

CAH/FLEX

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From North Carolina: Strengthening Billing Systems for Rural Emergency Medical Services

What is the Strategy? Who is Doing it?

The Flex program has provided North Carolina with an opportunity to help support a new **countywide billing system for Emergency Medical Services (EMS)**. The system, which is being implemented in Halifax County, is designed to remove service inequities, become self-sustaining, and serve as a model for rural EMS throughout North Carolina.

Why Is the Strategy Important?

- ◆ Rural EMS systems often struggle for their financial survival. In addition to a relatively poor local tax base, many rural EMS providers still do not bill patients for ambulance transports. If they do, they often have poor collection rates.
- ◆ A survey conducted by the North Carolina Office of EMS showed that about half of rural EMS systems bill for services and that the average rural collection rate is only 25 percent. Therefore, improving the capacity of rural EMS systems to collect transport fees has become one of the top priorities for the state EMS office.
- ◆ The EMS system in Halifax County was fraught with inequities. Some providers did not bill for transports. Others billed only during the day. Fees for those that billed ranged from \$100 to \$225 per transport. Collection rates for ambulance transports in the county varied between 20-60 percent for those who billed.

This is the second in a series of periodic reports of findings from tracking actions taken by states, hospitals, communities, federal agencies, and others to implement the Rural Hospital Flexibility Program (including supporting Critical Access Hospitals (CAHs)). This series will report interesting and useful strategies used, and specific actions taken, in various states.

How Does the Strategy Work?

In 1999, County Commissioners passed a 2 1/2 percent property tax assessment to finance a county-based EMS systems that would replace the independent volunteer squads. This new system was to expand capacity and operate with a fully paid EMT-paramedic level staff. However, county funds were expected to cover only 60 percent of the operating costs. Additional revenue was to be obtained through implementing a centralized billing system and improving collections.

The centralized billing system, which was implemented in January 2000, relies on two full-time equivalent administrative assistants and a billing clerk with an expertise in Medicare and Medicaid billing. Eight new personal computers supported by a central server complement billing suite software (Sweetsoft Ambulance 2000), which was also purchased for this purpose. The billing software generates a variety of reports, including Automated Call Reports, which can be used to track response times and monitor other indicators of quality. The software also interfaces with an inventory control system. Emergency response personnel can enter data at a remote site, and these data are then downloaded to generate bills at the central office.

Flex funds are being used to pay for a portion of the salaries and supplies during the start-up period. They also will support a centralized inventory control system, which is integrally tied to the county-based system, but has not yet been implemented.

What are the Potential Benefits?

The costs of the billing system are expected to run \$160-170,000, or about seven percent of total EMS system operating costs. System designers are forecasting revenue collections of \$1.2 million with a 62 percent collection rate. With improved collections, the new billing system is expected to more than cover the costs. An additional benefit of the system is the avoidance of third-party billing fees, which typically amount to 20 percent of revenue.

What Factors Helped to Make This Strategy a Success?

Halifax County was the site of a former Essential Access Community Hospital / Rural Primary Care Hospital (EACH/RPCH) network which has been grandfathered into the

Halifax County . . .

- ◆ is located in the northeast corner of North Carolina and is one of the poorest counties in the state.
- ◆ Medicare or Medicaid covers an estimated 70-80 percent of county residents.
- ◆ The county is sparsely populated, and spans a wide geographic area.
- ◆ Before 2000, five independent volunteer squads provided emergency ambulance responses in the county.
- ◆ In 1998, these squads responded to just over 12,000 emergency calls.

Flex Program. According to persons interviewed, the introduction of the EACH/ RPCH network six years ago planted the seed for the EMS system to evolve.

- ◆ *First*, the demand for interfacility transports increased in the county, which further stressed the volunteer base. Average round-trip transport time to the referral hospital was three hours. During this time, paramedics were not available to respond to other emergencies or supplement emergency department staff at the RPCH (a role that had increased in importance with conversion).
- ◆ *Second*, under the new network, the emergency medical director at the referral hospital became concerned about improving standards for the EMS system in the county as a whole.
- ◆ *Finally*, members of the RPCH hospital board felt the preservation of a 24-hour emergency department and EMS system were critical to the survival of the hospital, and convinced the county to establish an EMS task force to propose a remedy.

Moving away from a system of independent volunteer squads toward a county-based system was a critical first step needed to establish an equitable fee structure and a viable billing system for EMS in the county. All parties interviewed underscored the importance of open communication with the community and other stakeholders as key to success. Proponents spent considerable time talking with school groups, civic organizations, clinicians, and EMS squads to demonstrate billing and service inequities. As might be expected, one of the biggest obstacles faced in implementing a county-based system was convincing the fiercely-independent volunteer squads of its benefits. To break down these barriers, it was important to bring all stakeholders to the same table and document service inequities in the county with facts. Finally, time and patience may be required to establish the framework to support a full-time paid billing staff. Although successes have been realized rapidly, the evolution of the idea began six years ago.

Conclusion

From the State Office of Rural Health's perspective, it has been important to pick an EMS program with a high likelihood of success and committed local proponents. Although this program most likely would have been implemented without Flex program funds, Federal dollars have served as an important temporary bridge for establishing a good billing system. This billing system will help to ensure the long-term survival of a strong pre-hospital support system in Halifax County.

Where Can I Get More Information?

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About this project: Check our website: <http://www.rupri.org/srhf-eval/>

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Background

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. It:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

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