Ambulance Association of Pennsylvania

Testimony for Public Hearing

For the

Public Hearing on House Bill 1013

House Veterans Affairs and Emergency Preparedness Committee

April 20, 2017

Good morning Chairman Barrar, Chairman Sainato and distinguished members of the House Veterans Affairs and Emergency Preparedness Committee, I am Donald DeReamus, Board member and Legislative Chair of the Ambulance Association of Pennsylvania (AAP). With me today is my counterpart Charles Cressley and Heather Sharar our Executive Director.

Once more we come before this Committee seeking one part of a larger plan to avert an impending public safety crisis and ultimate collapse of the EMS System in this Commonwealth. The Medical Assistance reimbursement increase and reinstatement of the mileage payment remains the central component of this plan.

Next in importance is obtaining payment for the coverage for emergency services provided during the period of an emergency, including evaluation, testing, and if necessary, stabilization of the condition of the patient, emergency transportation and related emergency care provided by a licensed ambulance service. Thus, the impetus for House Bill 1013, the re-embodiment of House Bill 339 that passed the your chamber last year 188-0.

While we commend Chairman Barrar for tirelessly advocating this concept, we believe two principal questions need to be answered;

1. Why there is a need to legislate something already codified in Statue and Regulation?
2. Why is the Insurance Department not imposing existing Statue and Regulation on Insurers?

We chose our words very carefully in the prior paragraph. In essence these words are paraphrased from the language that has existed for nearly two decades in Insurance Law at 40 P.S. §§991.2102 and 991.2116 and promulgated regulations at 28 Pa Code §9.672. Are we attempting to legislate for payment of a service we should already be reimbursed for? Regardless, we are here today to speak to House Bill 1013.

Emergency Medical Service (EMS) is unlike any other healthcare provider business model. We are a public safety service mandated by statute to respond as dispatched by a public safety answering point to a call for a person's perceived emergency (28 Pa Code §1027.3(g)(4)) . We respond, assess, render care and transport when necessary, regardless of and without knowledge whether a patient has health insurance or the ability to pay. We have no idea when we will respond, who we will respond to, or how many patients we will see daily, monthly or annually.

EMS requires substantial capital investment and suffers from high fixed costs to satisfy licensure and regulatory standards. We sustain the "cost of readiness" to be able to respond to that perceived emergency 24 hours a day, seven days a week, 365 days a year. These costs, like the emergency call volume that generates revenue to perpetuate our service, are variable between urban, suburban and rural environments. With such volatility in revenue and expenses, the ability to recoup cost outside of the government program "transportation" payment model is imperative to help curb this pending public safety crisis.

EMS response to emergency calls where a patient is medically assessed, evaluated, treated and refuses transportation to definitive care is an EMS Agency's and EMS provider's greatest liability. Many of these refusals involve medical direction from a medical command physician; while some are autonomous decisions by the EMS provider based on established State Basic and Advanced Life Support protocols and patient response to treatment. The trend, supported by evidenced based medicine, is to treat and not transport patients who will not benefit from additional healthcare assessment and cost just to confirm a resolved medical issue.

This liability is exacerbated by the fact that some patients are refusing transportation to definitive care out of fear of paying high deductibles and co-payments or an increase in their auto insurance premiums. The opioid epidemic has also added to the frequency of this exposure and increased our fixed costs.

Nevertheless, EMS is suffering from below cost reimbursement from Medicare and all payors and paltry reimbursement from Medicaid. Any reimbursement for assessment, evaluation and/or treatment without transport would greatly assist in balancing the cost for EMS across all payors. Receiving a base rate payment for a level of service provided without transportation would meet the "reasonably necessary costs associated with the emergency services provided during the period of the emergency" threshold codified in 40 P.S. §991.2116.

Thank you for this opportunity to provide our thoughts on House Bill 1013. We would appreciate the Insurance Department weighing in on their perceived statutory and regulatory responsibility on this issue. We would be happy to answer any questions you may have.

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

Our nearly 250 members are based throughout the Commonwealth and include all delivery models of EMS including not-for-profit, for-profit, municipal based, fire based, volunteer, and air medical. Our members perform a large majority of the patient contacts reported to the Department of Health.