.9 billion dollars of uncompensated care is about half the total amount paid ($5.2 billion) to ground ambulance services by Medicare in 2010 (Richardson & Gaumer, 2012)."*

Let me reiterate, EMS is a business and income must at least equal or exceed costs for us to remain solvent. If we receive below-cost reimbursement for 72% of all transports and represent a portion of this 2.869 billion in total EMS uncompensated care, how as a business are we supposed to survive?

We are also living with the failure in the implementation of Act 103 of 2018. This statute codified in Title 40 requiring that a managed care plan shall pay all reasonably necessary costs associated with emergency services provided during the period of emergency, subject to all copayments, coinsurances or deductibles, and the managed care plan may not deny a claim for payment solely because the enrollee did not require transport or refused to be transported. The payment was also codified that it shall be in accordance with the current managed care contracted rates.

Unfortunately, managed care organizations have failed to follow this statute and there is no consistent coding requirement or standardized payment in accordance with contracted rates. The AAP has attempted administrative remedies through the PA Insurance Department and PA Office of the Attorney General to no avail.

Proposals

- **Increase the Medical Assistance Reimbursement rate to at minimum Medicare rates and pay for ALL loaded mileage HCO2716 (Causer)**
- **Pass HB 1293 (Masser) requiring direct pay from insurers regardless of be in-network**
- **Exempt the collection of co-pays for emergency ambulance service and limit the level of co-pays to non-emergency ambulance and medical transportation to no more than 20%**
- **Reform Medical Assistance payment policy and regulations for ambulance service to be consistent with Medicare guidelines**
- **Pressure needs to be placed on the PA Insurance Department and the Administration to develop payment policy consistent with the intent of Act 103 of 2018**

Funding – Why We Need Funding for Support of EMS Operations

As we have shown, reimbursement our primary method of funding, fails miserably in covering the cost the cost of readiness as well as the cost of EMS Operations. Since 2002 after implementation of the Medicare Ambulance Fee Schedule, costs had risen 70% while reimbursement rates have risen only 27% during the same period.

In my organization we have seen tremendous increases in overhead from a low of 8% for supplies to a high of 104% for insurance. Current national policy, and now world affairs, have driven our budgeted fuel costs to increase by 40%. The result of national economic policy and an EMS workforce shortage has also driven up and created artificial wages well beyond historic and regional wage structures for our business (See-Chart 4 2020 Overhead Percentage Increase).

EMS Agencies have increased their wages to attract EMS providers even though they do not have the revenue to support these increases. This has created a Russian roulette scenario where EMS Agencies are gambling their revenue will increase to offset the wage increases, they have been forced to invoke to attract EMS providers.

EMS budgets were strapped prior to Covid but during the first year of the pandemic a geographic representation of the state revealed an average in lost revenue of $959,603.65 (*See* Chart 5-2020 Lost Revenue). Our budgets also took a major hit in 2021 as some facets of EMS rebounded, like 911 emergency calls, while non-emergency medical transportation and paratransit work failed to recover.

My service has also seen a huge percentage increase in personal protective equipment (PPE) in the period 2019 to 2021 from a low of 18% for PPE Kits to a high of 238% in molded surgical masks (*see*-Chart 5-PPE Pandemic Era Cost Increase). Understanding that during the pandemic each EMS provider is wearing an N95 mask, safety glasses and at least one pair of gloves on every call that relates to a cost of $7.61 per call solely for PPE. Prior to the pandemic, the per call cost for PPE would merely be $.55 per call for a pair of gloves per crewmember. (See-Chart 5 Pandemic Era PPE Cost Percentage Increase)

Proposals

- **Pass HB 743 (Ortitay) or SB 944 (Pittman) to provide additional relief from loss revenue related to the COIVD-19 pandemic**
- **Increase reimbursement from all payors or investigate the feasibility of an adequate statewide fee schedule reviewed annually against the Medicare Ambulance Inflation Factor**

Workforce – Why We Need Assistance to Help with The EMS Workforce Shortage

EMS in the Commonwealth and nationally is facing a crippling workforce shortage, a long term problem that has building for a decade. Nationally an EMS workforce survey found that overall turnover among paramedics and EMT's ranges from 20-30%. My organization mirrors this result with an employee turnover rate of 27.5% and a 2 year turnover rate of 44% (*See*-Chart 8 EMS Provider Turnover). EMS Agencies are competing with other labor markets and the artificial increase in wages because of our current national economic policy. We are failing to attract a workforce with significant pay increases, sign on bonuses, employee recruitment bonuses and generous benefit packages.

The pandemic exacerbated this shortage and highlighted our need to better understand the drivers of workforce turnover. There are many factors contributing to this issue. In a survey conducted by the AAP (n=61) the top four reasons EMS providers left the workforce were **wages, burnout, career change and Covid-19**.

In that same AAP survey, it was revealed that 97% of those surveyed had unfilled positions in their EMS Agency (See-Chart 9 Unfilled EMS Positions Over Time). Our survey also discovered that 67% of respondents say workforce challenges were either somewhat worse (25%) or much worse (42%).

EMS Agencies will continue to face continuing workforce challenges especially with the aging of seasoned clinical providers and the failure of younger generations to enter the profession for the before mentioned reason.

Any solution to our workforce challenges will need to be based on sufficient reimbursement for EMS treatment and transportation, appropriate funding from municipal sources and tuition waivers for people entering our profession.

Proposals

- **Amend HB 612 (Struzzi) that creates a Tuition Assistance Program by including and enrollee who is looking for a career in EMS as well as volunteering**
- **Amend SB 149 (Ward, J) that creates a Tuition Credit Program by expanding to career providers**
- **Amend and Pass HB 2097 (Hamm) to permanently reduce the minimum staffing level for a BLS ambulance for the entire Commonwealth**
- **HB 2161 (DeLuca) establishing a front-line worker loan forgiveness program**
- **Move any funding or reimbursement mechanism previously cited**

I realize this is a tremendous amount of information and data to digest, but I will end with this. EMS Agencies have done a tremendous job with minimal assistance from the Commonwealth, County, or local government, because it is our mission. Public safety folks are very adept of making something out of nothing. The time has come when we cannot adapt, improvise or overcome anymore.

If we do not receive support or assistance, patient outcomes will be poor or fatal. As I stated in the beginning of this testimony, a non-viable EMS System impacts 911 emergency response, the movement of critically ill patients between acute care and specialty care hospitals and the movement of patients between hospitals, skilled nursing facilities and other medical care. Any failure in the System directly impacts morbidity and mortality. We have reached critical mass and our System is failing.

Chart 1

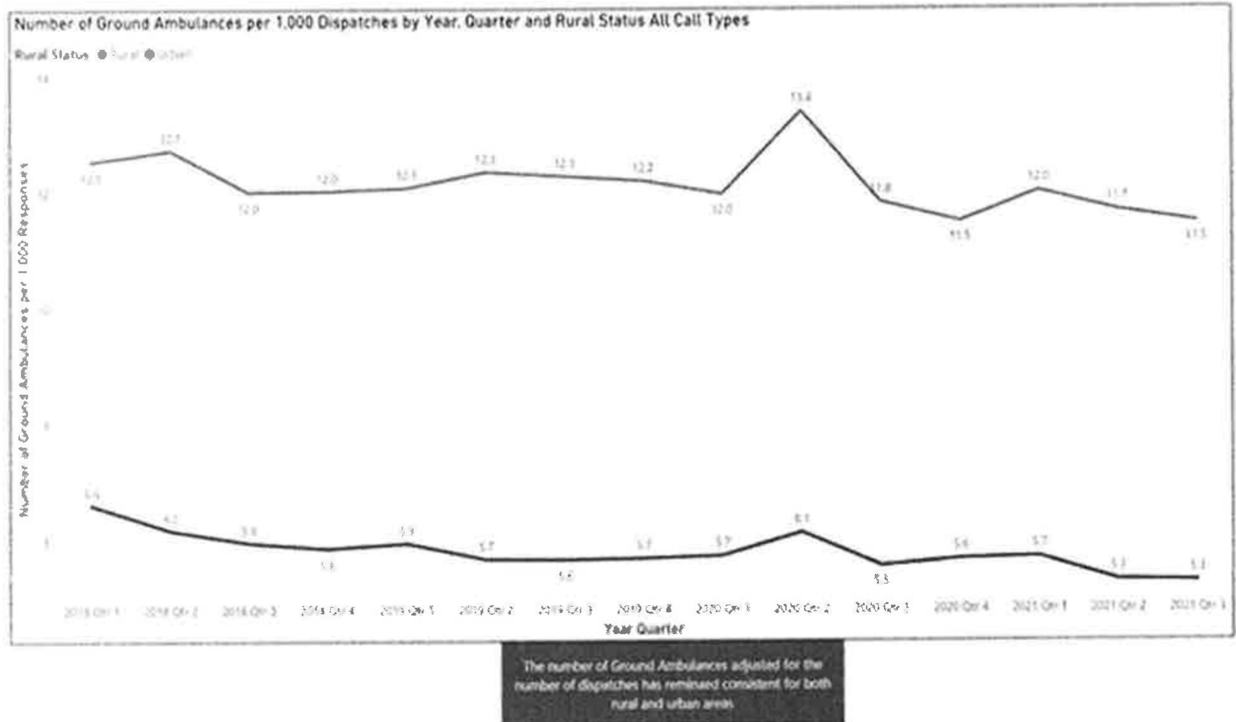


Chart 2

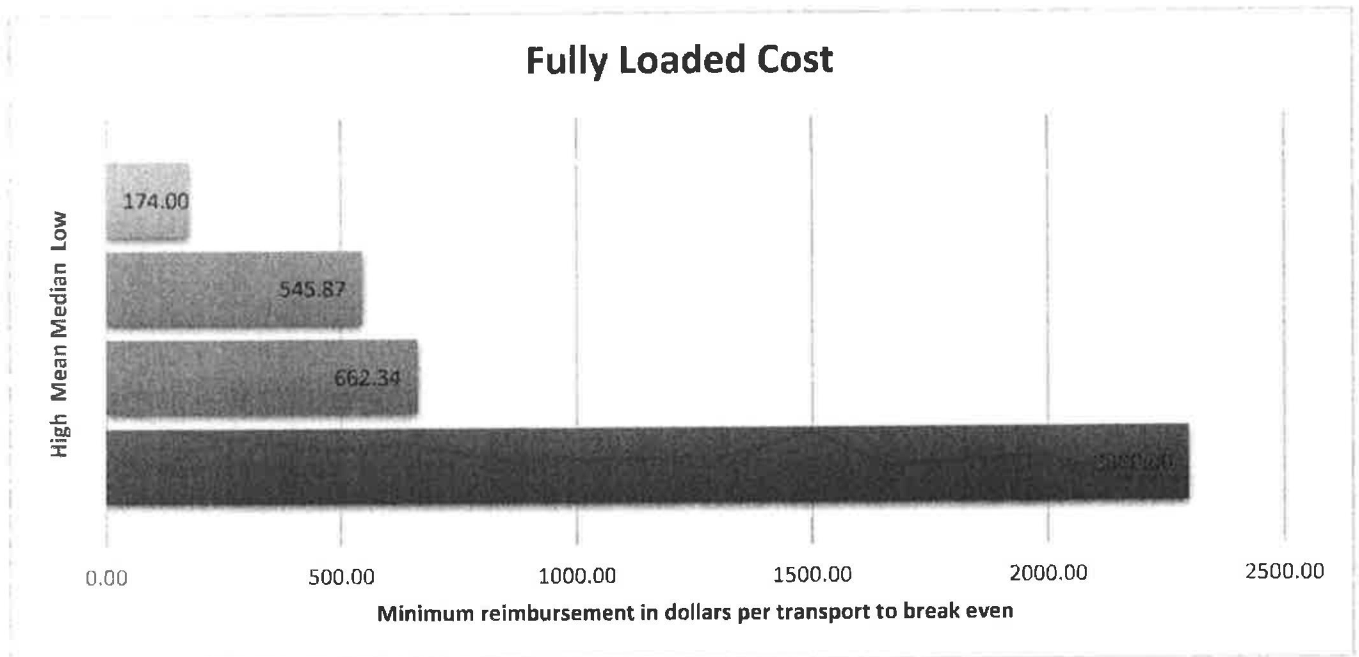


Chart 3

LEVEL OF SERVICE	CODE	URBAN CARE ALLOWABLE	RURAL CARE ALLOWABLE	MEDICAID ALLOWABLE	MEDICAID ALLOWABLE	AUTO ALLOWABLE
Ground Mileage, Loaded	A0425	$ 8.02	$ 8.10	$2.00 >20 loaded	$2.00 >20 loaded	$ 8.82
BLS, Emergency	A0429	$ 381.66	$ 385.40	$ 180.00	$ 180.00	$ 419.82
BLS, Non-Emergency	A0428	$ 238.54	$ 240.87	$ 180.00	$ 180.00	$ 262.39
ALS, Emergency	A0427	$ 453.22	$ 457.66	$ 300.00	$ 300.00	$ 498.54
ALS, Non-Emergency	A0426	$ 286.24	$ 289.05	$ 300.00	$ 300.00	$ 314.86
ALS, 2	A0433	$ 655.97	$ 662.41	$ 300.00	$ 300.00	$ 721.56
SCT	A0434	$ 775.24	$ 782.84	$ 300.00	$ 300.00	$ 852.76
Treat/No Transport-BLS	A0998	$ -		$ -	?	80% of billed
Treat/No Transport-ALS	A0998	$ -		$ -	?	80% of billed
Treat/No Transport-ALS2	A0998	$ -		$ -	?	80% of billed
Treat/No Transport-ALS / 2 meds administrations	A0998	$ -		$ -	?	80% of billed
QL Response (DOA)	A0429	$ 381.66	$ 385.40	$ -	$ -	$ 419.82
				no payment available	no standardize d payment	

Chart 4

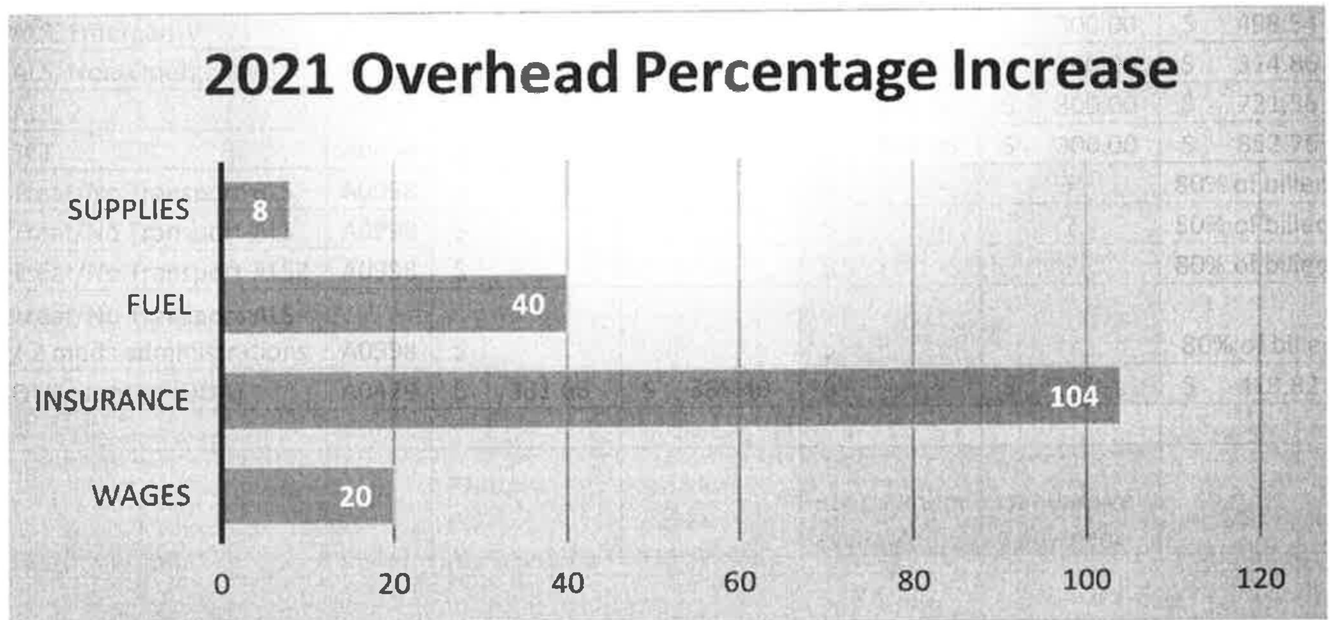


Chart 5

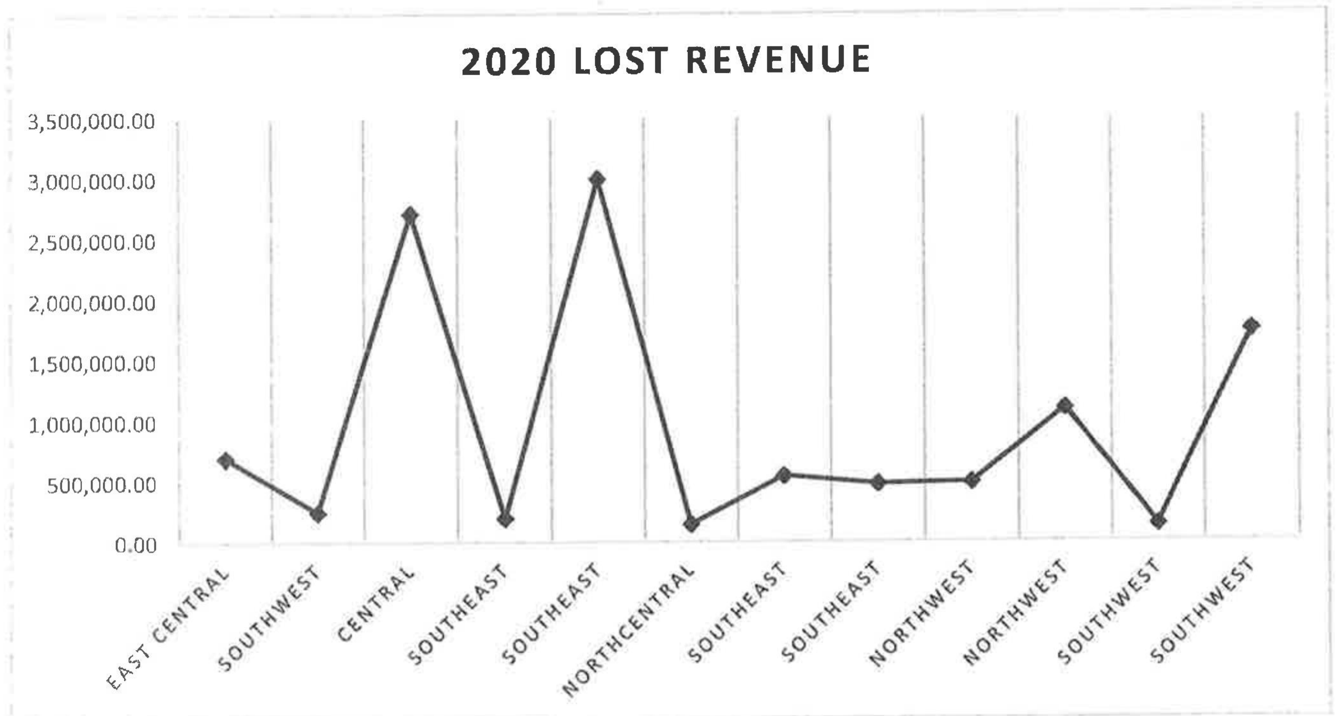


Chart 6

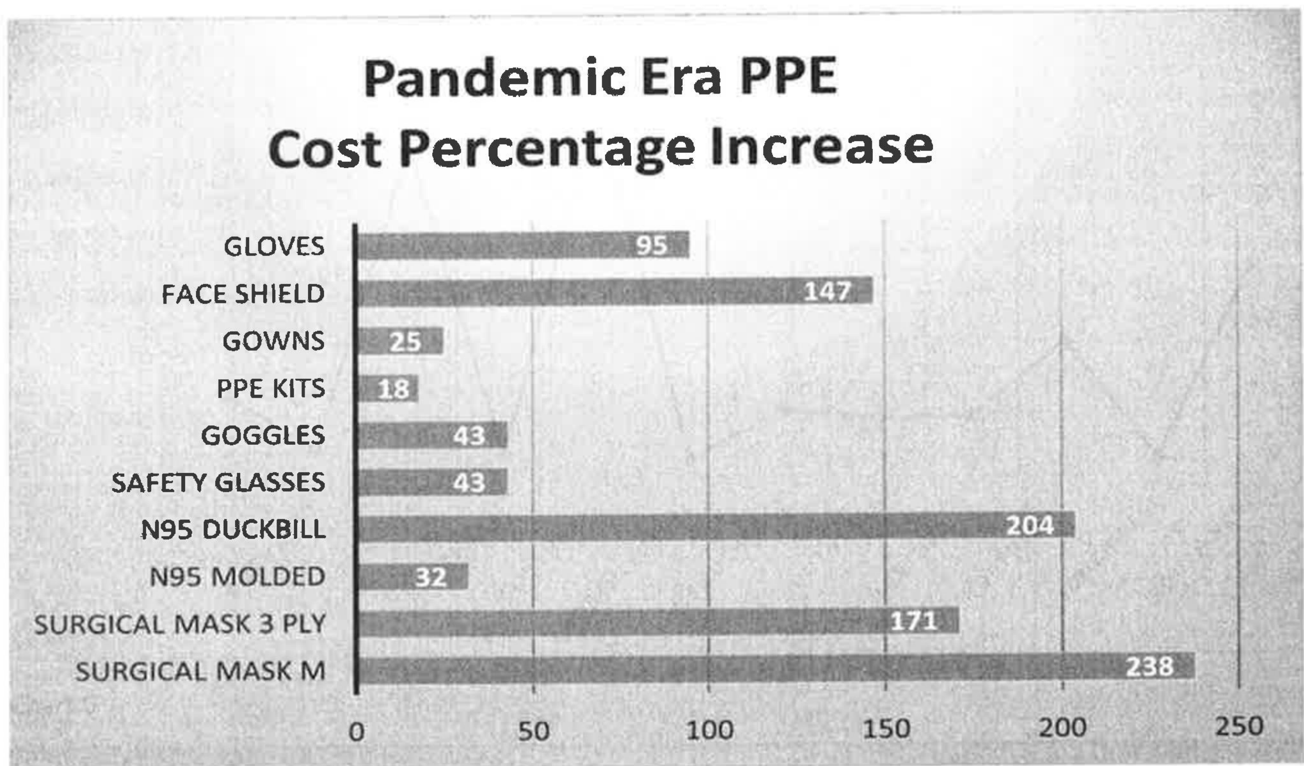


Chart 7

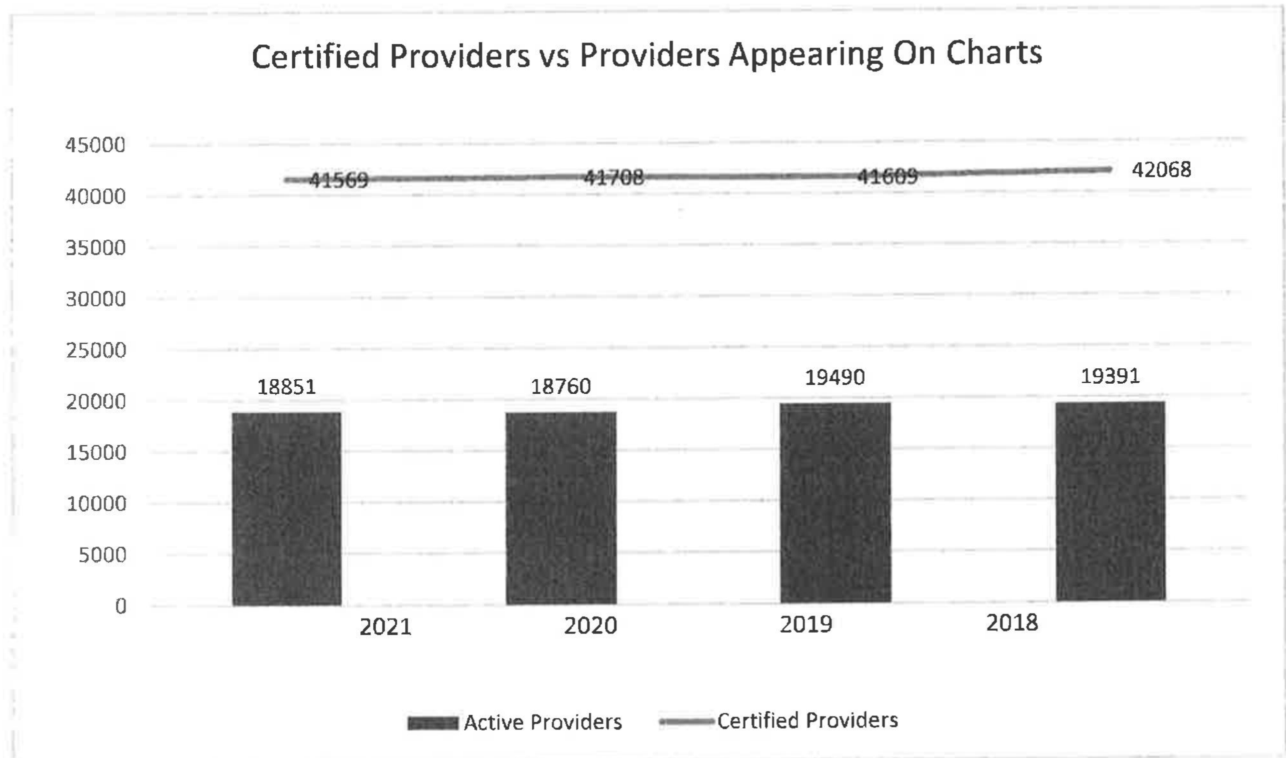


Chart 8

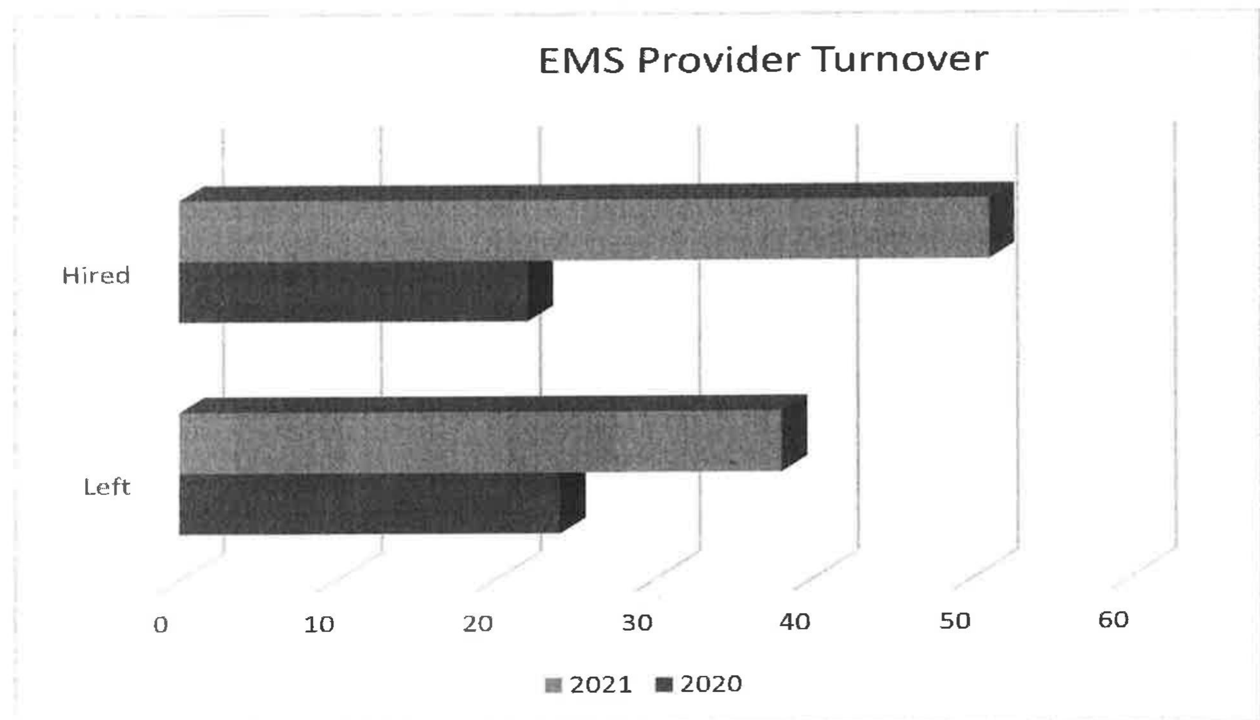
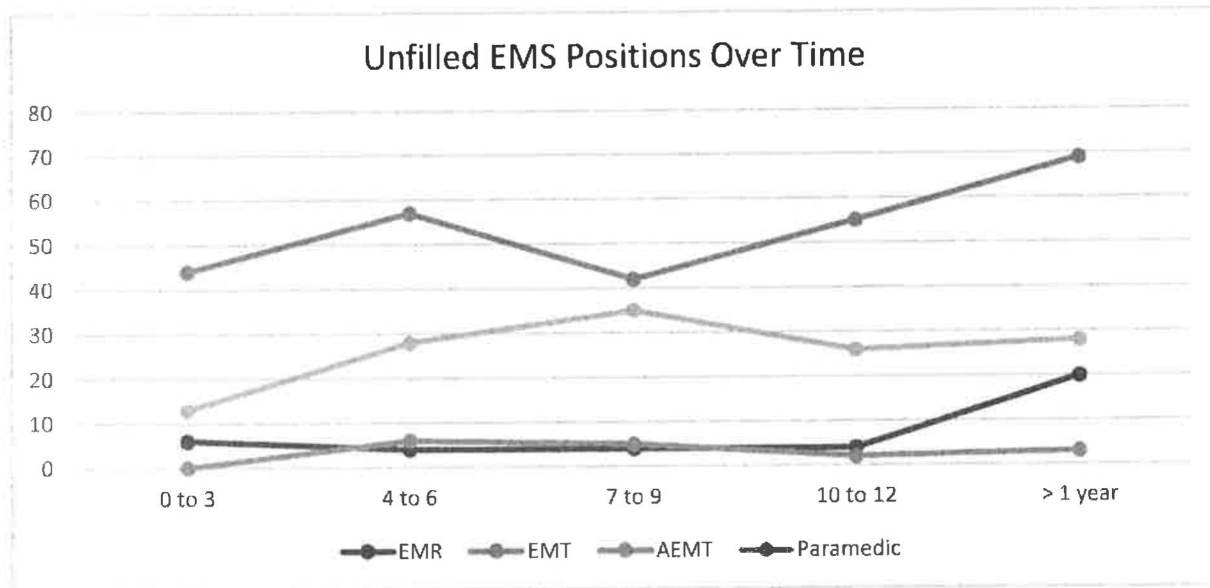


Chart 9



The Ambulance Association of Pennsylvania (AAP) is a member organization that advocates the highest quality patient care through ethical and sound business practices, advancing the interests of our members in important legislative, educational, regulatory and reimbursement issues. Through the development of positive relationships with interested stakeholders, the AAP works for the advancement of emergency and non-emergency medical services delivery and transportation and the development and realization of mobile integrated healthcare in this evolving healthcare delivery environment.

Our membership includes all delivery models of EMS including not-for-profit, for-profit, municipal based, fire based, hospital-based, volunteer and air medical. Our members perform a large majority of the 2 million annual EMS patient contacts reported to the Department of Health.