



MONOC's Paramedic Services;

How We Determine What to Charge and Why it Seems so Much?

A State Mandated, Unique Two-Tier System

There are two levels of EMS (emergency medical services) in New Jersey. They are separate and distinct from each other, and each serves a specific need. The most basic level, called BLS (Basic Life Support), is the only service that responds when most ambulance calls are received. Usually, the local first aid squad (or a paid BLS ambulance service) responds and often at least EMTs (emergency medical technicians) render basic medical aid¹. The EMTs splint fractures, dress wounds, perform CPR and so forth. They are the front line of pre-hospital care in emergency situations. In many cases, the BLS EMTs volunteer their time, do not charge for their services, and receive funding through municipal and individual donations.

But, by law, BLS EMTs can not administer medications, insert breathing tubes, or start intravenous lines. These more critical skills are reserved for caregivers with substantially more training, know as paramedics. New Jersey's paramedic system is called ALS (advanced life support). ALS is needed when patients are seriously ill or injured. In New Jersey, paramedics respond in MICUs (Mobile Intensive Care Units) that often look like ambulances. The ALS Paramedics are ***not*** volunteers, but are paid, career professionals. Paramedics respond to the most serious, life threatening requests for help. Dispatchers use a set of State issued, specific criteria to help them decide when to send only the BLS squad, and when it is necessary to send both the BLS & ALS units. In the worst cases, like severe trauma, respiratory difficulties or cardiac problems, paramedics are dispatched along with the local BLS squad. The BLS & ALS units operate as a team in these cases. All paramedic services in New Jersey bill the patients they treat for the care they provide. This is because the ALS Paramedics are not subsidized or funded in any way through State or Local taxes. The ALS system's ***only*** source of revenue is through billing the patients that use the ALS service.

¹ In New Jersey, since volunteer BLS agencies that do not bill for their services are exempt from licensure and regulation, they determine their own training and staffing levels. It is not uncommon for one of these agencies to respond personnel that have limited or no training in emergency medical services to assist patients.



The Impact of Federal Billing Rules and the Provision of Charity/Indigent Care

Because of this, MONOC often receives questions regarding New Jersey's billing and reimbursement system for paramedic services. First, it is important to remember that the Federal and State laws and regulations that govern the Medicare and Medicaid programs (as well as New Jersey's indigent care programs), require specifically established "price caps" for more than 60% of the patients MONOC treats. Therefore, the most financially vulnerable in our society, including the elderly, are protected from substantial out-of-pocket expenses related to ambulance service. It is also important to remember that New Jersey's "charity care" hospital subsidy system does NOT provide ANY funds for MONOC's ALS service. Charity care patients pay nothing for the service and the ALS providers receive nothing for providing this care. In 2017, MONOC provided more than \$1.1 Million in free care for indigent/charity care patients.

New Jersey decided decades ago that the State's paramedic system would operate without tax monies or other public subsidy. As a result, paramedic services in New Jersey seek reimbursement through "fee for service" billing. In other words, those who use the system, pay for the system. Less than 5% of the population of the State uses paramedic services each year. It is this small number of patients that must "foot the bill" for the maintenance of the entire ALS system. Because of this, all paramedic services in the State must charge enough to each patient so that, at the end of the year, they have collected enough funds to cover their entire yearly costs of operation.

"Charge" versus "Revenue"

The average charge for paramedic service in New Jersey at the beginning of 2017 was about \$3,089. It is important to note that the amount a paramedic program actually receives in payment for the services it renders is far less than the amount charged. In MONOC's case, we receive, on average, about 50% the amount we charge. The methods by which the Federal government sets ambulance service reimbursement rates, and the way in which commercial insurance companies pay for ambulance service create this substantial "disconnect" between the amount that must be charged and the amount that is actually collected for providing the service.

Elements of a Charge for Paramedic Service

Due to this "disconnect", paramedic programs establish their charges so as to recover, on average, the cost of providing the service. There are four main components in calculating a service's charge; 1) cost per case of service, 2) number of cases not reimbursed, 3) amount of underreimbursement, and 4) length of time reimbursement takes.

Cost per Case of Service



In MONOC's case, each year we analyze how much needs to be spent in order to provide the level of service mandated by Federal and State laws/regulations, as well as to the superior level justly expected by the residents of our service areas. Some of these costs are market driven, such as salaries, employee benefits, costs of supplies and equipment, etc. Others are the direct result of mandates from the government; for example, certain regulations require that each paramedic unit carry relatively expensive equipment and medications on each vehicle; other rules specify how many vehicles must be in a provider's fleet; laws require that each paramedic program pay for direct physician management of every case. There are also costs that are simply inherent in the American model of medical care delivery, such as malpractice insurance costs, consumers' decisions to delay primary preventative care resulting in increased use of emergent healthcare, and our high national standard for acute healthcare provision. Finally, the state's two-tiered approach to EMS causes paramedic systems to subsidize BLS ambulance agencies that charge for their services because of a Medicare billing provision. This added cost of operation contributes significantly to the paramedic fee. *Amazingly, in some cases, BLS agencies actually refuse to cooperate with MONOC regarding Medicare billing rules, forcing us to provide care that would otherwise be paid for, for free or make the patient responsible for the entire bill. This drives the cost of ALS care needlessly higher.*

New Jersey's paramedic system requirements are more extensive when compared to most other states. In fact, the equipment and medications carried in our MICUs, and the medical care provided by our paramedics, are so advanced, patients now receive treatment in the field that they once had to wait to receive until they arrived at the hospital. This is one reason why paramedic bills are sometimes higher than the emergency department's fees. As a result, New Jersey has one of the most expensive, albeit one of the best, paramedic systems in the country.

Number of Cases Not Reimbursed

State and Federal laws require paramedic services to treat everyone who needs ALS care, whether they can pay for it or not. Other regulations financially protect the most vulnerable of our society, the elderly and the poor, through price caps and mandated discounts.

As noted above, some patients simply have no financial resources and do not pay for these services; among these are the homeless and the indigent. In 2017, MONOC provided more than \$1.1 million dollars worth of free or reduced-price care for charity care, indigent, Medicaid and other uncompensated/undercompensated patients. Since New Jersey's paramedic services do not receive tax subsidies or charity care payments of any sort, the cost for all of this free and/or heavily discounted care must then be spread out among the rest of the patients (and their insurance companies) who use the service and do pay for their care.

Amount of Under-Reimbursement



There are also a group of patients whose health insurance companies simply decide that they will only pay for a portion of the care that the patients require. It seems unbelievable that a health insurance company would fail to pay for necessary emergency care; however, it can and does happen every day. In many of these cases, these “underinsured” patients are unable to pay the balance due for their care. The converse is also true; there are those patients who have no insurance and can afford to pay some amount, but not the full charge. Again, the uncompensated cost to deliver care to these patients, must be spread to the remaining individuals who have full insurance coverage and/or can afford to pay the entire amount of the bill. In 2017, MONOC provided more than \$2.3 million in reduced price care for these kinds of patients

Length of Time Reimbursement Takes

The last component used to calculate a paramedic service’s charge is the length of time it takes for that service to receive payment from the patients and their insurance companies. The phrase “time is money” applies here in a very real sense. Employees must receive their salaries on pay-day; supplies, vehicles and equipment must be paid for in a timely manner; insurance, gasoline and rent bills must also be paid for on time. Failure to have sufficient cash on hand to pay these bills when due means that paramedic services, just like any other company, must borrow money to finance many of their expenses. Financing (taking loans, paying by credit, etc) causes the paramedic services to incur interest charges that increase the cost of operations. Insurance companies are notorious for taking months to pay submitted claims. The time it takes to collect payment from confused or resistant patients also causes significant delays in reimbursement.

There are other concerns as well that should be considered when examining the State’s EMS reimbursement system.

Not-For-Profit Agencies

MONOC, like every Paramedic service in New Jersey, is a not-for-profit agency; Monies that MONOC collects in excess of charges go back into the MONOC system to buy new ambulances, train the crews, and improve the service. For example, MONOC operates the most advanced dispatch center in the State; all of MONOC's vehicles are equipped with GPS locating devices that constantly send data to MONOC's computer aided dispatch (CAD) program over a wireless link. This system ensures that the closest ambulance is dispatched when a call for critical assistance is received, and cuts precious minutes off of response times, leading to better patient outcomes. This system helps MONOC to save more lives; investing in it, we feel, was money well spent for the benefit of our patients.

Mandates for Patient Balance Billing

Often, patients don’t understand why they receive a bill for co-payments or deductibles after their insurance company has paid whatever amount the insurer believes should be paid for the paramedic bill.



Some patients think that the paramedic service doesn't "need" to collect the copayment, and some even feel that the service is just being greedy. However, State and Federal law both mandate that patients be held accountable for their share of all healthcare bills (including paramedic service bills). The amounts that the patients pay include co-payments (sometimes called coinsurance), and deductibles. A paramedic service would be violating the law if it routinely waived these patient balances. In addition, because of these laws, the patient's portion of the paramedic bill is calculated as part of the revenue anticipated when a paramedic service develops its charge.

Collection Practices and Law Suits

Every healthcare agency uses different methods to assure payment for the services they provide. Most turn to collection agencies when accounts become substantially overdue. Collection agencies licensed by the State vary in the aggressiveness of their collection attempts, but all must comply with Federal laws concerning the collection of debts. MONOC utilizes collection services as needed. Such contact is authorized in two very specific types of cases: 1) when the patient has ignored repeated attempts from our billing department to contact them and resolve their account, and 2) when the patient, instead of MONOC, has received payment from their insurance company for our services, and has kept the money.

Any patient that can demonstrate genuine financial hardship associated with a MONOC bill may be eligible for an extended payment plan, a "sliding scale" fee adjustment, or, in extreme cases, free care, as mentioned above. It is ONLY where the patient REPEATEDLY REFUSES to speak with a MONOC representative, or CHOOSES to keep insurance money that is rightfully MONOC's, that, regrettably, MONOC must turn to a collection agency for assistance.

Paramedic Assessment Charges

We often receive questions asking why we bill when MONOC paramedics answer emergency calls, but decide that ALS treatment is not needed and ultimately releases the patient to the local BLS agency after our assessment. These types of calls are referred to as "ALS-R-BLS" (ALS release to BLS). Many patients, and even BLS agencies, do not understand why we bill for these cases and raise concerns about the amount of the charge. In essence, billing for a "paramedic assessment" is equivalent to doctors billing for a "check-up" or a person receiving a bill for going to the emergency room, being examined and released without any further care.

It is recognized that the overwhelming majority of the expenses associated with operating ALS services are incurred in the preparation for, and response to, an emergency. Depending on the location and nature of the particular paramedic service, as much as 85% of the cost to maintain a "24/7" paramedic service is based on its "stand-by", "response" and "patient assessment" expenses. Only 15% of the total cost is attributable to the direct provision of ALS treatment.



Notification Issues

Another important fact, often not understood, relates to notification to patients of paramedic service charges prior to treatment. Federal EMTALA restrictions prohibit healthcare providers from raising the issue of charges, costs and insurance, with patients prior to emergency treatment. This law is intended to assure that every person receives necessary emergency care regardless of their ability to pay for same. In addition, this law recognizes that persons experiencing a medical emergency are in no mental condition, nor do they have the time, to consider these issues during that moment of crisis.

Actual Patient Cost Experience

Below, we have attempted to demonstrate the average “out-of-pocket” cost any particular person would be responsible for if they were to receive paramedic care from MONOC. “Out-of-pocket” means the amount of money the patients, themselves, would actually be responsible to pay. It does not refer to how much Medicare, Medicaid or commercial insurance companies pay, nor does it refer to what MONOC originally charges. This is important because the patient is not responsible for the original charge generated by MONOC. But, some patients are responsible for certain out-of-pocket expenses.

These rates are based on 2017 figures and are calculated taking into account State and Federally mandated “caps” for such service.

<u>Type of Patient Coverage</u>	<u>Patient’s Average Out-of-Pocket Expense</u>
a) Charity Care/Indigent Patients	\$0
b) Medicaid Patients	\$0
c) Medicare Patients	\$0 - \$750
d) Patients in Motor Vehicle Accidents	\$0
e) Patients with Commercial Insurance	\$450 ²
f) Uninsured Patients with financial resources	\$1,900

² There are many different Insurance companies, each with several different plans. Because of this and the variability of deductibles and plan requirements for co-pays, it is not possible to reflect exactly how much any given patient in this category will pay “out-of-pocket” for paramedic service. We simple show here the overall average from our historical experience.



It is vitally important to remember that, in the end, MONOC is morally, ethically and legally committed to treating ALL patients needing our help, regardless of each patient's ability to pay. Furthermore, MONOC is dedicated to continuing our tradition of constantly improving the services we provide, so that the residents of our service areas continue to receive the finest, cutting-edge ALS and BLS care available in the state.

Further questions regarding charges and billing practices in New Jersey for paramedic services may be directed to:

Mr. Vincent D. Robbins, FACHE
President & Chief Executive Officer
MONOC; the Monmouth Ocean Hospital Service Corporation
4806 Megill Road
Neptune, New Jersey 07753
(732) 919-3045 extension 1112
Vince.Robbins@MONOC.org www.MONOC.org