Center for Excellence in Local Government at Albright College

Berks County Water & Sewer Association

The Center for Excellence in Local Government

Emergency Medical Provider (EMP) Initiative

October 25, 2024

Berks EMS Providers

Berks County Based EMS Agencies

Bally Community Ambulance

Bethel Ambulance

Boyertown Community Ambulance

Hamburg Ambulance Service

Life Lion EMS

Lower Alsace Ambulance

Muhlenberg Area Ambulance

Northern Berks EMS

Oley Fire Company Ambulance

Reading Fire Department

Topton Community Ambulance

Tower Direct EMS

Western Berks Ambulance

Other County Based EMS Agencies Providing

Primary Coverage to Berks Municipalities

Cetronia Ambulance

Elverson Ambulance

Goodwill Fire EMS (Pottstown)

Myerstown First Aid Unit

Newmanstown Ambulance

Coverage Map in Appendix A

EXECUTIVE SUMMARY

The leadership of the Center for Excellence in Local Government at Albright College (CELG), through newsworthy happenings as well as through normal interactions with member municipalities became aware of a crisis developing in the delivery of (EMS) services in Berks County. Minimal research was necessary to understand that this problem exists almost universally throughout Pennsylvania and even throughout most of the nation. Lobbying and professional organizations representing both EMS and local government have published on the issue with efforts to both describe the problem as well as provide solutions.[1] The County Commissioners Association of Pennsylvania undertook a project in 2022 to examine the "EMS Crisis" in PA and published a 2023 report on the matter. [2] Even the PA Senate has convened hearings to examine the issue.[3]

It is apparent that the root causes of the troubles affecting EMS are far outside the scope of immediate influence of the CELG member municipalities. Regulatory challenges, reimbursement mechanisms, societal changes in views about employment, and an increasing demand on those entities providing all governmental and pseudo-governmental services are all the real causes of the EMS Crisis.

Never-the-less, the obligation to provide for these services in Pennsylvania falls to the local government units. While this was previously an area that was highly open for interpretation, since 2008, through amendments to the 2nd Class Township and Borough Codes, and through similar amendments to the 1st Class Township Code in 2020, it is clearly the obligation of the local government units to ensure that both fire and EMS services are provided within their jurisdictional boundaries. This fact alone necessitates the member municipalities engaging in solutions to help bolster the system of delivery locally, while also lobbying for longer term legislative and regulatory solutions at the state and national levels.

In an effort to better understand and characterize the problems locally, CELG representatives met twice with all of the 17 EMS organizations that provide primary coverage within Berks County in a group discussion format. Sensing that there was more information to be garnered that would be shared in a group environment, additional private meetings were conducted with each of the organizations.

This report efforts to summarize the information collected and provide the CELG member municipalities clarity about the extent and urgency of the issue. Additionally, it suggests priorities or focus points that should, in the view of the authors, become the next steps in working to harden and improve our local system of EMS delivery. However, it is crucial to note that the information herein is generic and that municipalities must engage with their specific EMS providers to understand the unique conditions and

[1] https://icma.org/articles/pm-magazine/ems-economic-and-staffing-crisis-creates-opportunity-improved-system-design

https://www.jems.com/administration-and-leadership/unveiling-the-national-ems-workforce-crisis/

https://www.ems1.com/defying-ems-retention-crisis-why-are-great-people-leaving-ems

[2] https://www.pacounties.org/advocacy/reports-and-resources/ems-task-force

[3] https://www.pasenategop.com/news/health-060623/

circumstances that apply in their local area. Further, this information has been aggregated and summarized by the CELG leadership and the recommendations herein are a product of same. While EMS agencies and municipal officials were consulted in the development of this report, the writing herein does not necessarily reflect the opinion of any specific agency apart from CELG.

CELG leadership has examined and validated a number of serious issues that affect the ability to continue to deliver EMS services in the way that has become customary throughout Berks County. The relationships among our EMS providers and our municipalities must be immediately strengthened, and all parties must work to preserve the broken system that we have.

At the same time, there must be a commitment to explore and implement a new way of delivering these critical services. This should be pursued through the development of a strategic plan for service improvement led by an experienced consultant with extensive experience in EMS service delivery models and challenges. All parties involved in the delivery of these services must openly participate and commit to the serious consideration of the implementation of recommendations.

All elected officials must work individually, and through their respective professional organizations, to elevate the legislative and regulatory issues affecting delivery of EMS services to the top of their legislative agendas.

NOTE - Below, in the report section entitled "Report Conclusions and Matters for Further Examination," each specific section includes an Action Item summary. These Action Items are best reviewed with the preceding supporting information for context. However, for executive convenience, the Action Items are compiled in Appendix D.

BACKGROUND

EMS delivery in our area has transitioned from a primarily volunteer service to a primarily paid service. As with many other examples of this sort of change in the public safety world, this is predominately due to regulatory changes that were intended to bring about professionalism and minimum standards in the provision of the services. While there can be no doubt that these changes are positives for those needing the services, the application of structure almost always brings about a decline, or even an end to the ability of these services to be provided predominately in a volunteer or ad hoc nature. Time commitments for maintenance of training, as well as obligations of the organization to have a ready response in the station speak to the need to more broadly, or even exclusively, rely on compensated personnel to perform services.

In EMS, this is even more the case, where there has been a fairly dramatic enhancement in the services provided in the prehospital environment. In the last 40 years, EMS has moved from a "load and go" service that was primarily intended to swoop the most serious patients from their place of need and transport them to definitive care in a hospital as rapidly as possible, to a "treat on the X" service where there are a significant number of diagnostic and interventional techniques applied in the field, sometimes before even moving the patient. These new techniques require a better educated provider able to execute the skills and make interpretive decisions about the need to engage medical command authorities or treat under protocols. Nothing illustrates the increased reliance of the skills of the field providers more than the fact that hospitals now mobilize very expensive specialty teams and/or prepare treatment rooms based on the information coming from the field where they previously only made those kinds of decisions when they had hands and eyes on the patient in the emergency department.

These changes came with increased, albeit perhaps still not enough, regulatory oversight. In Pennsylvania, all EMS agencies operate under the auspices of the PA Dept. of Health Bureau of EMS (DoH). Act 37 of 2009 rolled what was previously stand-alone legislation into PA Title 35 under Chapter 81. This body of law is commonly referred to as the "EMS Act." One of the most significant things accomplished by the EMS Act is the empowerment of the PA DoH to create regulations relating to the provision of EMS. "The Regs" are encapsulated in 28 Pa Code §1001-. These are the primary statutory and regulatory drivers of the delivery of EMS in the Commonwealth, and they cover everything from agency licensure to provider certification to vehicle and equipment standards to discipline and administration.

Primarily though, the "rules" that cover the actual treatment of patients are within a series of EMS Protocols that are published, reviewed and updated regularly by PA DoH. It is within these protocols that EMS providers find their "playbook" for the treatment of illness and injuries. Using these plays, and applying their knowledge, skills and abilities, along with the capability to engage with hospital based medical command physicians when needed, EMS providers facilitate improved outcomes for hundreds of patients transported to the hospital each day across the Commonwealth.

The actual number of persons employed by PA DoH Bureau of EMS is very small. The primary responsibility for training and certification, licensure, discipline and administration is assigned to contracted private not for profit entities referred to as EMS councils. There are thirteen "Councils" in PA (Appendix A), and Berks County is served by the Eastern PA EMS Council that also provides services to Carbon, Lehigh, Monroe, Northampton, and Schuylkill based EMS providers. These Councils serve as the

front line of application of DoHs authority and responsibility. As would be expected, this system of delivery creates some degree of disparity in approach from region to region as there are different teams of people applying regulation, interpreting rules, and prioritizing mission. There are occasions where the councils are highly unified but other occasions where their different approaches are readily apparent. Recently, under almost universal criticism from the various leadership teams of the councils throughout the state, a change in leadership at the Bureau of EMS was undertaken as prior leadership was viewed as having become disconnected from the needs of the organizations and individuals providing EMS services. It is worthy of note that the prior bureau director, as well as the newly named (November, 2023) director both have roots as Berks County based providers in the emergency services.

This system of governance may seem convoluted (and justifiably so), but the actual provision of services is no less convoluted wherein we have, generally, unaffiliated 501c3 classified organizations providing a critical and life-saving capability that is legally defined as the responsibility of local government and doing so, sometimes, with less involvement/engagement by the local government unit than is given to the franchisee that provides cable television service in the area.

A significant difference between EMS and many other government services that are provided is an essential guarantee of availability regardless of where you live, and/or to what level your government unit invests in the service. As required by law/regulation, a licensed EMS agency must respond when dispatched. Failure to do so jeopardizes the agency's license and could result in sanctions up to and including provisional licensure (high oversight/ongoing performance audits) or even revocation of license. This means that an individual in a jurisdiction that makes minimal investment in their EMS service will be afforded a response that is effectively identical to that offered in another jurisdiction where there is significant investment. The biggest difference is response time. Generally, jurisdictions that fail to invest in their EMS needs are unable to demand the positioning of response assets within/nearby. As such, the responding agency may travel a distance to arrive, but once on scene brings at the minimum skills and equipment defined as required in regulation for an EMS agency. A parallel could be drawn to a decision between local policing and state police. In a jurisdiction that relies on state police, it is expected that a response could be delayed due to a larger area/population being serviced by the state police barracks as compared to a local police agency. The big difference though, is that in the policing world, it is almost unheard of that a "locally funded" officer is unavailable to provide coverage to their local constituency paying for the service because the officer is in a state police coverage area providing service. In the EMS world, this is a happening that takes place MANY times a day throughout Berks County wherein an EMS unit based in municipality A that makes significant investment in EMS goes to handle a call in municipality B that makes minimal investment in EMS, while a resident in municipality A has a need for service that is unable to be met promptly because they have to now wait for yet another ambulance to come from municipality D, E or F.

This combination of discretionary support, with a guaranteed level of service that is uncoupled from the support, is a significant contributor to the issues that affect our EMS services.

FUNDING SOURCES

The sources of revenue for operation of EMS agencies are similar across most agencies, with some subtle but important differences that tie to predictability of funds, and then the subsequent ability to properly plan and budget. While almost every one of these funding sources are present in the funding model of each EMS organization, the socio-demographics of the area served drive the prevalence of each component. For example, an aged community, or a community with many long-term care facilities, is likely to result in a greater reliance on Medicare reimbursements. A community with a large percentage of individuals in poverty is likely to drive Medicaid to being a larger funding source percentage of total revenue.

It is broadly noted that many people, particularly those in decision-making capacities in local government, do not understand the difference between what they view as the magnitude of an ambulance bill versus what the EMS agency actually collects when that bill is generated. While payment from government providers is generally reliable when the patient is covered, and when the transport meets rules to permit payment, the amount actually received is a fraction of the original bill and does not pay for the cost of the provision of the service, particularly when it is recognized that, in EMS like all emergency services, the cost of readiness far exceeds the cost of the delivery of the service. This concept of fractional cost recovery is further discussed after the revenue types are described below.

Even with a multitude of possible payment paths/revenue sources, it is very common for EMS agencies to have high demand patients in their local area who have amounts outstanding, and which will ultimately be uncollectable, in the multi 5 -figure arena.

1. Government Payers
    a. Medicare – the largest insurer of retirees and also pays for certain younger individuals such as those with disabilities. The rules for how Medicare pays are defined in law and regulations issued by the Centers for Medicare and Medicaid Services. These funds come from the federal government. CMS publishes a fees schedule that describes the approved rates that are paid for services including EMS services. The patient is generally responsible for 20% of that approved rate and Medicare pays the balance. The recipient (EMS agency) is not permitted to pursue any additional payment from the patient beyond the 20% copay. Some patients may have a Medicare supplemental insurance provider (at their own cost) that will assume responsibility for the 20%. It is important to note that Medicare's obligations are limited to treatment and transport that is medically necessary. A patient that is transported to the hospital for a non-medically necessary reason is not able to have the bill satisfied by Medicare. If the patient has Medicare BUT NOT Medicaid (see below), the patient is responsible for 100% of the bill. If the patient has Medicare and Medicaid, and both services deny the claim due to lack of medical necessity, the EMS organization is left WITHOUT the ability to pursue payment from anyone including the patient directly.
        i. Medicare B – Fees for materials and professional services related to healthcare and is the subpart of CMS regulations under which almost all EMS agencies can bill.

ii. Medicare A – Facilities – This is a schedule only available to hospital-based EMS providers who transport into their own hospital system, and when the patient is admitted. This permits the agency to itemize each component of care and transport in the same way a hospital inpatient bill is itemized.

b. Medicaid – this is commonly referred to as medical assistance (welfare) and is the mechanism of payment for indigent, disabled (likely in conjunction with Medicare), institutionalized (but not incarcerated), and those with special waivers. These funds come from a combination of federal and state government but are managed by the state. Any payment from Medicaid disqualifies any other means of revenue collection from the patient. It is the sole source of revenue allowed and is the payer of last resort. Like Medicare, there is a published fee schedule, but this is published by the state.

c. Veteran's Administration – Obviously represents the means of payment for those who are entitled to VA coverage. This is paid at 100% of the agency's billing rate.

2. Private Insurance – Most private insurers will not pay direct to an EMS agency if there is not a contract in place. In order for a contract to be in place, the agency must have the capacity and wherewithal to negotiate with each insurance provider and will ultimately have to agree to a lowered rate in exchange for direct payment (generally the negotiated rate is at or below Medicare rate). As most agencies don't have the means to undertake this work with the large number of insurance providers, or the desire to accept reduced rates, the norm is that a patient with private insurance will receive payment direct from the insurer and the EMS agency will need to pursue payment from the patient.

   This model has resulted in most agencies having a handful of "professional patients." These are people who, when the car payment or rent is due, will call the ambulance to go to the hospital. They get a check from the insurance company but never pass on payment. The EMS agency files against their credit profile, but the patient is already so underwater financially they don't care. Some agencies will transport these patients (because the patient cannot be refused transport) and not bill them to try to break the cycle.

3. Subscriptions
   a. Individual subscriptions – Most EMS agencies will offer an annual individual or household subscription. Typically, the subscription is between $65 and $150 and will protect the subscriber from any costs beyond that paid by a government payer or insurance when the service is an emergency transport. There is little uniformity among agency subscriptions apart from this hold harmless for emergency transports. Some agencies will offer limited non-emergency or public service assistance at no or reduced costs. These programs are required to be actuarily sound and not write off more than they bring in across the entirety of the program. Most agencies report a rate of return of approx. 15-25% on offers of individual subscriptions in their service areas.

   b. Municipal-wide subscriptions – Approximately 30 municipalities in Berks County make a payment to their EMS agency that is intended to be in lieu of a private subscription payment. This revenue can be collected as a dedicated EMS tax or as a component of

the general real estate or earned income taxes. The amount generally calculates out to $30 to $50 per household and will generally have similar stipulations about emergency/non-emergency coverage as those described above.

4. Fund Drive/Donations (private and/or municipal)
   In addition to subscriptions, most agencies accept cash contributions from the community for general operations or special capital projects. These are usually solicited in conjunction with subscription drives or using special mailers/newsletters.

   In some jurisdictions this is the means by which the municipality contributes to the EMS agency. A simple discretionary payment from the municipal coffers is offered as a gratuity for the provision of services. This is often with limited accountability for the expenditures undertaken with the funds.

5. Endowments
   Some agencies have the benefit of "old money" that is providing interest-based infusion of operating revenue into annual budgets. This can also be in the form of facilities access/housing.

6. Direct Payments
   The national average of direct collection of any amounts due from patients is approximately 30%. Unpaid balances can be sent to collections which generally has limited success and, which, when successful, results in a further reduction of revenue collected as the debt collection agency takes a share. Under recent changes (July, 2023) made by the major credit reporting agencies, unpaid medical bill balances under $500 cannot impact an individual's credit rating which has brought about another motivating factor for patient's not to pay their bills.

   Even in cases where the patient is honest and desires to satisfy their debt, many are left confused by the process with convoluted Explanation of Benefits (EoB) being provided by the insurers. These documents make it difficult for a patient to understand what portion of the bill is actually covered by the insurer and what portion remains a patient obligation. In some cases, these EoBs are updated multiple times, with the patient receiving bills from different providers of services (hospital, EMS, physician, etc.) for the same hospital admission and not understanding who is still owed money.

Revenue Collection Case Study

Below efforts to describe how revenue collection works. This is further illustrated in Appendix C with a chart that shows the expected revenue collection for a few different types of calls with different types of insurance/payer.

A patient transported to the hospital with a serious condition like a heart attack in progress would likely generate an ambulance bill of approximately $1,700.

- If this bill were submitted to most private insurance providers, they would pay as little as 30% of that amount IF the patient's deductible had already been met and IF there were no copays. This could mean 0% is recovered from insurance if the patient has a deductible. The balance of the bill must be pursued directly from the patient and the ability to actually collect on this varies with socio-demographics of the area being served.
- If the patient were Medicare eligible, this bill is immediately reduced to $511 which is the Medicare approved rate for a call of the nature described. Medicare will pay approx. $400 of this bill and the patient is responsible for the $111. This $111 could also be paid by a Medicare supplemental insurance or Medicaid if the patient is dual eligible. The balance is adjusted off as required by Medicare.
- If the patient were Medicaid eligible this bill is immediately reduced to $400 and there is no opportunity to collect any balance elsewhere. NOTE – As of January 1, 2024, this has been adjusted to $600 plus $13/loaded mile. This is an incredible increase, particularly given that, prior to 2019 the PA Medicaid fee schedule had not been changed for 20 years.

A final concept that is important to grasp is that of "treat, no transport." There are a number of common scenarios where an EMS response could result in the patient receiving treatment on scene but not being transported to the hospital. Some brief examples include:

- A diabetic emergency that is reversed by administration of IV "sugar" or other medications.
- An asthmatic patient whose condition is improved through a series of breathing treatments.
- A drug overdose reversed with Narcan.
- A cardiac arrest where the patient is not able to be resuscitated.

These calls can result in the EMS agency using medications and supplies with a replacement cost of $300-$1,200. The government payers do not pay for these calls. Even more incredible is that there is a law in Pennsylvania that requires commercial insurers to pay when these services are provided. However, despite that obligation, commercial insurers, almost universally, violate the law and provide no payment. The very few that do pay, do so at a ridiculously low rate.

LOCAL ORGANIZATIONAL MODELS FOR EMS ORGANIZATIONS

There are at least 4 different models (with some sub-models) for funding and operating EMS organizations in Berks County

Hospital-Based Providers – (both entities serving Berks County jurisdictions are part of not for profit health systems)

There are two hospital-based providers with primary jurisdiction in Berks County. However, between these two models there are differences:

1. Provider 1 typically charges a per residence subscription to the municipalities it serves and gets direct payment from government and private insurers. They have indicated they will look at opportunities to provide service/expand if asked, but need to focus on areas which makes sense for their hospitals and existing coverage.

2. Provider 2 offers no subscription program. Gets direct payment from government and private insurers, only wants to expand where it makes sense for their service area.

There were significant misunderstandings of the mechanism of operation/funding for these entities. However, investigation reveals that their means to recover costs following a call for service very much looks like those available to agencies operating under other organizational models with one exception. The hospital systems have negotiated contracts with private insurance providers which carry through to the provision of EMS services and allow the hospital-based EMS providers to receive direct payment rather than pursue the patient for payment/pass-through of the insurance reimbursement. The hospital-based providers will tell that the trade-off for this is that their recoverable amounts are significantly negotiated down from what they would otherwise collect. So, what appears to be a benefit to these providers at face-value is really a sword that cuts both ways.

Private Non-Profits

This is the most common model in Berks County and generally throughout PA. These agencies generally have a history of being volunteer based and have transitioned into primarily paid staff operations.

There is a broad range of revenue support offered by the local governments served. This support can vary from nothing to small financial contributions, to significant dedicated EMS tax based municipal wide subscriptions. Of significant note is that the variation in support models is not variation among EMS agencies, but among the municipalities served, with a given EMS agency perhaps receiving a significant sum from one or two municipalities while the municipality right next door gives nothing.

For Profits

With the cessation of operations of Kutztown Area Transport Service in 2023, there are no for-profit providers with “9-1-1” coverage in Berks County. There is at least one private for-profit provider based in Berks County and offering “non-9-1-1” service.

Municipal Based

The City of Reading is presently the only municipally based EMS provider in Berks County. Costs are paid by tax revenues and cost recovery through insurance and patient billing offsets the costs.

LOCAL OPERATIONAL MODEL CONSIDERATIONS

In addition to the above-described organizational structure and funding models, EMS agencies are further defined by their operational models. This can include differences in a number of key areas as follows:

Staffing (paid/volunteer)

Volunteer staffing is almost unheard of in EMS in our area. Most providers are compensated as employees and in fact, many work at multiple organizations for various reasons.

Station Locations

In almost every case, the location from which services deploy their resources is set by some historical driver as opposed to a systemwide consideration of need, current call volume concentrations, or even proximity to other EMS agencies.

# of Units/Stations in Service

The number of units in service and the number of stations from which they deploy is also not necessarily defined by any objective metric. Demands of the municipalities and historical coverage seem to be significant influencers of the number of trucks and stations that are operated. In some parts of the county a deployment methodology called "system status management" is used. In this methodology, ambulances are always on the move and being sent to staging locations to minimize coverage holes created by units being committed to calls. Some advanced systems even use predictive technology based on historical data to position units at ideal locations to handle the "next expected" call. Only one agency is noted to commonly use a formal system status management process, and that agency is rumored to be discontinuing that practice to address employee satisfaction.

It is anecdotally noted that staffing considerations are affecting some agencies more than others and this results in those agencies being unable to keep the number of ambulances/stations in service that they traditionally had.

It is important to note that state regulations which require an agency to be in service 24x7 DO NOT require all stations to be staffed 24x7. In effect, an organization operating out of 4 stations could have an ambulance in service in only one of those 4 stations and is not impacting its license obligations.

In Berks County, all providers have voluntarily signed a plan agreeing to a higher level of accountability in this regard. However, some agencies are not meeting these voluntarily agreed upon metrics.

Level of Service

Level of service is generally described as Basic (BLS) or Advanced Life Support (ALS) support. An overly simplified description is that an ALS unit is staffed with a paramedic and can offer a higher level of diagnostic and interventional care. In addition to these two levels of care, a "middle-ground" called Intermediate Advanced Life Support has existed since approximately 2016. This level of care does not require a paramedic (the senior provider is called an Advanced EMT), and there are some advanced skills that the crew is not trained or equipped to perform, but they can do more than a BLS unit.

These levels are hierarchical, but an agency must separately license at each level of service they desire to provide.

Regulations require that the agency be in service at its highest licensed level of care 24 x 7. This is not the case for IALS. An IALS licensed agency may be in service only at a BLS level and be compliant with license requirements. There are cases where this is not being accomplished at the required level in Berks County.

Non-emergency Transports

Some agencies supplement their revenue with the provision of wheelchair or litter non-emergency work. These transports are generally scheduled trips to or from treatment or discharges from acute medical facilities to home or short- or long-term care facilities. While these trips can generate supplemental revenue, they also bring additional cost, staffing needs and equipment requirements. In some cases, these transports can be long distance, including interstate. This means the ambulance and crew are committed for an extended period of time and are not providing 9-1-1 services. Some agencies accommodate this by staffing specific units for non-emergency work while others will pull a "9-1-1 crew" to do the work while still conforming to obligations to serve their municipalities by maintaining a minimum number of crews in service.

Some agencies do not provide these services, and some provide them only to subscription members. The ability to provide these services to their own hospitals is a significant motivator for hospital-based EMS.

SPECIFIC CHALLENGES

Provider of Last Resort

As our society changes, and as people generally exhibit a higher dependency on government and pseudo-government services, the emergency services have become the front line in this change. This could not be truer than in the provision of EMS.

- Parents who decide that kids who act out are in need of mental health services instead of better parenting.
- People who lack a primary care physician and desire EMS come and "just check them out."
- People who desire transportation to the emergency room for non-emergent conditions but decide that a $600 ambulance bill they will never pay makes more sense in their financial model than a $20 taxi bill for which immediate payment would be demanded.
- Domestic conflicts where the most expeditious way to end the conflict is for law enforcement personnel to tell one of the parties that they have a choice between going to the hospital for treatment of their "first-aid level" injuries or going to jail.
- Individuals with chronic mental health and/or self-care challenges who summon EMS to adjust them in bed, provide food or drink from the kitchen, or simply to complain about the care being provided by an in-home or institutional caretaker.
- Transport from the emergency department of one hospital to a different hospital because the patient is unhappy about wait times or the care being offered at the first hospital.

If these examples were one-offs or anecdotal stories that EMS providers could talk about, they might be humorous. But the real truth is that these, and many other similar scenarios, play out throughout Berks County MULTIPLE TIMES EACH DAY, creating further stress on an already strained system of delivery. EMS workers have become social workers, mediators, parenting advisors, medical educators, and bus drivers in addition to all the other skills and services expected of them.

Capital Funding

Many ambulance providers are losing their capital because the capital reserves are being used to simply meet operating budgets. This affects the ability to replace durable high-cost materials like ambulances/vehicles, power gurneys, heart monitors, etc.. The cost of durable medical equipment to outfit a new ambulance can be $100-150k above the cost of the actual vehicle. While most agencies have maintenance programs for the high-cost durable medical equipment, this is costly in and of itself and, while it may prolong the usable life of the gear, it cannot avoid eventual replacement entirely.

Personnel

1. Compensation - Pay varies widely, with municipal and hospital-based organizations generally bringing to the table an opportunity for better pay and benefits.
    a. EMT's are paid between $15-22/hour, AEMT's earn $20-24/hr., and Paramedics earn $23-30/hr. Frequently, these salaries are accompanied by only very basic benefits, if any. Obviously, an annual salary of between $31,200 and $62,400 with little to no benefits does not engender a good recruitment tool for someone looking for a career.
    b. Due to the relatively low compensation, many EMS providers work multiple jobs to augment their income. It is common for a full-time EMS provider to

work 60-80 hours a week, every week. This creates poor work/life balance, and results in rapid burnout of workers. Additionally, the single provider multiple positions model creates a cascading staffing shortage when a provider's unplanned absence results in the position being covered by an off-duty co-worker who is mandated back to work. If that co-worker was scheduled at their second job, they then have to call off. This cascade can result in a single provider missing a shift creating staffing challenges at 3 or 4 different organizations.

Sadly, this multiple employer model which is bad for the individual providers and their families has become an almost necessary part of the delivery system. Services are being provided at the level they are today thanks to the number of providers who work weekly hours equal to 2 or more jobs. If they scaled back to a "normal schedule," it is valid to worry about where the system would find qualified people to fill the schedule.

2. Workforce Development - There is an absolute lack qualified personnel at all levels of certification. The higher the level of certification, the more apparent the deficit is. The availability of required entry level training used to be prevalent and very inexpensive. In 1990 an EMT class cost approximately $75. Today that class costs approximately $1400. In 1990, a local Paramedic program was under $1000. Today that program is $6,000 - 10,000.

   Agencies will frequently scholarship employees to earn high levels of certification in exchange for work time commitments. One agency recently became credentialed to offer its own training programs to try to facilitate workforce development.

   In addition to the difficulty in finding qualified personnel, recruitment into the field in general is suffering just as it is with most 24x7 positions. Police, fire, 9-1-1 telecommunicators, nursing homes, and even healthcare in general are suffering recruitment challenges in our new post-COVID norm where M-F, 9-5, and remote whenever possible are the order of the day.

   Working weekends, holidays, and nights in all weather, exposure to infectious diseases and psychological trauma, and being assaulted by patients and family are not ideal recruitment tools for a job that pays equitably to a shift asst. manager position at Wawa, and often has less desirable benefits.

   This is somewhat illustrated in the table below which shows all the providers listing a residence in each county in the Eastern EMS Council region, along with a count of providers who appeared on Patient Care Reports (a required record that is generated for each EMS response). The delta between these numbers is representative of providers who possess the necessary certifications, but do not actually provide services on a front-line EMS unit.

Providers in Residence	County	Providers on PCRs	% of Providers in Residence That Appear to Be Working In EMS
1056	Berks	428	40.53%
240	Carbon	132	55.00%
898	Lehigh	348	38.75%
401	Monroe	177	44.14%
820	Northampton	240	29.27%
545	Schuylkill	269	49.36%

It is worthy of note that .1% (428) of the population of Berks County is represented as individuals who are providing front line EMS services in 2023. Considering all those persons qualified to do so (1056), only .25% of the population is even certified to do this work if they chose to.

Unit Depletion

Mutual aid is a necessary and sensible part of the provision of emergency services where the preponderance of the cost of providing the service is the cost of readiness. An environment where an agency NEVER needs to rely on a mutual aid partner is unsustainable and inefficient.

However, there is a subjective balance that must be achieved. As units are down staffed or even go out of service due to staffing challenges, there is no ability to throttle call volume. An agency unable to reasonably cover its calls will need to rely on neighboring agencies to come in from a longer distance away and provide coverage. This often requires additional support from fire personnel who are dispatched to assist on critical calls, or when the responding EMS unit is coming from a distance.

Ultimately, this displacement of units creates further holes that are backfilled until a lack of crews in one end of the county has created a hole in the opposite end with middle units having been sent well outside their normal coverage areas.

It is not clearly understood if this is creating detrimental impacts to the provision of fire services, but this is an important question to pursue.

Reporting and Municipal Assistance

With increasing frequency, municipalities are being asked to increase funding to EMS agencies. No standard of reporting has been established and it is unclear if any entity has the authority to do so. It appears that either EMS agencies or the municipalities being served will need to cooperate to set a standard. What “financial information” means is highly subjective. It is clear from conversations that some agencies do not desire to provide this information, and others are simply not clear on how to do it properly. How this would be done by hospital-based providers is even more unclear where hey may be a business unit of a bigger entity.

There must be satisfaction achieved in this regard. The EMS agencies are providing a service that is an obligation of the governmental units. However, the governmental units do not simply write blank checks, even to their own departments. Each party has an obligation to explain to the other the needs and then justify any demands for the provision of service. Either party feeling they are hostage to the other will have detrimental outcomes to the system of delivery.

While the EMS agencies are providing a crucial and necessary service, they cannot believe they have a right to make unsubstantiated demands. Audits, following Governmental Accounting Standards Bureau standards, are not presently a common practice. Many agencies are commonly providing an IRS 990 as their means of financial reporting. This is completely inadequate to establish financial need. When a municipality is being asked to provide significant revenue, they should have access to properly detailed justifications including compensation and staffing plans, accounting of capital reserves, and a P&L statement.

Executive Leadership

Some of the EMS organizations presented executive leadership that demonstrate a keen business savvy. In other cases, it was apparent that the leadership had a strong operational knowledge base, but limited business skills. Further concerning is that some of those leaders did not indicate a business support mechanism backing them up.

A lack of strategy including cost containment and long-term planning can have just as much of an impact on the system of delivery as poorly trained or equipped providers. This "Peter Principle" for promotion and leadership is not unique to EMS and is a common suffering of the emergency services where advancement, by necessity, comes from the ranks below. Municipal leaders can assist in this regard by demanding proper business practices, and then offering financial support needed to make that a reality.

Interagency Relationships

While these agencies are serving a higher calling in the provision of medical care and transport, the system of delivery necessitates that they view each other as business competitors. When on the street supporting each other in the provision of care of patients with need, they regularly cooperate and support each other's needs in the community's best interests. However, when discussing systemic issues, or broad efforts to improve the delivery of service throughout the region, the discussions and potential for change are often overshadowed by a degree of distrust borne of the agencies competing for service area and revenue that is necessary for them to be able to execute their mission.

These efforts to cooperate off the street are sometimes further challenged by distrust and worries that the agency next door may be looking to marginalize our organization. This is not paranoia. It is real and built of examples where agencies saw a time of weakness as an opportunity to dominate a neighbor instead of supporting them. There were even assertions made by some agencies that a structured effort exists by other agencies to use the Council/DoH reporting mechanism to place their license at risk.

This model of operations within which the organizations are forced to work, one created in part by some municipalities that have leveraged EMS agencies against each other in search of a “better deal,” has a direct negative impact on collaboration and improvements to the system of delivery. Further, while there needs to be a professional and well-understood process by which providers and agencies that are deficient in their provision of care can be brought to the attention of regulators, it is not a process that should be weaponized.

There needs to be open dialogue among the organizations, and cooperation must exist at that level for the EMS agencies to reasonably expect cooperation from the municipalities.

REPORT CONCLUSIONS & MATTERS FOR FURTHER EXAMINATION

Urgency of Need and Ownership of Responsibility

It is clear that there is not a magic solution to this crisis. The issues are layered and intertwined. One thing is clear. This is a crisis, and taking no action will ultimately result in long delays or no response to a 9-1-1 call for an ambulance. The municipal codes in the Commonwealth are clear that the provision of EMS services is the responsibility of the local municipalities. Further, the 3rd Class County Code, (Berks County is a county of the 3rd class) has no provision for allowing the County to provide EMS services.

Mutual Aid

With 13 primary providers, all but two EMS providers provide aid at close to equal the amount at which they receive it. The two outriders receive mutual aid disproportionally more than they give it when compared to other EMS agencies. This is a strength in the overall service in Berks County. To further highlight an often-misunderstood fact in this regard, the City of Reading (the only fully municipal service, and the busiest provider of services) is one of the agencies who gives and receives aid in a balanced ratio despite the generally held belief that the City, due to call volume and density, is a drain on the overall system.

1. The current system of dispatching requires that the provider designated by the local jurisdiction as being its primary provider for the level of service required by the call be sent to the scene. If that provider is busy, then the call is assigned to the next locally designated mutual aid provider and so on, until an agency is found who is available to respond. This locally established "run card" being followed means that there could be an available ambulance passing right past the address, or even parked up the street getting a soda or sandwich. Irrespective of its geographical proximity to the call in the moment of need, if that ambulance is not next in the mutual aid hierarchy, it is not notified to respond.

    i) One recommendation of this report is to progress to GIS based dispatching. While Berks County may not directly provide EMS service, this is a way the County could assist in improving response times. The County has implemented the centralized technology to allow for this transition, but the EMS agencies who were initially enthusiastic partners, have largely elected to not implement their end of the technology and/or compel their personnel to use it. Short of refusing to dispatch non-compliant EMS agencies, the County lacks the means to compel its use. The municipalities should compel their EMS providers to utilize this technology to permit location-based dispatching, and the County should begin this practice as soon as practical. Where the EMS agency does not possess the technology to participate in this program, the costs of this service should be borne by the municipalities being served by tying designated funding to the enhancement.

Action: All EMS providers must be compelled to utilize GIS based dispatching if municipal financing is provided.

2. There is very little communication between providers when an agency is unavailable or in service at a reduced license level. Adjacent EMS providers should share their anticipated staffing and units count/service level. If it is known that the anticipated staffing is not going to be met (eg. a crew call-off and no ability to replace the crew) the EMS should notify all adjacent agencies that they cannot provide the expected level of service as early as possible to allow those adjacent agencies to potentially up staff to handle out of service unit/station. In addition, the Berks DES should notify all EMS agencies of the anticipated down staffing (and its duration) through the use of the County mass notification system. The municipalities should compel their EMS providers to participate in this process.

   Action: EMS providers should be compelled to share anticipated staffing schedules with adjacent providers and in particular last-minute changes to anticipated unit deployment or unit service levels when they are reduced due to staffing or out of service equipment so that surrounding agencies have the opportunity to upstaff to mitigate the shortage.

3. The County should begin investigating, and implement as soon as practical, a dispatching model that incorporates primary dispatch of intermediate ALS (IALS) capabilities, as well as non-transport/squad ALS to better stretch access to limited ALS personnel.

   i) It is recognized that the EMS agencies will need to work together to revise billing agreements to ensure that agencies providing squad capabilities in a mutual aid situation are receiving a portion of the reimbursement/billing that represents the cost of readiness of this the neighboring agency maintaining this unit. Without this component, the chase model is financially unsustainable as the rights to the revenue primarily rest with the transporting agency, despite the significant costs borne by the supporting non-transport agency.

   Action: The County and EMS providers must work to modify the dispatching model to incorporate the primary dispatch of intermediate ALS (IALS) units, as well as non-transport/squad ALS to better stretch access to limited ALS personnel.

<u>Staffing/Recruitment and Retention</u>

Staffing is perhaps the greatest challenge to the proper provision of EMS services and touches almost every other challenge in some way. Proper staffing is restricted by a number of issues:

Training

1. The cost of training has increased tremendously since the 70's and 80's. Most agencies fund the training for staff which puts a greater burden on financials.

2. Availability of training is as much of a challenge as the cost of the training. There needs to be regularly conducted part-time and full-time training programs for all levels of EMS certification available locally. The availability of basic EMT training seems to be adequate, but AEMT training is

limited to non-existent. There is a Paramedic training program available in Berks County, but the delivery of the program is highly limited in its flexibility/scheduling. Local elected officials, county elected officials, stakeholders, and providers of education in the community (hospitals, EMS agencies, RACC and the four-year colleges) should collaborate to make increased training availability and variety in programming (PT and FT) conveniently available in Berks County.

Action: Elected officials from local, county and state levels must work together with community educational resources such as the colleges and universities, as well as technical and healthcare training schools to ensure an adequate availability of EMS educational programming. This should include training to executives and management personnel.

Compensation/Benefits

1. Compensation for EMT's, AEMT's, and Paramedics is substandard for a livable wage given the responsibility and expectations placed on these emergency services providers. The hourly rate for EMT's ranges from $15.00 to $32.00. AEMT's range from $17.00 to $35.00. For Paramedics, the local range is from $19.00 to $38.00. It is critical to understand that the breadth of the ranges above are represented accurately, but the top ends are significant outriders among agency pay scales. The customary pay for most EMS agencies for each certification level in Berks County is below the average of each range. Career police and fire personnel in Berks County range in entry level pay from $60,000 to $90,000 ($30-$45/hr.). These amounts increase to $90,000 to $150,000 mid-career. These figures do not include overtime and other incentive pay.

   This deficient pay scale has two negative impacts:
   i) Few responsible and competent individuals can commit to a career at these wages, as they do not represent a living wage to support a family.
   ii) Employees of the caliber we all want providing these services in our community can go to many other opportunities at this wage and not have to contend with shift work, holidays, physical and psychological impacts/risks and the other detractors in this career path.
2. The typical employee works for multiple agencies an extra 20-30 hours a week just to make a livable wage. This also has a spin off effect in that when a provider loses a staffed person due to illness or emergency, the provider will call the staff person back to their operation leaving the provider who was providing an extra shift short in their operation. In some cases, this occurs over three of four providers during a single shift. There are few benefits paid to EMS workers at private non-profits and, in most cases, there are virtually no retirement benefits. Where there are retirement benefits, they are generally not public pensions such as those afforded to most municipal public safety workers. There are some exceptions to this. One exception is the City of Reading, where EMS is a component of the fire department, and the personnel are represented by a labor union.
3. Berks agencies are in competition with other markets where the pay for comparable positions is significantly higher. This is particularly true for employees who can work in Berks County as well as either Chester, Montgomery, or Lehigh counties.

Action: While the current crisis calls for an immediate improvement in pay, a long-term solution can only be established subsequent to a comprehensive salary and benefit analysis to fully detail the process to establish EMS as a bona fide career and ensure positions in the Berks County geography are market competitive.

Funding

Apart from grants, which are generally small and recurring, or of potential significance but competitive and not guaranteed, there are generally four means by which EMS agencies generate revenue:

1. Billing – The system of Medicare/Medicaid/private insurance is woefully underfunding the actual cost of EMS service delivery. This is a state and federal legislative issue and a Commonwealth Insurance Commission enforcement problem. There are laws in the Commonwealth about how providers are to be compensated, and the insurance providers, in some cases, simply disregard them, and the Commonwealth does not follow the issue or enforce the law.

   In all cases, the amount of the reimbursement from Medicare/Medicaid/private insurance for ambulance service is only a fraction of the cost. This has changed dramatically in the past 20-30 years when services were predominantly able to be provided with costs covered by billing for service.

   Making the problem worse is that the private insurance companies generally pay directly to the patient (the exceptions are the two hospital providers who do get direct payment because they are part of the actual healthcare systems and have negotiated contracts with insurers). Patients are then expected to pay the funds to the provider. This issue gets even more difficult as patients disregard the reimbursement to the provider and simply keep the payment. Even more egregious is the patient who routinely calls for ambulance service so that they get their payment which is then used for bills, vacation, or simple budgetary needs. We heard from one provider that, when these "professional patients" are identified, in an effort to break the cycle, they do not even bill the carriers for the service, so the patient does not get the opportunity to skim the repayment even though they were taken to the hospital and generated a legitimate bill.

   Action: Develop a campaign to educate federal and state elected and appointed officials about the lack of insurance funding, the inconsistent application of funding rules, and the ability of private insurance companies to compel EMS providers to accept reduced reimbursements in order to accept direct payments and the reimbursement inequity for direct reimbursement verses payment from the patient. CELG will coordinate the effort.

2. Subscriptions/Memberships – typically only net 15-20% payees from their service area. Subscription service means that the provider will bill your private insurance carrier, but not bill the subscriber for uncovered costs.

3. Donations – can be provided by municipal governments as a gratuity to the EMS provider(s) that service the jurisdiction. Some providers also get private donations, but they are only a minor fraction of their budget.
4. Municipal Based Subscriptions/Memberships - The final common method of revenue generation is municipally paid subscriptions. This has become increasingly common where municipalities have elected to engage to better support EMS, but also desire to offer the taxpayer a tangible benefit in exchange for the consideration. These programs confer the protections of an individual membership but are "purchased" in aggregate by the municipality. They are typically based on a $35.00 - $70.00 per household rate. It is estimated that up to 30 municipalities pay for some form of a membership/subscription on behalf of their residents.

   Action: Each EMS provider must meet with the municipalities in their service areas to establish an appropriate annual actual subscription rate/per household contracted cost. Each municipality must commit to paying that rate.

   In-Kind Services - there are municipalities that provide station facilities, fuel, utilities, etc. for their EMS providers. The costs associated with this arrangement need to be monetized to a real value so that adjacent municipalities will understand the actual benefit. This will assist in creating equity among the contributions each municipality makes to its EMS provider.

   Action: If a municipality is providing in-kind services, these services must be monetized, and the value used to offset agreed upon annual municipal subscription costs.

It is important to understand that, how the local dollars that contribute to the above are generated (general property tax or EMS tax), has no direct effect on how they are provided to the EMS agency. The dollars generated can be paid out with or without any reciprocal expectation for service by the EMS provider.

Many municipalities are paying upward of $100,000, with some up to $250,000 annually. When their residents call, and the primary provider is tied up elsewhere, perhaps in a municipality which does not provide significant support, there begins to be issues between the municipality and the EMS provider. This stresses the current system and creates discord with the EMS provider who was "unavailable to serve," despite the fact that the EMS provider had no discretion in handling the call that distracted them from their primary obligations.

The system overall is presently so underwater that, even if every municipality were to provide in-kind services or paid a subscription or a combination, it is apparent that the funding would not be adequate to raise salaries and benefits to a level that would attract enough EMT's, AEMT's, and Paramedics to properly staff providers in Berks County.

Municipalities should immediately meet with their EMS provider(s)to understand the financial situation they are experiencing, and work with them to take action to shore up their operation in the near term. This should include clarity about the level and reliability of service being provided, and the possible introduction of written agreements covering municipal financial support and EMS agency performance requirements. It is crucial that these activities avoid the pitting of agencies against one another to maintain service areas, as the current situation is precarious enough that such changes could have serious systemwide consequences.

The above must include coordination among municipal leaders to ensure that the support being provided is proportionate and ends the existing situation where some municipalities are effectively supporting the access to service of other municipalities that do almost nothing.

Action: The above referenced subscription program, inclusive of the recognition of in-kind services should be established through an intergovernmental cooperation agreement similar to regional police and fire operations.

Reporting

Until the past 20 years, EMS providers generally operated under the radar and had little interaction with host municipalities. The EMS agency provided a service and had minimal need for municipal engagement. The municipality was happy to have a fairly self-sufficient entity meeting the need for the service. This is not the situation today. Almost all EMS agencies need municipal support, and some are asking for significant public dollars. This generates a justified corresponding need for accountability to the municipality(ies) to show that the funds are being spent efficiently and in the pursuit of the delivery of the public service.

As meetings were conducted with the individual EMS providers, the City of Reading was the only agency which has public budget information, and they are the only municipally run agency in Berks County. As previously mentioned, the other providers are either hospital-based non-profits or they are traditional private non-profits. In most cases, the leadership of the organizations instructed the managers to not share (or to share minimal) financials in this effort.

Action: Where any public funding is provided, within an EMS service area:

1. **There should be a standardized reporting process to report planned and actual staffing of units including the level of service delivery.**

2. **Request for funding, especially those that exceed a prior year's request, should be substantiated fully. Why does the agency need more money? The present model is that all that a municipality sees is a request for additional funding. Generally, the "justification" provided is in the form of a shortfall from existing funding for a single call versus actual cost/call, or the cost of staffing a single ambulance annually, or the cost of some single piece of equipment like an ambulance. This falls short of the process generally required for a department of government making a budget presentation for a funding increase.**

3. **If municipal funding is being requested, a detailed operational budget with staffing and a separate capital budget, shall be provided to the municipality no later than October 1 of the preceding year, or within the process established by the municipality for its own budget.**

4. **Quarterly operational and financial updates must be provided to each municipality. These reports should address financial viability of the EMS provider and, where EMS providers are larger than the local Berks County area being served, whether the cost of the local operation**

in the form of budgeted versus actuals, is being properly supported by local revenues. CELG will work with EMS providers where assistance is needed.

5. **The budget should be supportive of their funding request and uniformly spread among all the municipalities in the service area.**

Agency Consolidation

Consolidation or merger is often perceived as a simple answer to achieve efficiencies. While this may be the case in "back-room" tasks like fleet, purchasing, high-level management, billing etc., it is not necessarily the case in the provision of frontline services "on the street." It is now understood that almost every single EMS agency in Berks is stretched well beyond optimum staffing service levels.

As noted previously, two agencies have openly expressed concerns about their ability to maintain service delivery through the end of 2025 given their current financial picture. Both agencies are in areas where municipal support is very limited. The agencies are not fully staffed. If either cease operations, an agency taking over the area will be stretched in territory and will, at best, inherit the staff from the previously understaffed provider, thus reducing service levels in both areas. This does not even consider the fact that it is likely some of the providers were already employed at the second agency.

A common belief, legitimately generated by similar circumstances in the past, was that there were a number of agencies who would immediately step in to serve an area if the legacy provider ceased operations. It is now very clear that there is no EMS agency in Berks County that will accept a new service area without due diligence ensuring the assumption of responsibility fits the core/current mission and is financially a clear positive.

There are few opportunities wherein it appears that a simple merger or consolidation will work to generate a more efficient or capable overall system **without sweeping changes through that system** and which encompass the other agencies who would be otherwise unaffected.

Action: All EMS agencies need to develop interagency cooperation agreements to foster better service delivery. Areas of opportunity include billing, purchasing including capital items, scheduling, and physical asset and personnel sharing.

FINAL CONCLUSIONS

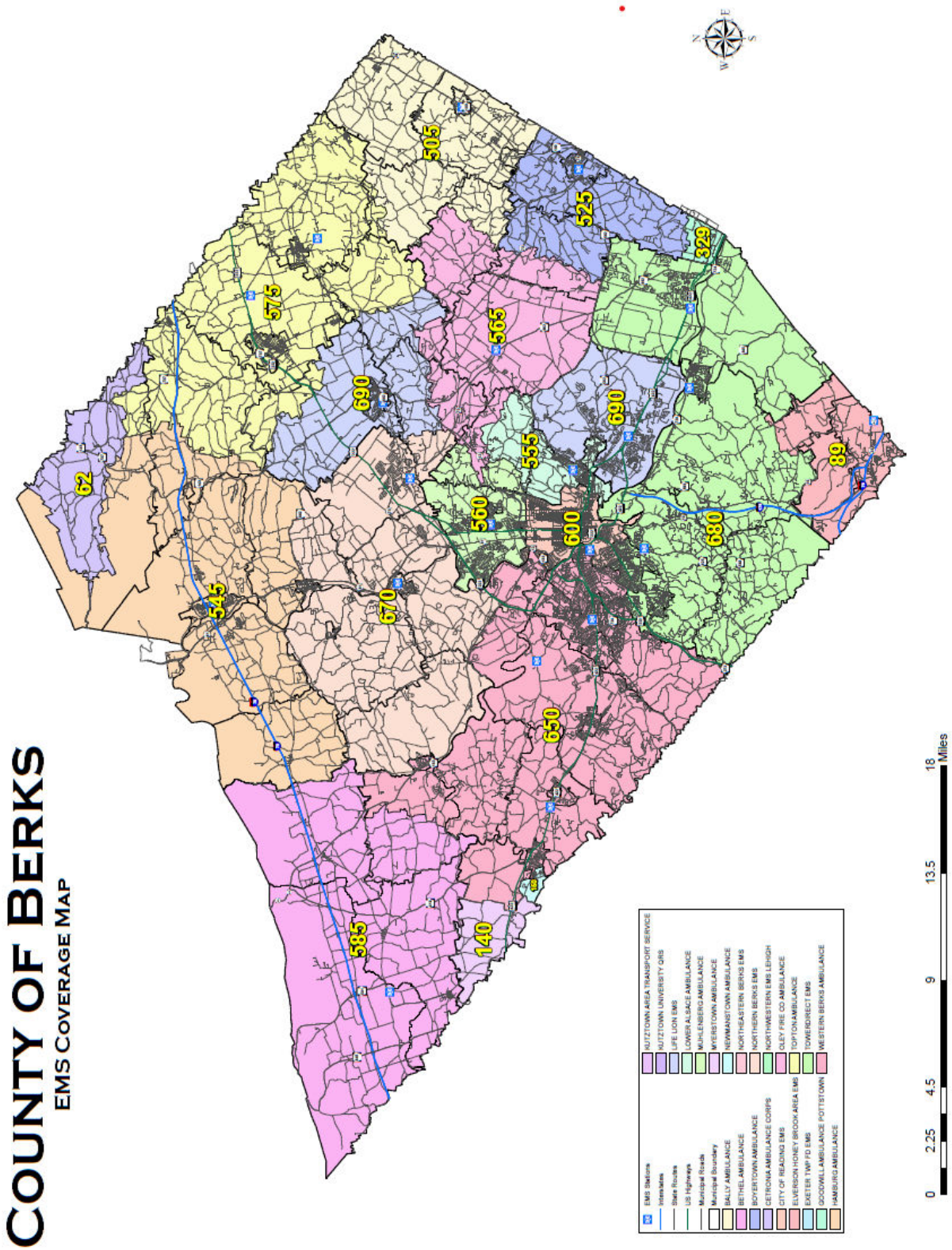
While there are actions that can be taken now to shore up the existing system given the lack of alternatives, these are short term solutions that are unsustainable and perhaps even irresponsible in the long term. The municipalities throughout Berks County should be unified in an ask to the Berks County Commissioners to financially support a qualified consultant to conduct a regional assessment and develop a strategic plan intended to overhaul the provision of EMS services in Berks County. All municipalities and EMS agencies must actively and openly participate in this process and commit to serious consideration of the implementation of recommendations in order to ensure that this is not a fruitless task.

This study should include a deeper examination of the questions/problem posed in this report (among others) and require the consideration of models that differ from the existing countywide model which is, according to almost every participant, highly inefficient and no longer viable.

Action: CELG will hold regional meetings with municipalities and EMS providers to inform elected officials of the findings and action items detailed in the report. CELG will work with the county commissioners to fund the referenced strategic plan to be conducted under CELG guidance.

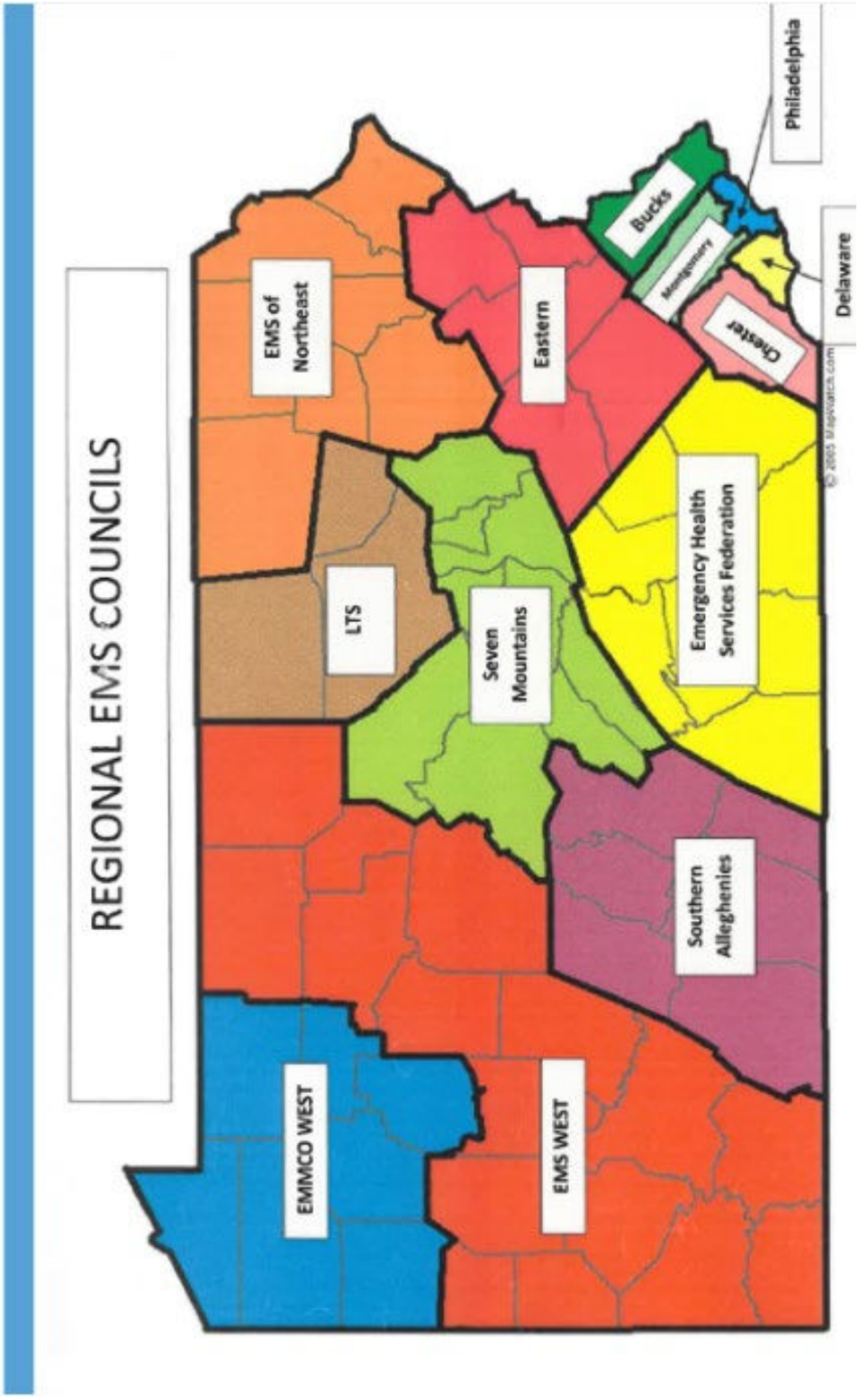
APPENDIX A

Map of Primary EMS Coverage in Berks County



APPENDIX B

Map of PA EMS Councils



APPENDIX C

Examples of billing/cost recovery in various medical scenarios and payer scenarios

ALS Emergency **(Heart Attack)** *Using ALS1 (HCPCS: A0427)*	Total Amount Billed	Amount Paid by Insurer or Gov Payer	Amount Paid by Secondary "Insurer"	Amount Required to be "Adjusted" (written off) by EMS	Amount Pursued from Patient
Medicare	$1,700.00	$434.22	$108.55	$1,157.23	$108.35
Medicaid (Medical Assistance)	$1,700.00	$607.23		$1,092.77	$0.00
Private Insurance	$1,700.00	$499.80		$0.00	$1,700.00
Private (Patient) Pay	$1,700.00	$0.00	$0.00	$0.00	$1,700.00

BLS Emergency **(Fractured leg)** *Using BLS Emergency HCPCS A0429*	Total Amount Billed	Amount Paid by Insurer or Gov Payer	Amount paid by secondary "Insurer"	Amount Required to be "Adjusted" (written off) by EMS	Amount Pursued from Patient
Medicare	$1,200.00	$369.24	$87.83	$742.93	$87.83
Medicaid (Medical Assistance)	$1,200.00	$511.35		$688.65	$0.00
Private Insurance	$1,200.00	$352.80		$0.00	$847.20
Private (Patient) Pay	$1,200.00	$0.00	$0.00	$0.00	$1,200.00

BLS Lacking Medical Necessity **(Abnormal Lab Values, Dizziness, Toothache)** *Using BLS Emergency HCPCS A0429*	Total Amount Billed	Amount Paid by Insurer or Gov Payer	Amount paid by secondary "Insurer"	Amount Required to be "Adjusted" (written off) by EMS	Amount Pursued from Patient
Medicare	$1,200.00	$0.00	$0.00	$0.00	$1,200.00
Medicaid (Medical Assistance)	$1,200.00	$0.00		$1,200.00	$0.00
Private Insurance	$1,200.00	$0.00		$0.00	$1,200.00
Private (Patient) Pay	$1,200.00	$0.00	$0.00	$0.00	$1,200.00

Medicare: Utilizing Urban Rate including Ambulance Inflation Factor (AIF), Does not include deductions for Federally regulated sequestration

Amount that is LIKELY to be collected

Amount that MIGHT be collected – **NATIONWIDE 30% collection rate**

Amount that is legally uncollectable

APPENDIX D

Action Item Compilation

Mutual Aid

Action: All EMS providers must be compelled to utilize GIS based dispatching if municipal financing is provided.

Action: EMS providers should be compelled to share anticipated staffing schedules with adjacent providers and in particular last-minute changes to anticipated unit deployment or unit service levels when they are reduced due to staffing or out of service equipment so that surrounding agencies have the opportunity to upstaff to mitigate the shortage.

Action: The County and EMS providers must work to modify the dispatching model to incorporate the primary dispatch of intermediate ALS (IALS) units, as well as non-transport/squad ALS to better stretch access to limited ALS personnel.

Staffing/Recruitment and Retention

Training

Action: Elected officials from local, county and state levels must work together with community educational resources such as the colleges and universities, as well as technical and healthcare training schools to ensure an adequate availability of EMS educational programming. This should include training to executives and management personnel.

Compensation/Benefits

Action: While the current crisis calls for an immediate improvement in pay, a long-term solution can only be established subsequent to a comprehensive salary and benefit analysis to fully detail the process to establish EMS as a bona fide career and ensure positions in the Berks County geography are market competitive.

Funding

Action: Develop a campaign to educate federal and state elected and appointed officials about the lack of insurance funding, the inconsistent application of funding rules, and the ability of private insurance companies to compel EMS providers to accept reduced reimbursements in order to accept direct payments and the reimbursement inequity for direct reimbursement verses payment from the patient. CELG will coordinate the effort.

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Action: If a municipality is providing in-kind services, these services must be monetized, and the value used to offset agreed upon annual municipal subscription costs.

Action: The above referenced subscription program, inclusive of the recognition of in-kind services should be established through an intergovernmental cooperation agreement similar to regional police and fire operations.

Reporting

Action: Where any public funding is provided, within an EMS service area:

a. **There should be a standardized reporting process to report planned and actual staffing of units including the level of service delivery.**

b. **Request for funding, especially those that exceed a prior year's request, should be substantiated fully. Why does the agency need more money? The present model is that all that a municipality sees is a request for additional funding. Generally, the "justification" provided is in the form of a shortfall from existing funding for a single call versus actual cost/call, or the cost of staffing a single ambulance annually, or the cost of some single piece of equipment like an ambulance. This falls short of the process generally required for a department of government making a budget presentation for a funding increase.**

c. **If municipal funding is being requested, a detailed operational budget with staffing and a separate capital budget, shall be provided to the municipality no later than October 1 of the preceding year, or within the process established by the municipality for its own budget.**

d. **Quarterly operational and financial updates must be provided to each municipality. These reports should address financial viability of the EMS provider and, where EMS providers are larger than the local Berks County area being served, whether the cost of the local operation in the form of budgeted versus actuals, is being properly supported by local revenues. CELG will work with EMS providers where assistance is needed.**

e. **The budget should be supportive of their funding request and uniformly spread among all the municipalities in the service area.**

Agency Consolidation

Action: All EMS agencies need to develop interagency cooperation agreements to foster better service delivery. Areas of opportunity include billing, purchasing including capital items, scheduling, and physical asset and personnel sharing.