

Emergency Medical Services Program Policies – Procedures – Protocols

Ambulance Rates Process (1006.00)

Overview

The Ambulance Rates Process defines the methods for establishing baseline rates, determining annual adjustments, and evaluating other rate change requests.

The goals of the process are to determine the most appropriate rates for ambulance services within the communities being served. Ambulance rates should reflect the performance required of the service provider, market conditions, and Medicare/MediCal reimbursement formulas.

Ambulance rate adjustments will be made using one of two methods – 1) an annual adjustment or 2) re-establishment of a baseline. Ambulance rates will be adjusted annually from the baseline using a cost of living index, unless there have been substantial changes in required operational performance, market conditions, or Medicare/MediCal reimbursement formulas. Once every five years ambulance rates will be thoroughly evaluated and a new baseline established. If an ambulance provider believes that the annual cost of living adjustment will be insufficient to offset operational costs, the provider may request that rates be re-evaluated, unless contractually prohibited. Such a request will initiate the process to re-establish baseline rates.

Establishing Baseline Rates: Establishing a baseline rate outside of a competitive RFP process involves an analytical method that uses a number of factors. The factors include actual expenses over time, actual revenues over time, a comparison of similar ambulance markets, a cost of living index based on consumer prices and a Medicare inflation factor, and ambulance industry metrics to evaluate operational efficiency and performance. This method will yield a valid baseline rate.

Method of Calculating a Baseline Rate: Calculating a yields a rate range, and any proposed rate request would be expected to fall within the range. Proposed rates falling outside the range are likely to be either too high or too low relative to demands placed on the ambulance provider.

The method used to calculate a baseline rate is not based solely on revenue and expenses. A standard metric within the emergency medical services

industry is unit hour utilization ratio (UHUR). UHUR is an indicator of the operational efficiency of an ambulance company. Like any metric, UHUR by itself does not provide a comprehensive perspective of any operation. However, it is a valid gauge when used in combination with cost and revenue factors to measure efficiency.

For example, proposed rates that are at the high end or above the expected range and the ambulance company has a low UHUR number may indicate the operation is inefficient. The proposed rates may be at a high level to offset costs associated with operational inefficiencies.

Use of the UHUR as a metric for benchmarking efficiency is only valid as a comparison to a similar service area. Comparing a rural operator's UHUR to an urban area operator's UHUR would likely not be a valid comparison. Rather, urban should be compared to urban, and rural compared to rural.

The factors collected and used to establish a new baseline rate include:

- Analysis of actual expenses over a period of years,
- Analysis of actual revenues over a period of years, including payer mix
- A comparison of rates of similar ambulance markets,
- A cost of living index based on consumer prices and a Medicare inflation factor, and
- UHUR to evaluate operational efficiency and performance.

Annual Rates Adjustment: Once a valid baseline rate has been established, the rates will be adjusted annually in accordance with a cost of living index. This will be applicable to those providers that have executed an interim performance contract or long-term performance contract with the County.

The initial rate for any provider will be that rate that was in effect at the time the applicable performance contract was executed. The ALS, BLS, and CCT base rate amounts will be adjusted annually prior to each July 1 thereafter. The adjustment will be calculated by multiplying the provider's annual average charge per transport by the Consumer Price Index, Series ID CUSR0000SEMC04, Services by Other Medical Professionals, published by the U.S. Department of Labor. The CPI will be adjusted to reflect the provider's payer mix.

A maximum of four annual rate adjustments will be made for each provider from the establishment of a baseline rate. The baseline rate must be re-established using the Method of Calculating a Baseline Rate described herein before a provider is eligible to receive another annual rate adjustment. Ambulance providers choosing not to submit sufficient information to facilitate the re-establishment of a baseline rate will not be eligible for the annual rate

adjustment. At a minimum, a baseline rate would need to be re-established every fifth year to be eligible for ongoing annual rate adjustments.

Other Rate Change Requests: Ambulance providers may seek a rate adjustment if it is believed that specific circumstances warrant change inconsistent with the Annual Rate Adjustment. The Method of Calculating a Baseline Rate will be used to evaluate the proposal. The ambulance provider initiating the request will submit all information necessary to facilitate such an evaluation.

Annual Rates Adjustment

The Board of Supervisors will consider adjusting base and standby rates annually using the procedures detailed below.

- A. The maximum rates chargeable to the public as established in a provider's performance contract may be adjusted annually prior to July 1, beginning in the calendar year following the initial contract execution date.
- B. Each contracted ambulance provider who is subject to rate regulation shall submit the following information to the EMS Division prior to March 1 of each year. This data shall be submitted every year, regardless of the CPI percentage change from the prior year.
 1. Number of transports for the previous calendar year, for each of the following payer categories:
 - a. Private Pay
 - b. Facility Contract
 - c. Private Insurance
 - d. Medi-Cal
 - e. Medicare
 - f. Collection Agents
 2. Gross charges for ambulance service for previous calendar year for each of the payer categories listed in number 1.
 3. Net revenue for ambulance service for the previous calendar year for each of the payer categories listed in number 1.
 4. Operating expenses for the previous calendar year.
 5. Number of unit hours for the previous calendar year.
 6. A statement from a certified public accountant licensed in the State of California attesting to the accuracy of the financial data being provided.

- C. The average gross charge per transport and the payer mix for the past calendar year will be calculated. The annual adjustment will be calculated by dividing the CPI percentage change by the payer mix rate, and then multiplying the quotient by the average charge per transport. The dollar amount will be added to the base rate categories. Payer mix is calculated by dividing annual gross revenues by annual gross charges. Standby rates will be changed simply by the CPI percentage change, as payer mix is not an appropriate factor to consider in adjusting standby rates. All other rate categories will remain unchanged.
- D. The Consumer Price Index to be used for the cost of living adjustment calculation shall be as compiled and reported by the U.S. Department of Labor, Bureau of Labor Statistics, annualized, as follows:
 - 1. Series ID: CUSR0000SEMC04
 - 2. Adjusted: Seasonally Adjusted
 - 3. Area: All Urban Consumers, U.S. City Average
 - 4. Item Category: Services by Other Medical Professionals
- E. Each ambulance provider will be eligible for a maximum of four consecutive annual rate adjustments of a valid baseline rate. No additional annual rate adjustments will be allowed until a valid baseline rate has been re-established using one of the two methods described herein.
- F. The County may forego, reduce, or increase the annual rate change amount if there have been any of the following circumstances since the last rate adjustment 1) substantial changes in required operational performance, 2) substantial changes in Medicare or MediCal reimbursement rates, or 3) substantial changes in market conditions.
 - 1. The decision to deviate from the annual rate adjustment formula based on the listed circumstances will be entirely at the Board of Supervisors' discretion.
 - 2. The parameters of any substantial change, as used in this Section, will be entirely at the Board of Supervisors' discretion.
 - 3. Proposed annual rate adjustments require approval of the Board of Supervisors.
- G. Ambulance providers with a valid long-term performance contract that was obtained without a competitive process (e.g. grandfather provision) are not eligible for an annual rate adjustment described herein, until a baseline rate has been established.

Method of Calculating a Baseline Rate

An ambulance provider proposing to charge any ambulance rate amount or ambulance rate category in excess of the maximum amounts or categories established by the Board of Supervisors shall establish a valid baseline rate using this process. Provider shall submit a formal written request to the Department to initiate the process.

- A. The written request will include all of the following:
 1. Provider name, address, and contact information;
 2. The specific rate or rates, rate category or rate categories planned for change;
 3. A narrative justification for the requested change(s), including reasons for the change(s), any measures taken to contain costs, and implications if the change(s) is/are not approved; and
 4. Signature of the CEO, President, or owner of the ambulance service.
- B. Applicant shall provide information related to scope, reimbursement, costs, and other factors currently and since the last rate change for the operational area, as follows:
 1. Initiation or termination of any levels or service:
 - a. For any ambulance service;
 - b. Ambulance or related services served by the business unit outside the area (neighboring area, other contract in the region, etc.);
 - c. Within the area (CCT, helicopter, gurney van, wheelchair van, special events, first response, etc.);
 - d. The purpose of collecting information on initiation or termination of services is to determine the impacts, if any, on the ambulance business. Shifting of costs to or from the ambulance service is an important consideration in establishing ambulance rates.
 2. Any general changes in the local business climate that the provider believes justify a rate adjustment (entry or exit of competitors, regulation, changed demographics, costs, etc.);
 3. A detailed analysis of positive and negative revenues and expenses that support the requested rate review;
 4. Expenses beyond the reasonable control of the provider (industry-wide cost increases for insurance, taxes, governmental compliance);

5. Any reductions in productivity, changes in deployment methods, and increases in labor or benefit costs;
 6. Changes in corporate allocations, inter-company charges, overhead, payments to related companies and bonuses or increases in executive compensation; and
 7. Any temporary cost increases such as those for fuel or insurance.
- C. Applicant shall provide a profit-loss statement for each of the past three consecutive years. The following information may be requested by the Department:
1. Adequate financial data, including accounts receivable records, benefits documentation, financial statements, aggregate payroll information, contracts, invoices, and other records that provide clear and convincing support of the requested rates; and
 2. Affidavit from the applicant's certified public accountant that the profit-loss statement accurately reflects status of the business and is based on complete, accurate, audited, or reviewed and examined records.
 3. Business information considered to be proprietary by the applicant may be submitted to a third party for review and verification in accordance with Section L, rather than submitted to the Department. In instances where a third party is used, third party certified public accountant shall certify under penalty of perjury that the statistical information provided for Appendix C is true and correct to the best of his/her knowledge and belief based on the confidential business information he/she reviewed.
- D. The provider(s) may submit any other documentation to support the request.
- E. Applicant shall provide market comparison information as described in Section 3 of Appendix B. Completion of the form in Appendix D will provide the required information.
- F. Applicant shall submit the statistical information listed in Appendix C to enable the Department to analyze and evaluate of the proposed rate change.
- G. The ambulance rate change request will be reviewed for completeness and accuracy. Incomplete or inaccurate applications will not be processed. The Department will notify the applicant of any additional or revised information needed to deem the application complete.
- H. Once an ambulance rate change request is submitted by an ambulance service to the Department, the requested change(s) shall be final. An

ambulance service may withdraw an ambulance rate change request in writing at any time prior to the final decision by the Board of Supervisors.

Evaluation Process

- A. The Department will evaluate the completed ambulance rate change request. Any data may be subject to third party review and examination at the discretion of the Department. If the department requests a third party review and examination, the applicant shall pay all expenses.
- B. The Department evaluation will include analysis of the following:
 - 1. Costs and cost sources, and revenues and revenue sources;
 - 2. Demand and performance, including unit hour utilization, total costs, unit hour cost, total cost per transport, and total cost per capita;
 - 3. A market comparison of similar ambulance providers and/or ambulance services provided in other jurisdictions;
 - 4. Extraordinary costs experienced by the applicant;
 - 5. The appropriate consumer price index; and
 - 6. Fluctuations and changes in Medicare reimbursement.
- C. The Department may require additional specific data, including but not limited to prior year data for comparison purposes, during the evaluation process.
- D. To the extent authorized by law, the County will maintain records specifically designated proprietary by an ambulance service, as confidential. Producing the statistical information required in Appendix C and Appendix D may involve review and verification of proprietary business information. The Department or applicant may request that detailed proprietary business information necessary to produce or verify the accuracy of the required statistical information be referred to a third party source. Use of a third party source would be for purposes of maintaining confidentiality of proprietary business information and/or to verify accuracy of the information used in the County rate review process. The County will select the third party. The third party will be an individual or organization that is 1) independent from the applicant, 2) based outside Kern County so as to avoid any inherent possible bias, 3) experienced in the healthcare industry, and 4) that will ensure the financial analysis component is conducted under the direction of a certified public accountant. Representatives from the organization analyzing the proprietary business information will be required to sign a County approved agreement to maintain confidentiality of applicant's proprietary records, if so requested by the applicant. The aforesaid agreement shall be subject to the applicant's prior approval. The

applicant shall reimburse the County for all costs associated with the third party.

Market Comparison

- A. During the baseline rate calculation process, the Department will analyze and compare current and requested ambulance rates using a market comparison methodology. The market comparison methodology will follow procedures outlined in the Appendix B.
 - 1. The Department will compare the Survey Comparison Price, the applicable comparison price index change, and the Medicare Index Comparison Price. This information will be used to establish a comparable baseline market comparison price range.
 - 2. The market comparison price range will be adjusted to account for any local government payments for indigent services provided to the ambulance provider. This will be the adjusted average charge per transport range.
 - 3. The Department and the provider will determine, based on the frequency of use and level of reimbursement for each charge item, a rate schedule that will produce an adjusted average charge per transport that falls within the acceptable rate range.

Cost Validation/Performance Efficiency Evaluation

- A. The Department will evaluate ambulance service costs and efficiency in maintaining services to meet or exceed minimum performance standards.
- B. The Department may examine alternatives, both internal and external of the ambulance service, to reduce costs. If such analysis is conducted, it may be included in the Department's final recommendation to the Board of Supervisors.

Rate Increase Review Guidance

- A. The burden of proof in justifying a rate increase is on the provider making the request (applicant).
- B. Local rate increases should not be used to subsidize growth or expansion of the provider's services in other jurisdictions.
- C. Issues generally beyond the reasonable control of the provider will be considered in the evaluation. For instance, reductions in Medicare or

Medi-Cal payments resulting from changes in either program, industry-wide cost increases for insurance, taxes, governmental compliance, and clinical advancements may be considered beyond the provider's reasonable control. Such cost increase may be valid evidence for increasing rates. Reduced efficiency in collections as a result of provider effort may not be considered valid.

- D. Reductions in productivity, changes in deployment methods, and increases in labor or benefit costs may be considered. Sufficient documentation must be presented to illustrate improvements in response times, clinical capabilities, or labor availability. The provider is expected to make a clear and convincing case that increasing ambulance service rates are in the public interest.
- E. Significant changes in corporate allocations, inter-company charges, overhead, payments to related companies, and bonuses or increases in executive compensation, above and beyond compensation paid to the rank and file employees, will generally be considered in the full control of the provider. Costs that are in full control of the provider may not be considered sufficient justification for increasing ambulance rates. If the provider is able to adequately document that certain corporate or inter-company charges reasonably represent and pay for services that would otherwise be paid directly by the local operation, those costs may be considered. The burden of proving the reasonable level and direct expense nature of these charges is on the provider(s) making the request for rate review.
- F. In some cases, the County may entertain temporary rate increases in response to temporary cost increases such as those for fuel or insurance.
- G. Providers will furnish adequate financial data and documentation to provide clear and convincing evidence that the requested rates are justifiable.
- H. The baseline rate methodology described herein shall not be used to override ambulance performance contracts that restrict or prohibit the pursuit of rate changes.



Ambulance Rates Process (1006.00)

Revision Log:

- 4/19/2005 – Approved by Board of Supervisors
- 6/19/2007 – Board of Supervisors approved addition of Appendix E, updated format and cover, add TOC
- 6/17/2008 - Board of Supervisors approved addition of Appendix F to add process for fuel surcharge
- 12/17/2013 - Revise methodology for annual rate adjustment

Appendix A - Glossary of Terms

Unit Hour: The basic unit of production in EMS is a unit hour. A unit hour is defined as one hour of a stocked and staffed ambulance unit, available for, or assigned to a call, or otherwise engaged for a period of one hour. One staffed ambulance on duty for eight hours produces eight unit hours. Unit hours may be classified as productive, non-productive, wasted, etc.

Response: A response is any instance in which an ambulance is dispatched to a call for emergent or non-emergent ambulance services. The response may be cancelled according to local EMS protocols, result in a transport, or result in a non-transport or patient refusal of service.

Transport: A transport is the occasion of one ambulance taking one patient to the hospital or other appropriate destination. Productivity is tied to transports because ambulance providers bill primarily for transportation rather than clinical care. For purposes of this Ambulance Rate Evaluation Process, each patient transported by an ambulance will count as one transport. For example, one ambulance that simultaneously transports three patients will be credited with three transports.

Unit Hour Utilization Ratio (UHUR): The Unit Hour Utilization Ratio is the industry standard measure of productivity in EMS. The UHUR is result of dividing the number of transports by the number of unit hours in a given situation.

$$\text{UHUR} = \frac{\text{Transports}}{\text{Unit Hours}}$$

An ambulance that transports eight patients in a 24-hour day would achieve a UHUR of 0.33. In other words, it would produce one transport for every 3 hours on duty.

$$\text{UHUR} = \frac{8 \text{ Transports}}{24 \text{ Unit Hours}} = 0.33$$

Normally, unit hours produced especially to cover standby events and long distance transports are not included in the calculation of the UHUR.

Net Net Revenue (NNR): Typically, ambulance providers are unable to recover 100 percent of the gross amount charged for services due to a number of factors; the payer mix. Net Net Revenue (NNR) is the amount of revenue actually received for all services. NNR is calculated by determining the total gross amount charged for services, minus the sum of the amount of facility contract allowances and the amount of other unrecoverable receivables (bad debt). Any other payments for ambulance service are added to the sum. These would include payments from County for indigent services, or membership fees.

Net Net Revenue = (Gross Amount Charged for Service – (Total Facility Contract Allowances + Total Other Unrecoverable Receivables)) + Payment Received from County for Indigent Services

If an ambulance provider is unable to collect 100 percent of the amount charged for services, it is important to determine the actual amount received. In this example, the provider's total gross charges are \$3,000,000. The provider has a contract with a hospital for transfer services for a ten percent reduction in service costs, resulting in a \$250,000 allowance. Medicare covers several of the patients transported throughout the year, and only a fraction of the amounts charged are received as revenue, resulting in \$850,000 in unrecoverable receivables. Additionally, fifteen percent of the patients transported were uninsured and have no ability to pay for services, resulting in a \$450,000 in unrecoverable receivables. The provider and County have a contract for indigent services resulting in a flat annual payment of \$7,000 to the provider.

$$\text{Net Net Revenue} = (\$3,000,000 - (\$250,000 + (\$850,000 + \$450,000))) + \$7,000$$

$$\text{Net Net Revenue} = \$1,457,000$$

NNR per Unit Hour: NNR per Unit Hour is defined as the total cost of providing ambulance services for a given period of time divided by the total number of unit hours produced during that same time period. Unit hour cost is described as fully loaded, meaning that full (direct, indirect, fixed and variable) costs. All unit hours are used in the calculation are to be either fully loaded or marginal. Marginal unit hour costs are used in evaluating marginal increases and decreases in business volume and resources. Marginal unit hour costs use only specified direct, variable costs as a means to identify impacts from a specified factor.

$$\text{NNR per Unit Hour} = \frac{\text{Net Net Revenue}}{\text{Total Unit Hours}}$$

An ambulance company producing 50,000 unit hours at an annual cost of \$5 million would have a fully loaded unit hour cost of \$100/uh.

$$\text{NNR per Hour Cost} = \frac{\$5,000,000}{50,000 \text{ Unit Hours}} = \$100/\text{uh}$$

If the same company produces 10 unit hours per week at a direct cost (personnel, supplies, gas, etc.) of \$750/week, its marginal cost of producing the additional unit hours is \$75/uh.

NNR per Transport: The NNR per Transport is calculated by dividing the Net Net Revenue of providing ambulance services for a given period of time by the number of patients transported during the same time period.

$$\text{NNR per Transport} = \frac{\text{Net Net Revenue}}{\text{Total Patients Transported}}$$

Patient Transports

An ambulance company transporting 15,000 patients at an annual cost of \$5 million would have a Total Cost per Transport of \$333.33.

$$\text{NNR per Transport} = \frac{\$5,000,000}{15,000 \text{ Transports}} = \$333.33$$

NNR per Capita: The annual NNR per Capita is defined as the total costs incurred by all emergency and non-emergency ambulance providers serving a population divided by the number of people comprising the population. It is important to note that if more than one ambulance service serves an area, the evaluation of Cost per Capita is meaningless unless the costs for all providers are included in the calculation.

$$\text{NNR per Capita} = \frac{\text{Net Net Revenue}}{\text{Population}}$$

If an exclusive (emergent and non-emergent) ambulance provider serves a population of 150,000 at an annual cost of \$5 million, its cost per capita is \$33.33.

$$\text{NNR per Capita} = \frac{\$5,000,000}{150,000 \text{ people}} = \$33.33/\text{capita}$$

If one ambulance provider serves the 911 segment of the same market, at a total cost of \$4 million and another company serves the non-emergency, interfacility segment of the market at a total cost of \$2 million the total cost per capita of the system is \$40.00.

$$\text{Total Cost per Capita} = \frac{\$4,000,000 + \$2,000,000}{150,000 \text{ people}} = \$40.00/\text{capita}$$

Appendix B – Market Comparison Methodology

Market Comparison Methodology: Calculating a Baseline Rate includes a provision that the Department will conduct a comparison of current and requested ambulance rates using a Market Comparison Methodology. The Market Comparison Methodology will include the following procedures:

1. The Department will review the applicable consumer price index (CPI).
2. The Department will review the Medicare Inflation Index for ambulance services, issued annually in January, by the Federal Centers for Medicare and Medicaid Services (CMS). This information will be used to determine Medicare's estimates of and allowances for inflation since the last price adjustment for the provider whose rates are being evaluated.

Example:

It is December 2005. Provider A last received a rate adjustment in December 2003. CMS implemented an Inflation Index of 2.1% for 2004. For 2005 (hypothetically) CMS implements an Inflation Index of 3.0% for 2005. Using the following formula, the Department determines that the Medicare Inflation Index has increased by 5.1%

$$\begin{array}{r} 2.1\% \text{ [CMS IIC 2004]} \\ + \underline{3.0\% \text{ [CMS IIC 2005 (hypothetical)]}} \\ 5.1\% \text{ [Medicare Inflation Index Increase]} \end{array}$$

The applicant and the Department will each attempt to identify the current ambulance rates for five EMS systems with similar attributes to the market being evaluated. These attributes might include similar market size, call volume, geography, response time performance, exclusivity or non-exclusivity, clinical sophistication, and other attributes. Applicant and Department will identify the attributes of each EMS system that justify its similarities to the applicant's market(s). At least three attributes of each identified system must be similar to the applicant's market. Information regarding the current total charges billed, total number of transports, and the total subsidy or government payments received for indigent services (cash and non-cash) must be obtained for the systems of comparison. Total cost per unit hour will be obtained, if available.

The Department may eliminate two EMS systems identified by the applicant from further consideration. The applicant may eliminate two EMS systems identified by the Department from further consideration.

The remaining identified EMS systems may be reviewed for purposes of understanding the similarities to the applicant's system. The Department may eliminate systems of comparison from further consideration if it is believed use of the system unrealistically skews the average charge per transport or cost per unit hour data is not available, at the Department's discretion.

If the applicant elects not to provide, or cannot obtain information about comparable EMS systems, only the information obtained by the Department will be used in the calculations. In such a circumstance, the applicant waives their ability to disqualify the Department's choices for comparable EMS systems.

The Department will compare each of the system attributes to identical data type for the applicant. The price used for comparison shall be total charges plus subsidies and/or government payments for indigent services (GPIS). An average charge per transport will be calculated using the following formula:

$$\frac{\text{Total Charges Billed} + \text{Total Subsidy and/or GPIS}}{\text{Total Transports}} = \text{Average Charge/Transport}$$

The result will be compared to the surveyed systems to determine the 50th, 75th, and 90th percentile of Average Charge per Transport for the selected EMS systems. The 75th percentile will be the **Survey Comparison Price**.

4. The Department will compare the Net-Net Revenue per Transport to the CPI using the following method:
 - a. Compute the Net-Net Revenue per Transport of the provider at the last rate adjustment. This will be the **NNR-Baseline**.
 - b. Determine from provider records the percentage of Transports billed to Medicare, MediCal and other fixed reimbursement governmental payers.
 - c. Determine the approximate collection rate for all other payers combined.
 - d. Multiply the NNR-Baseline by the percentage increase or decrease in the CPI. This will be the **NNR-CPI**.
 - e. Subtract the NNR-Baseline from the NNR-CPI to determine the required increase or decrease in Net-Net revenues required to adjust for inflation as determined by the CPI. This will be the **NNR-CPI Adjustment**.
 - f. If the NNR-CPI Adjustment is a negative number, subtract it from the NNR-Baseline and proceed to the final rate comparison. This will be the **CPI Comparison Price**.
 - g. If the NNR-CPI Adjustment is a positive number, divide the NNR-CPI Adjustment by the percentage of transports that that are billed to payers other than Medicare, MediCal and other fixed reimbursement government payers. This will be the **Medicare Adjusted Price**.

9. The Department and the provider will negotiate, based on the frequency of use and level of reimbursement for each charge item, a rate schedule that will produce the calculated Adjusted Average Charge per Transport. Typically, the dollar change in the Adjusted Average Charge per Transport will be added to or subtracted from the ALS and BLS base rates, and all other rate categories will remain unchanged.

Appendix C – Ambulance Provider Statistical Information

Applicant Statistics

Provider		
Operational Area No(s).		
	Period of Last Rate Change (Year or FY)*	Current Period (Year or FY)*
Date Period		
No of Responses Annually		
No of Transports Annually		
Private Pay		
Facility Contract		
Private Insurance		
Medi-Cal		
Medicare		
Collection Agents		
Gross Charges Annually		
Private Pay		
Facility Contract		
Private Insurance		
Medi-Cal		
Medicare		
Collection Agents		
Net Revenue Annually		
Private Pay		
Facility Contract		
Private Insurance		
Medi-Cal		
Medicare		
Collection Agents		
Annual Operating Expenses		
No. of Unit Hours Annually		

* Whichever period is provided (calendar year or fiscal year), the interval must be the same for both columns.

EXTRAORDINARY COSTS

Scope of service	Amount	Short Description
Added Services		
Discontinued Services		
Change of Service Area		
Regulatory		
Competitive		
Demographic		
Productivity		
Reimbursement Issues		
Medicare		
MediCal		
Insurance		
Managed Care		
Payor Mix		
Cost Issues		
Industry-wide		
Labor/Productivity		
Overhead and Internal		
Temporary		
Other		
Other		

Appendix D – Market Comparison Worksheet

Market Comparison Worksheet

	Surveyed Providers									
	1	2	3	4	5	6	7	8	9	10
Jurisdiction										
Service area (Sq Mi)										
Population										
Total Responses (last full year)										
Total Transports (last full year)										
Total Unit Hours Deployed										
NNR/Unit Hour										
NNR/Transport										
NNR/Capita										
Unit Hour Utilization (UH/U)										
Total Charges Billed (last full year)										
Net Net Revenue										
Total Subsidy										
Average Charge/Transport										

Appendix E – Rate Categories and Definitions

- A. All contracted ambulance providers are authorized to include within their rate categories only a charge for the following:
1. Basic Life Support Base Rate, or
 2. Advanced Life Support Base Rate.
 3. Unscheduled Emergency Call, applicable to Response Priority Codes 1, 2, 3, 4, or 5.
 4. Use of Oxygen, per patient per transport
 5. Night Call, where time of dispatch is between the hours of 1900 and 0700.
 6. Mileage, one-way transport miles from scene to destination.
 7. Waiting Time, per quarter hour after first quarter hour period.
 8. Spinal Immobilization: long and short spine board, cervical collar application, sand bag/head immobilization and scoop stretcher. There shall only be one flat rate charge for any individual or combination of procedures listed per patient.
 9. Electrocardiogram: ECG monitoring, tape readout or telemetry or combination per patient. There shall only be one flat rate charge for any individual or combination of procedures listed per patient.
 10. Splinting: traction, cardboard, velcro, air and ladder. There shall only be one flat rate charge for any individual or combination of procedures listed per patient.
 11. Major Trauma/Medical Condition: defibrillation, CPR, MAST, thoracentesis (or thoracic decompression), and cricothyrotomy. There shall only be one flat rate charge for any individual or combination of procedures listed per patient.
 12. Disposable Supplies: oxygen supply tubing, nasal cannula, oxygen mask, disposable oxygen humidifier, disposable linen, disposable cervical collar, bandaging/tape supplies, and irrigation solutions. Charges for disposable supplies shall not be assessed if ambulance is re-stocked by the hospital.
 13. Extra Attendant: one flat rate charge for extra EMS certified personnel that is
 - a. An employee of ambulance provider whose presence is required by written physician order; or

- b. Any other medically qualified personnel such as registered nurses, employed by the ambulance provider, whose presence is required by written physician order; or
 - c. An employee of ambulance provider whose presence is required to provide for adequate critical patient management during transport, at the discretion of attending ambulance paramedic.
- 14. Advanced Airway Maintenance: endotracheal intubation, nasotracheal intubation, nasogastric intubation, ventilation assistance, and suctioning. There shall only be one flat rate charge for any individual or combination of procedures listed per patient.
- 15. Medication Administration. There shall only be one flat rate charge for any individual or combination of procedures listed per patient of paramedic scope of practice medication administration initiated at scene or during transport.
- 16. Venipuncture: blood draw or intravenous fluid administration. There shall only be one flat rate charge for any individual or combination of procedures listed per patient of paramedic scope of practice venipuncture initiated at scene or during transport.
- 17. Special Handling includes any of the circumstances listed below. There shall only be one flat rate charge for any individual or combination of procedures listed per patient.
 - a. Off road terrain that caused actual damage to the ambulance. Off road does not include road shoulders, turnouts, parking lots, and other areas near the paved roadway.
 - b. Water rescue or rope rescue wherein ambulance provider personnel assisted in patient movement.
 - c. Extrication of a patient from a vehicle involving the use of rescue tools to effect safe patient movement, wherein ambulance provider personnel assisted in extrication.
 - d. Any known hazard at the scene or during patient transport that presents a physical threat to ambulance provider employees.
 - e. There may be four different rates for "a" through "d" above, however; only one charge per patient may be made from the special handling rate category.
- 18. Pulse Oximeter. There shall only be one flat rate charge for paramedic scope of practice use of pulse oximetry initiated at scene or during transport per patient.

19. Ambulance Standby Service: Minimum standby charge is four hours (a two-hour minimum, plus an hour for set-up and an hour for clean up). The ambulance provider may negotiate the beginning and ending times of each standby and the level of coverage with the requesting party. The ambulance provider shall only charge for standby services when such service is both requested to be and provided with a dedicated ambulance. The ambulance provider is encouraged to provide non-dedicated standby coverage to community-service-oriented entities' events, when possible. Notwithstanding Section C. below, an ambulance provider may reduce or waive its standby rate, at the ambulance provider's discretion.
- a. BLS Ambulance Standby Rate, per hour: service provide by a basic life support ambulance and crew.
 - b. ALS Ambulance Standby Rate, per hour: service provide by an advanced life support ambulance and ALS crew.

The Board of Supervisors as part of the Annual Rate Adjustment process, using the CPI index and percent change factor, may adjust standby rate amounts at the time base rate amounts are adjusted.

20. Non-Transport Dry Run: the ambulance provider arrived at scene, provided on-scene patient assessment and administered care at the request of the patient or request of known responsible private party if applicable, but patient transport was refused (or transport not provided because patient was deceased). Non-Transport Dry Run may be charged under the following circumstances:
- a. Response to a commercial location for an employee at the request of an employee of the business.
 - b. Response to a hazardous materials incident caused by a known responsible private party.
 - c. Department requested response under the Kern County Med-Alert System to a disaster or potential disaster caused by a known responsible private party.
 - d. Response at the request of the patient, patient's family, or a legal guardian/ conservator of the patient.

The amount charged for Non-Transport Dry Run shall not exceed the sum of the itemized (Section A, No. 1 or 2 through 5, and No. 7 through 18, as applicable) services provided on-scene by the ambulance provider. In no case shall the maximum rate for Non-Transport Dry Run established by the Board of Supervisors be exceeded. An ambulance provider may charge for either an Ambulance Standby Service for use of a dedicated ambulance if applicable or for a Non-Transport Dry Run for the same incident if applicable, but not for both rate categories. Notwithstanding Section C.

below, an ambulance provider may reduce or waive its Non-Transport Dry Run charge, at the ambulance provider's discretion.

- B. Ambulance providers shall not charge more than one complete base rate, plus other applicable individual charges, per patient, per transport. The number of patients during transport must be able to be treated appropriately during transport by the medical personnel. The medical applications provided for each patient must appear on the individual appropriate Prehospital Patient Record in order for the charge to be billed.
- C. Ambulance provider shall not bill patients or third party payers at a rate less than the fee schedule established by the Board of Supervisors unless the ambulance provider can demonstrate that there is a cost benefit in doing so (e.g., discount for prompt payment, or claims simplification). Such arrangements made by an ambulance provider and a customer will not be affected by these procedures. However; the agreed upon rates shall not be higher than the rates established by the Board of Supervisors. The requirement to bill patients or third party payers at a rate less than the fee schedule shall not apply to government or third party payers who by Federal or State law are not obligated or required to make reimbursement at usual and customary rate(s).

Appendix F– Fuel Surcharge Calculation Process

1. Determine the price of diesel fuel beginning January. This will be the benchmark price for fuel surcharge calculation. Using January as the benchmark month (or starting point), the average price for a gallon of diesel fuel will be determined.
2. The Energy Information Administration of the US Department of Energy posts diesel fuel prices for California weekly, and this data will serve as the source of fuel pricing information. The posted weekly prices for each month will be averaged to determine the monthly price. Determine the average price of diesel fuel for the past month.
 - a. For example, diesel prices from the Energy Information Administration for April 2008 are listed below. Using the figures, the average price for April has been calculated. The average price of \$4.265 will be inserted into the surcharge formula.

4/28/2008	\$4.390
4/21/2008	\$4.317
4/14/2008	\$4.234
4/7/2008	\$4.118
Average	\$4.265

3. Subtract the January price from the average monthly price. If the difference is a negative number, no surcharge is allowed. If the difference is a positive number, then a surcharge will be calculated.
4. Multiply the difference in per gallon price by 0.4 to produce the ambulance provider's estimated per chargeable mile fuel cost.
5. Multiply the ambulance provider's payer mix by the estimated per mile fuel cost. This step produces the allowable surcharge.
 - a. payer mix is calculated dividing the annual gross revenue by the annual gross charges.
6. Add the allowable surcharge to the base per mile charge to yield the maximum amount an ambulance provider can charge per mile.

Surcharge rates will be recalculated monthly, once all of the weekly pricing information for the entire prior month becomes available. Ambulance providers will be allowed to assess the revised surcharge as soon as the rate is posted on the Department's

website. Fuel surcharge rates will be calculated and posted as near to the first day of the new month as possible.

The fuel surcharge formula and rates will be evaluated annually by the Board of Supervisors to confirm its continued implementation. The surcharge process may be revised or revoked by the Board of Supervisors at any duly noticed public hearing.

Once ambulance service rates are adjusted, using either by establishing a new baseline rate or through the CPI factor process, the benchmark of the fuel surcharge formula is automatically re-set to January of the current year. For example, an ambulance provider gains approval of a rate adjustment by the Board effective July 1 of the current year, as part of the cost of living adjustment. The January benchmark for the fuel surcharge formula will be re-set to the current year.