Emergency Medical Services Day at the Capitol 2024

Briefing Booklet

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Emergency Medical Services Association of Colorado

Colorado EMS System Sustainability Task Force

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SB22-225 created an *EMS System Sustainability Task Force* to make statutory, rule, and policy recommendations for how to preserve, promote and expand consumer access to emergency medical services in the state, including the development of standards for state licensing of ground ambulances and the preservation of local county authority to contract with and authorize licensed ground ambulances operating in their jurisdictions.

Purpose

To explore and address the components of the five task force phases including:

Phase 1 – Regulatory structure for ambulance service oversight and a report on the state of emergency medical services in Colorado.

Phase 2 – Inequity and disparity in access to EMS in Colorado.

Phase 3 – EMS workforce recruiting and retention.

Phase 4 – Financial sustainability of the statewide EMS system.

Phase 5 – Long-term sustainability of the statewide EMS system

Progress

- The State EMS and Trauma Advisory Council established the Ground Ambulance Licensing Taskforce (GALT).

- CDPHE established the EMS System Sustainability Task Force (SSTF) and appointed members to the task force. The General Assembly assigned Senator Baisley and Representative Brown to the task force.

- Need two new representatives from the General Assembly to serve on the SSTF!

EMS System Sustainability

- Phase 1, creating an environment scan that measures where EMS in Colorado is now regarding access to EMS care, recruitment and retention, and financial sustainability.

- Exploring, reviewing and creating sources of data to identify gaps for EMS services, problems with recruitment and retention of EMS professionals, and shortfalls in EMS agency funding.

Should EMS be an "Essential Service?"

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Primary Problems

1. Shortage of Prehospital EMS Professionals

- Nearly all EMS agencies in Colorado are struggling to recruit and retain EMS clinicians – especially paramedics.
- Robbing Peter to pay Paul, many "better-funded agencies" are taking clinicians away from "poorer-funded agencies." Especially harms rural areas.
- There are fewer volunteers in rural areas to staff ambulances.
- Low pay and poor benefits are leading causes of recruitment and retention efforts. Demands for higher wages combined with flat revenues from payers worsen recruitment and retention efforts!

2. Funding Shortfalls

- Recent random survey suggests the cost of uncompensated EMS care could exceed $470 Million!
- Emergency medical services providers are funded largely through fees for service.
- Unlike most medical professionals, EMS professionals are not able to pick and choose their patients.
- EMS agencies are paid only for transporting patients, not for the care they provide: Treatment in Place (TIP) – EMS services provided without transport are not paid for by Medicare, Medicaid, and commercial payers.
- EMS readiness costs - 20% are direct transport costs, and 80% are readiness costs.
- Higher costs and supply chain shortages worsen financial sustainability.
- The consequence of the status quo is a gap in service that jeopardizes public safety!

Primary takeaways

- EMS is a critical component of public health and safety as it must be provided to all regardless of the nature of the call, ability to pay, day of the week, or time of day!
- EMS can't respond if it isn't ready to respond.
- EMS should be designated as an Essential Service and be adequately funded by payers local, state, and federal funding sources!

Understanding EMS Finance

Funding shortfalls

Uncompensated EMS costs

- Uncompensated EMS costs include all costs that were not offset set by payments from payers – Medicare, Medicaid, uninsured, and commercial insurance.
- Working to verify these costs through activities of the legislative-directed 225 Sustainability Task-force.

Emergency medical services (EMS) providers are funded largely through fees for service, specifically for transporting patients to or from a hospital by ambulance.

- Medicare and Medicaid patients make up nearly 70% or more of ground ambulance patients.
- Medicare and Medicaid both reimburse providers an allowable rate that is not based on providers' charges or their actual costs.
- Commercial health plans also rarely pay providers' full billed charges. The federal Ground Ambulance Patient Billing Advisory Committee is currently considering billing/payment solutions that may be applicable to federally regulated ERISA plans. ERISA plans comprise the majority of employer-provided health insurance plans.
- The Centers for Medicare and Medicaid Services is in the process of conducting a comprehensive cost collection study to determine how far below costs Medicare reimbursement rates currently are.
- EMS providers are deeply grateful that the Colorado General Assembly and Gov. Jared Polis significantly increased Medicaid reimbursement in 2022. However, Medicaid reimbursement for emergency transports is just 80% of the Medicare fee schedule.

Unlike most healthcare providers, EMS providers are not able to pick and choose their patients.

- EMS services are provided as a public good – services must be provided when patients call regardless of complaint, residency status, ability to pay, day of the week, or time of day.
- EMS providers do not check patients' insurance coverage before responding to 911 calls or providing emergency treatment and transport.
- EMS providers do not/cannot limit the number of uninsured, underinsured, Medicaid and Medicare patients they treat.
- Insurance verification and approval/denial related to EMS transports only happens after the transport is provided.

EMS agencies are only paid for transporting patients to facilities and not for the care they provide.

- EMS can't respond if it isn't ready to respond.
- Because EMS is a transport benefit instead of a healthcare benefit EMS is only paid for the transport-related services and not for the care they provide – especially when EMS evaluates and treats patients on the scene but does not take them to a hospital.
- Except in rare instances, EMS receives nothing for ambulance responses that don't result in transports or for treatment provided to patients on scene. What this means is that there is a built-in incentive to transport patients, even those who could be successfully cared for in their homes or at a clinic, to a hospital. Therefore, Treatment in Place (TIP) is not a payable benefit for EMS agencies.
- Supporting TIP for EMS agencies through legislation would improve EMS agency funding.

EMS providers are not reimbursed for readiness costs.

- Readiness costs are all the costs associated with having ambulances ready to respond to an emergency call 24/7/365. They include equipped, staffed, insured, stationed, training, quality management, and other costs).
- Payers don't want to pay for readiness costs.
- Transport costs are all the costs directly associated with the transport itself.
- Readiness costs are reflected by the estimated $470 million costs of uncompensated EMS care.
- Some communities provide taxpayer support to help fund EMS. Others operate using only fee-for-service revenue. When EMS agencies cannot secure adequate fee-for-service revenues, one of two things happens: either all taxpayers contribute more (in the form of increased support), or agencies scale back or end EMS operations.

Higher costs and supply chain shortages worsen financial sustainability.

- Rising costs not offset by higher payments raise readiness costs and worsen EMS financial sustainability.
- Ambulance chassis shortage raised ambulance purchases by 40%.
- Operational costs such as Fuel, medical supply and equipment, utility, and repair and maintenance are further straining EMS sustainability. These rising costs are not being paid by payers.
- The consequence of the status quo is a gap in service that jeopardizes public safety. (COMMUNITIES THAT HAVE NO SERVICE) have all lost their EMS providers over the past few years. It is not required for any community to ensure its citizens have prompt access to EMS service.

Understanding HUTF & State Funding

What is the Colorado Highway Users Tax Fund? (HUTF)

- The HUTF is a statutorily defined, state-collected revenue distributed to the state, counties, and municipalities for specifically defined purposes.
- The basic fund derives from fuel taxes and various motor vehicle registration, title, license fees and taxes.
- The EMS Fund derives specifically from an add-on to the motor vehicle registration fee.
- The fee is collected per each motor vehicle registered in Colorado and is deposited into the Emergency Medical Services subaccount (EMS Account) of the Highway Users Tax Fund (HUTF).

History of the Colorado Emergency Medical Services HUTF Fund Account

- In 1989, the General Assembly approved a $1 surcharge on motor vehicle registrations.
- Originally, 20% of the account funded CDPHE's EMTS administration, 20% was divided between all counties as an EMS subsidy, and 60% funded the EMTS Provider Grants.
- In 2000, the Regional Emergency and Trauma Advisory Councils (RETACs) were formed and funded solely by the HUTF account.
- In 2009, SB-02 increased the motor vehicle registration fee to $2 starting in 2010.
- In 2019 Department of Revenue stopped collecting the $2 fee on non-motorized vehicle registrations resulting in an unanticipated annual decrease.

What does the HUTF-EMS account fund?

- Primary sustainment revenue source for the Emergency Medical and Trauma Services System.
- CDPHE- EMTS Branch Administration and Operations
- The 11 Regional Emergency and Trauma Advisory Councils (RETACs)
- EMTS Grants Program (Provider Grants, Education Grants, Emergency Grants)
- Trauma Registry, Peer Assistance, and Regional Medical Direction (RMD) programs
- Is currently the only identified funding source for Ambulance Licensing starting FY25.

Increased PRESSURE on the HUTF-EMS account

- Significant additional costs in ALL funded categories, while the fund revenue has decreased!
- Inflation - No increase since 2010 has resulted in a significant decrease in buying power.
- The 2018 changes implemented by the DOR resulted in a more than 20% unanticipated annual decrease.
- SB22-225 mandates CDPHE-EMTS Branch begin licensing ground ambulances at an anticipated cost of over $1 Million.
- Inflationary costs make RETAC funding increases long overdue.

Possible Solutions

- Increase the EMS surcharge to the motor vehicle registration fee to meet current needs.
- Return to collecting EMS fees on “non-motorized” vehicles as was originally intended in both 1989 and 2009 legislative actions.

HUTF & State Funding, continued

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HUTF - EMS Account Revenues and Expenditures per Year

Fiscal Year	Revenue	State Personnel, Operating and Overhead	RETAC	Provider Grants	Total
2015-16	$11,242,971	$2,446,080	$1,785,000	$ 6,231,580	$10,462,660
2016-17	$11,568,479	$2,582,641	$1,785,000	$ 7,838,451	$12,206,092
2017-18	$12,016,048	$2,837,325	$1,785,000	$ 7,494,971	$ 12,117,296
2018-19	$10,400,510	$2,782,555	$1,785,000	$7,862,269	$12,429,630
2019-20	$10,364,873	$2,751,027	$1,785,000	$6,368,499	$10,904,526
2020-21	$10,323,292	$3,006,235	$1,785,000	$4,425,328	$ 9,216,563
2021-22	$10,366,762	$3,271,469	$1,785,000	$2,952,328**	$ 8,008,797
2022-23	$10,795,618	$2,116,333	$1,785,000	$ 6,129,363	$10,030,696

	Appropriated FY 2023-24	**Projected FY 2024-25**
Year Beginning Fund Balance (A)	$ 6,141,573.64 $	$ 2,210,287.00
Revenue Total	$ 10.119,397	$ 10,169,397.00
Expenses Total	$ 14,632,202	$ 10,708,074.00
DETAILED EXPENDITURES		
Provider Grants	$ 6,397,860.66	$ 5,684,948.00
TOTAL	**$ 14,632,202.00**	**$ 10,708,074.00**
RETACs	$ 1,785,000.00	$ 1,785,000.00
EMS Program Total	$ 3,471,074	$ 3,513,126.00
TOTAL ESTIMATED EXPENDITURES	**$ 11,653,934.68**	**$10,983,074.04**

Understanding Mobile Integrated Health

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Why should EMS agencies only be paid for providing the most expensive service, by ambulance, to the most expensive place, a hospital emergency department?

What is Mobile Integrated Health or MIH?

• MIH, also called Community Paramedic services (CP), are lower acuity healthcare-related services provided by EMS agencies in the field (often a home or business) using a wide range of clinicians, including community paramedics, nurses, advanced practice nurses, physician assistants, behavioral health specialists and others. Community Paramedics:

- Free up ambulances to care for more acute and critical patients.
- Are state-licensed Community Integrated Healthcare Services (CIHCS).
- Programs focus on enhancing access to care, especially to marginalized populations and rural areas, improving services provided and patient outcomes, and lowering overall healthcare costs.

What kinds of services and care do MIH/CP programs provide?

- Focused on individual community needs.
- Engage in a wide range of services, including behavioral health and Mobile Crisis Response.

Re-inventing physician house calls using MIH/CP clinicians to perform assessments and diagnostic services and engage physicians via telehealth, receiving diagnoses, prescriptions, and other care instructions - all at a lower cost!

How do MIH/CP services lower costs?

- **Improve system efficiency** by more effectively utilizing available resources.
- Treating patients where they are instead of transporting them by ambulances to emergency rooms.
- **Decreasing** unnecessary ER visits.
- MIH/CP programs also **target at-risk population**s such as homeless or homebound people, and immigrants.
- MIH/CP service's direct costs are **less than half of ambulance** costs.

Requiring payment for MIH/CP programs would NOT cost more money but instead change how current monies are spent!

Primary takeaways:

- Even though MIH/CP programs are significantly less expensive, **we are not being paid** for it!
- MIH/CP must be **included in HCPF and DORA, DOI patient care payment program**s that enhance access to care, improve patient care and outcomes, and lower cost – including telehealth services.
- **Legislation needed** to require Medicaid and commercial payments for MIH/CP programs.

MIH/CP programs provide the right care at the right time and place at a significantly lower cost!

HB24-1218 by Reps. McCormick and Soper

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Colorado Ambulance Agencies Support Common Sense Solution to Protect Patients from "Balance Bills"

HB 24-1218 by Representatives McCormick and Soper creates a fair reimbursement structure that protects patients, taxpayers, and Colorado ambulance agencies.

Background
Insurance carriers **often** fail to pay the ambulance rates that cities, counties, and publicly accountable officials set for their communities. When this happens, a balance bill (equaling the difference between a health care provider's actual billed charges and the payment amount that the carrier unilaterally determines is "allowed") may be sent to the patient.

Colorado's current balance billing protections (HB19-1174) prohibit private ambulance agencies from issuing balance bills for emergency transports. However, only 51 of Colorado's 205 ambulance agencies (25%) are private. Out of the total 205 ambulance services, 154 (75%) are publicly funded fire or governmental agencies that can still balance bill patients for emergency transports. Patients who receive non-emergency ambulance service (such as transports between hospitals or transfers to rehab centers upon hospital discharge) from any ambulance agency are still subject to balance bills.

Our Solution
HB 24-1218 would prohibit all ambulance agencies from balance billing patients for emergency and non-emergency transports.
The legislation would require carriers to pay:

- Locally set rates for ambulance service, provided that the city, county, or district has reported the rates to the state for publication in a public database held by the Division of Insurance.
- Where locally set rates for ambulance service don't exist or haven't been reported, the lesser of the ambulance agency's billed charges or 325% of the Medicare rate.
- Ambulance agencies directly after a transport. Many carriers issue checks to patients – and expect patients to then reimburse ambulance agencies – which is confusing, inefficient, and not friendly to consumers.

Though few are able to do so, ambulance agencies could still enter into contracts with carriers directly.

Why This Matters
No Coloradan ever wants to call 911, but all deserve to have sustainable ground ambulance service available when it matters most. This measure will protect patients who need care from receiving "surprise" balance bills and establish clear reimbursement rates for supporting sustainable ambulance service in all Colorado communities.

Ground ambulance agencies and their patients need a different balance billing solution than the rest of the health care industry because of the unique nature of how services are provided. Under Colorado state law, paramedics and EMTs working on board ambulances have a **duty to provide care** and are required to be ready to serve all patients **regardless of their ability to pay.**

Ground ambulance agencies are funded almost exclusively through transport revenue and taxpayer subsidies which vary community by community. However, under current law, insurance carriers **aren't required to reimburse ground ambulance services at their locally set rates.**

FAIR Health data shows that, on average, carriers only pay 61% of out-of-network emergency ambulance charges in Colorado.

Bottom line is less transport revenue means more local tax support needed, and when insurance carriers don't pay locally set rates they are making decisions that can directly impact local tax spending. Few carriers enter into contracts with ground ambulance agencies. 63% of Colorado's ground ambulance agencies respond to fewer than 1,000 calls per year and carriers are unlikely to pursue in-network agreements involving so few claims (under 100 transports per carrier, per year).

Also, most small EMS agencies also lack the expertise and capacity to engage in detailed contract negotiations with multiple insurance carriers.

According to FAIR Health, nearly 60% of all ambulance transports in the U.S. are out-of-network.

HB 24-1218 gives Colorado the opportunity to prohibit balance billing for Colorado consumers and align with the recommendations adopted in late 2023 by the federal Advisory Committee on Ground Ambulance and Patient Billing. California, Texas and Louisiana adopted similar policies over the last year.

Fiscal notes prepared by these states showed **minimal, if any, cost impacts to carriers** (0.00% to 0.06%). Washington, New Hampshire, Indiana and Missouri are all considering similar legislation this year. HB 24-1218 may also help carriers save time and money they currently expend working to resolve payment disputes and complaints raised by patients and ambulance agencies.

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Cost of one ambulance

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☑	Ambulance	$ 260,000
☑	Cardiac Defibrillator	$ 36,000
☑	Patient Stretcher	$ 58,000
☑	Medications & Supplies	$ 8,000
☑	Rugged, HIPAA Compliant Computer	$ 4,000
☑	Spinal Care & Air Vacuum Fracture Splints	$ 4,000
☑	Medication Pumps	$ 2,350
☑	Portable Airway Suction Unit	$ 900
☑	Two Portable Medical Equipment Kits	$ 1,725
☑	Emergency Airway Kit	$ 1,725
☑	Intraosseous IV Kits	$ 1,000
☑	Automatic Patient Ventilator & CPAP	$ 15,000
☑	3 Mobile Ambulance Radios	$ 6,500
☑	2 Portable Crew Radios	$ 8,000
	Total to place 1 ambulance in service	**$407,200**
	+ Annual Fuel, Maintenance, Insurance	$ 42,000