

# High-Performance High-Value Financial Outcome Measures



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CSIO, Medstar Mobile Healthcare



SPECIAL THANKS TO OUR HOST



[www.firstwatch.net](http://www.firstwatch.net)



# Webinar Series: The Benchmarking Survey

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Today | High Performance/High Value Metrics Deep Dive:  
*Financial Measures*

*This webinar is being recorded for future playback. Watch previous archived sessions at [www.aimhi.mobi](http://www.aimhi.mobi)!*



# Free Summary & Full Report!



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Executive Summary

## 2018 Member Benchmarking Study

Download the Full Benchmarking Report Free at [www.aimhi.mobi](http://www.aimhi.mobi)

The AIMHI benchmarking studies perform a fundamental service to EMS by providing tools through which we can continue to learn about the successes and opportunities of today's emergency care system, ensure its progress and growth, and work to expand the reputation and efficiency of EMS nationally and internationally. The 2018 study is the latest addition to the body of knowledge required for effective service delivery and improvement.

Since the first study in 1998, AIMHI has developed valuable evidenced-based studies to share clinical, response-time, and economic data across EMS systems serving diverse geographic and demographic communities. Our ultimate goal is to provide AIMHI members and the EMS community with tools, data, and outcomes to continue research that demonstrates the value of mobile healthcare as the initial point of entry to, and the safety net of, the healthcare continuum.

### High Performance, High Value Systems Surveyed

	Primary Service Area
Emergency Health Systems (EHS) Nova Scotia	Halifax, Nova Scotia
Emergency Medical Services Authority (EMSA) – Eastern Division	Tulsa, Oklahoma
Emergency Medical Services Authority (EMSA) – Western Division	Oklahoma City, Oklahoma
Mecklenburg EMS Agency	Charlotte, North Carolina
Medic EMS	Davenport, Iowa
MedStar Mobile Healthcare	Fort Worth, Texas
Metro EMS (MEMS) – Little Rock Ambulance Authority	Little Rock, Arkansas
Niagara EMS	Niagara-on-the-Lake, Ontario
Northwell Health Center for Emergency Medical Services	Syosset, New York
Pinellas County EMS Authority/SunStar Paramedics	Largo, Florida
Regional Emergency Medical Services Authority - REMSA	Reno, Nevada
Richmond Ambulance Authority	Richmond, Virginia
Three Rivers Ambulance Authority (TRAA)	Fort Wayne, Indiana

### What Is High Performance/High Value EMS (HP/HVEMS)?

High Performance/High Value EMS systems share key features of system cost-effective systems. Characteristics may include:

- Sole provider: Exclusive medical services are provided by a single provider.

VISIT [WWW.AIMHI.MOBI](http://WWW.AIMHI.MOBI) TO DOWNLOAD THE MEMBER BENCHMARKING SURVEY!



# About AIMHI

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## ORGANIZATIONS WITH HIGH PERFORMANCE DESIGN FEATURES

- Sole provider
- Externally accountable
- Full cost accounting
- Control center operations
- Revenue maximization
- Flexible production strategy
- Dynamic Resource Management

## VISION

To improve patient health and experience of care by promoting excellence in mobile healthcare system effectiveness and efficiency.

## FORMERLY

Coalition of Advanced  
Emergency Medical  
Systems (CAEMS)

National Association of  
Public Utility Models

# CURRENT AIMHI MEMBERS

**Emergency Health  
Service**  
Halifax, NS

**Emergency Medical  
Services Authority**  
Tulsa & Oklahoma  
City, OK

**Mecklenburg EMS  
Agency**  
Charlotte, NC

**Medic Ambulance**  
Vallejo, CA

**MEDIC Emergency  
Medical Services**  
Davenport, IA

**MedStar Mobile  
Healthcare**  
Fort Worth, TX

**Metropolitan  
Emergency Medical  
Services**  
Little Rock, AR

**Niagara Emergency  
Medical Services**  
Niagara-On-The-  
Lake, ON

**Northwell Health  
Center for EMS**  
Syosset, NY

**Pinellas County EMS  
Authority/Sunstar  
Paramedics**  
Largo, FL

**Pro EMS**  
Cambridge, MA

**Regional EMS  
Authority**  
Reno, NV

**Richmond  
Ambulance  
Authority**  
Richmond, VA



**Three Rivers  
Ambulance  
Authority**  
Fort Wayne, IN

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membership at  
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Participants









Speaking:

Panelist: 1



 Todd Stout (Host)

Attendee: 1 (No Privilege)


 Jenny Abercrombie (me)
 

Audio

Chat

Send to: Host, Presenter & Panelists

Select a participant in the Send to menu first, type chat message, and send...

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Participants

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▼ Panelist: 1

Todd Stout (Host)

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Jenny Abercrombie (me)

Hand icon

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### ***Survival Rates Similar for Gunshot, Stabbing Victims Whether Brought to the Hospital by Police or EMS, Penn Medicine, Study Finds***

<https://www.pennmedicine.org/news/news-releases/2014/january/survival-rates-similar-for-gun>



### ***More Advanced Emergency Care May Be Worse for Cardiac Arrest Victims: Study***

<http://health.usnews.com/health-news/articles/2014/11/24/more-advanced-emergency-care-may-be-worse-for-cardiac-arrest-victims-study>



### ***Need an ambulance? Why you may not want the more sophisticated version***

<https://www.washingtonpost.com/news/to-your-health/wp/2015/10/12/need-an-ambulance-why-you-may-not-want-the-more-sophisticated-version/>



### ***A healthcare expert explains why you should think twice before taking an ambulance to the hospital***

<http://www.businessinsider.com/think-twice-before-taking-ambulance-hospital-elisabeth-rosenthal-insurance-bills-healthcare-hospital-emergency-2017-4>



### ***Modesto rejects \$1M paramedic, firefighter grant***

<http://www.modbee.com/news/article106080287.html>



### ***White House Recommends Cuts to Fire Service in FY2020 Budget***

<https://www.firefighternation.com/2019/03/21/white-house-recommends-cuts-to-fire-service-in-fy2020-budget/#gref>



# Cost Drivers

- **Performance Standards**

- Response Time Goals
- Staffing (#1 Cost)
  - All ALS vs. Tiered
- Clinical Procedures
- EMS Bank Account

- **System Deployment**

- Fixed vs. Flexible
- Static vs. Dynamic

- **Pay & Pay Related**

- Product of the above

- **Other**

- Vehicle Type / Vehicle Maintenance / Fuel / Software Licensing

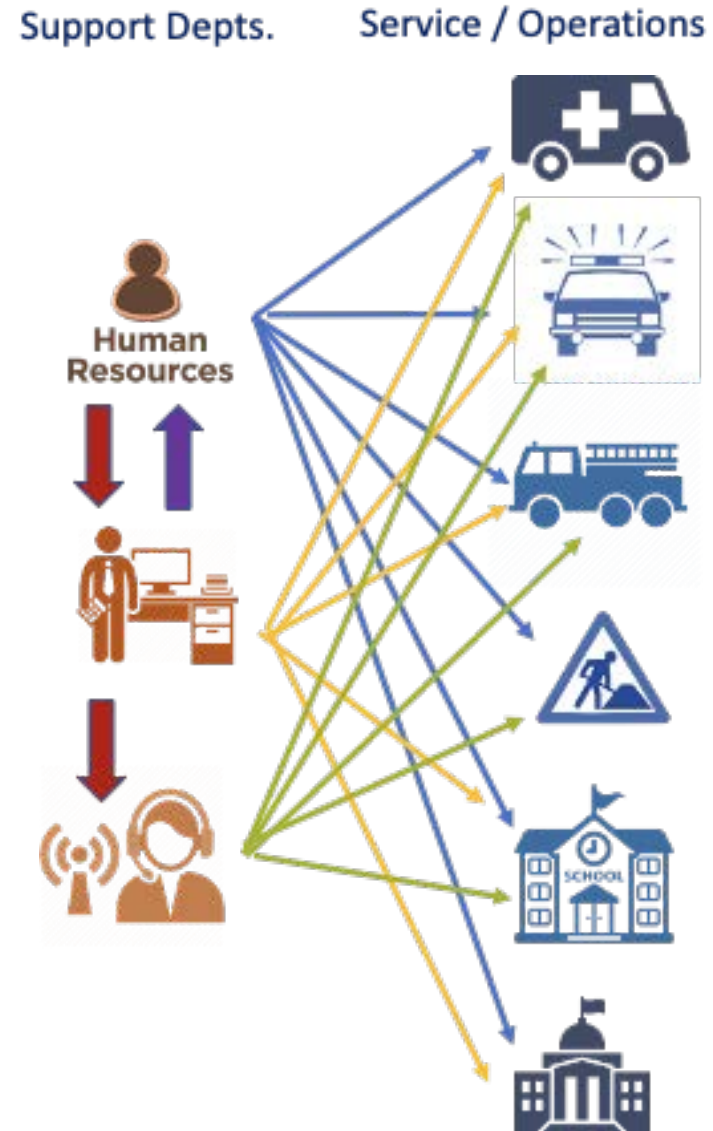


# Cost Analysis

- **Total Annual Cost**
- **Cost per Unit Hour**
  - Total costs ÷ *Produced* or *Scheduled* Unit Hours
- **Cost per Response**
  - Total costs ÷ Responses
- **Cost per Transport**
  - Total costs ÷ Transports
- **Cost per Capita**
  - Total costs ÷ Population Served
- **Fixed vs. Variable Cost Categorization**
  - Cost to manage the service | Stair step costs | Cost to run a call

# Cost capture

- **Accounting types**
  - General Ledger vs fund accounting
- **Accounting methods**
  - Cash, Accrual or Modified Accrual
- **Approaches to cost allocation**
  - Direct, Step or Reciprocal
- **Cost allocation methodologies**
  - Logical relationship to consumption
    - FTE, headcount or hours worked
    - Vehicle or miles driven
    - Square footage
    - Machine or service hour
    - Total actual usage





# Unit Hour Utilization

- **Measure of ‘*Productivity*’**
  - Transports/Responses Completed for “X” Period
  - Unit Hours Produced for “X” Period
- **Unit Hour = a staffed ambulance on duty available for response for 1 hour**
  - 1 unit 24/7 = 8,760 unit hours (24 x 365)
- **“Ideal” UHU determined locally based on many factors**
  - Seen one UHU (EMS System) seen one UHU (EMS System)

*Base Assumption = 1 hour Time on Task*

# Impact of UHU on Costs

	2017-18	2018-19	[2019-20]	[2020-21]	[2021-22]	[2022-23]
<b>Transports</b>	9,336	9,457	9,647	9,842	10,043	10,249
<b>Additional Ambulance 24/7</b>						
Annual Unit Hours ( <i>5 @ 24/7 as of FY 2019-20</i> )	35,040	35,040	<b>43,800</b>	<b>43,800</b>	<b>43,800</b>	<b>43,800</b>
Unit Hour Utilization - Transport	0.266	0.270	0.220	0.225	0.229	0.234
Ambulance Expense	\$ 6,361,298	\$ 6,869,179	\$ 8,844,068	\$ 9,109,390	\$ 9,382,672	\$ 9,664,152

Agency Name: Anytown, USA

= User Entered Fields

= Auto-Calculated/Protected Fields

Notes:

Population	20,000	Total population served
Annual Ambulance Unit Hours	8,760	Total Ambulance on-duty hours/yr (i.e.: 1 Ambulance 24/7 is 24 * 365 = 8,760)
EMS Calls/Yr	1,000	Annual EMS responses in which an ambulance was dispatched
EMS Transports/Yr	700	Annual ambulance transports
UH/U	0.114	Annual ambulance transports divided by annual unit hours

Per Ambulance

FTEs	7	Number of FTEs required to be hired to staff the ambulance(s)
Cost/FTE	\$ 80,000	All costs, pay, benefits, uniform, personal equipment, pension costs, etc.
Personnel cost	\$ 560,000	FTEs * Personnel cost

Ambulance	\$ 150,000	Cost of the ambulance, delivered
Equipment	\$ 50,000	Cot, monitor, etc.
Cost	\$ 200,000	Total costs
Useful Life/Years	5	Depreciaton expense
Number of Ambulances	1	Count of ambulances in the fleet
Ambulance Cost	\$ 40,000	Annual cost of each ambulance

Cost/UH	\$ 77.14	Total costs divided by annual <u>unit hours</u>
Cost/Response	\$ 675.75	Total costs divided by annual <u>responses</u>
Cost/Transport	\$ 965.36	Total costs divided by annual <u>transports</u>

Other

Maintenance	\$ 10,000	Annual allocated or actual cost of maintenance
Fuel	\$ 15,000	Annual cost of fuel
Supplies	\$ 18,750	Annual cost of disposable supplies and drugs

Total Annual	\$ 675,750
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Texas Ambulance Supplemental Payment Program

FY18 Cost Report - Trip Statistics at a Glance

	100% EMS	Fire-Based	Fire-Based	Fire-Based	Fire-Based	Fire-Based	Fire-Based	Fire-Based	Fire-Based	Fire-Based	100% EMS	Fire-Based	Fire-Based	100% EMS
Providers	Average of All Providers	MedStar	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5	Provider 6	Provider 7	Provider 8	Provider 9	Provider 10	Provider 11	Provider 12
Cost/Trip	\$ 1,974	\$ 403	\$ 2,749	\$ 1,685	\$ 2,950	\$ 2,342	\$ 811	\$ 1,799	\$ 4,423	\$ 1,070	\$ 1,290	\$ 3,231	\$ 1,996	\$ 649

Texas Ambulance Supplemental Payment Program

FY18 Cost Report - Trip Statistics at a Glance

Comparison Data

	EMS-Based Fire	Non Fire EMS	Difference
Cost/Trip	\$ 2,208.61	\$ 935.29	\$ (1,273.33)







## 2018 High Performance System Report

An Analysis of EMS System Design and Performance

### SECTION 7: ECONOMIC EFFICIENCY AND COSTS

The information reported in the three sections, General Information, Response-time Standards, and Clinical Performance, establish a comprehensive foundation from which to benchmark the cost-efficiency of the participating HPEMS systems. Maintaining response-time reliability, or the cost of the system's ability to be prepared to meet the response-time standard, is the primary determinant of EMS system cost. Two economic measures that furnish the basis for a fair and meaningful comparison of system costs and productivity are as follows:<sup>21, 22</sup>

- Total system cost per patient transported
- Total system cost per capita

The first step in determining cost-effectiveness, or economic efficiency, is to include all system costs in the analysis. The system design itself may pose another barrier to comprehensive cost analysis. In systems without exclusivity, two or more organizations may be competing for the non-emergent patients in that community and their costs may not be reported or even available. Not only does this make cost-comparison difficult, there is also evidence that the system may be less productive and the cost per transport may increase for the primary emergency provider as a result of the existence of multiple providers in the same market.<sup>23</sup> The majority of HPEMS participants in this study have exclusivity of the marketplace, meaning that all emergency and non-emergency transports are performed by the same organization in the system. This allows for more efficient production and also provides for meaningful comparisons of total system costs.

The efficiency of all-ALS systems is measured by Unit Hour Utilization (UHU), Cost per Transport, and Cost per Capita. These measurements are provided as follows:

- **UHU:** To determine a system's UHU, the number of transports performed in a given period of time is divided by the number of unit hours produced during the same time period.
- **Cost per transport:** This is determined by dividing the cost per unit hour by the system's UHU. All system costs must be included in the unit hour costs to ensure accuracy and comparability between systems.
- **Cost per capita:** This is defined by total system cost divided by the total population.

<sup>21</sup> Stout, J.L. (1994). System Financing. In W.R. Roush (ed.), *Principles of EMS Systems*, (2nd Ed.). Dallas, TX: American College of Emergency Physicians.

<sup>22</sup> National Highway Traffic Safety Administration. (1996). *EMS agenda for the future*. Washington, DC: NHTSA.

<sup>23</sup> Overton, J., & Stout, J. (2002). In A.E. Kuehl (ed.), *Prehospital systems and medical oversight*, (3rd ed.). Dubuque, IA: Kendall Hunt Publishing.



**Table 37: Description of Selected Measures of Economic Efficiency**

Agency Name	Annually Scheduled Unit Hours	Total System Costs	Unit Hour Utilization (UHU)	Total Cost per Unit Hour	Total Cost per Transport	Total Costs per Capita
EHS – Nova Scotia	852,840					
EMSA - (East) Tulsa	184,925	\$29,695,300	0.418	\$161	\$384	\$63
EMSA - (West) OKC	206,858	\$33,546,950	0.392	\$162	\$414	\$42
Mecklenburg	328,078	\$58,756,657	0.342	\$179	\$523	\$56
Medic EMS	50,084	\$10,339,285	0.476	\$206	\$434	\$59
MedStar	279,925	\$47,177,224	0.361	\$169	\$467	\$46
MEMS-LRAA	310,891	\$43,467,578	0.228	\$140	\$613	\$58
Niagara EMS	225,870	\$34,683,821	0.350	\$146	\$770	\$77
Northwell EMS	149,028	\$31,468,030	0.339	\$211	\$622	\$3
Richmond	123,829	\$19,705,727	0.408	\$159	\$390	\$89
TRAA	76,992	\$12,437,260	0.360	\$162	\$448	\$47

Canadian dollars were converted to US dollars at average annual conversion rate of 0.765733.

# Social Isolation Reality

Did a BIG load of pajamas so I would have enough clean work clothes for this week.

Day 27 at home and the dog is looking at me like, "See, this is why I chew the furniture."



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# Sources of Funds

- **Fee for Service**

- Transport fees
  - Emergency/Non-emergency
- Treat and Refer fees
  - AMA
- Standby/event medical
- Specialized services

- **Subscriptions**

- Membership fees
  - Usually results in discounted ambulance rate/waived fees





# Sources of Funds

- **Tax subsidy**
  - Property taxes
  - Sales taxes
  - Special use/assessments
- **Other funding sources**
  - GEMT (cost recovery)
  - Ambulance Provider Assessments
  - Matching fund assessment programs
  - Grants
  - “Loss leader” funding from parent organization
    - Hospital-based systems
  - Donations



# Fees for Service

- Impacted by “Service Mix”
  - Emergency/Non-Emergency, ALS, BLS, SCT, etc.

*Table 40: Comparison of Selected Retail Base Billing Rates by Agency*

Agency Name	ALS Emergency	BLS Emergency	ALS Non-Emergency	BLS Non-Emergency	ALS Transfer	BLS Transfer	Critical Care Transport	Treat/No-Transport	Emergency & Non - Emergency Mileage	Long Distance Mileage	Bundled Billing?
EMSA - (East) Tulsa											
EMSA - (West) OKC											
Mecklenburg											
Medic EMS											
MedStar											
MEMS – LRAA											
Northwell - EMS											
Pinellas/SunStar											
REMSA											
Richmond											
TRAA											

# Fees for Service

- Impacted by “Payer Mix”

- Insurance, Medicare, Medicaid, Uninsured/Self Pay

Metropolitan Area EMS Authority

**Payer Mix Analysis**

FYE 2019



	Billed				Collected		
	2019	%	Avg. % of Billed		2019	% of Cash	% of Payer
Insurance	\$ 26,716,065	15.1%	14.0%		\$ 16,995,694	38.6%	63.6%
Medicare	\$ 70,465,612	39.9%	37.9%		\$ 18,236,474	41.4%	25.9%
Medicaid	\$ 28,475,133	16.1%	16.2%		\$ 5,427,937	12.3%	19.1%
Facility	\$ 2,760,738	1.6%	2.0%		\$ 2,190,329	5.0%	79.3%
Bill Patient	\$ 48,075,576	27.2%	29.9%		\$ 1,149,197	2.6%	2.4%
<b>Total</b>	<b>\$ 176,493,124</b>	<b>100.0%</b>	<b>100.0%</b>		<b>\$ 43,999,630</b>	<b>100.0%</b>	<b>24.9%</b>

IRB Study Number: YYMM-Discipline-#

Date of Submission: 07/31/2019



INTERNATIONAL ACADEMIES OF EMERGENCY DISPATCH  
**INSTITUTIONAL REVIEW BOARD**

(IORG0005364 / IRB #00006450)

**Study/Protocol Proposal Submission Form**

**SECTION 1: TITLE PAGE**

**Study/Protocol Title:** Payer Mix Trend Analysis of High Performance EMS Systems

**Principle Investigator (PI):**

- Matt Zavadsky, MS-HSA, NREMT

**Institution:** Academy of International Mobile Healthcare Integration (AIMHI)

**Co-Investigators and Affiliations:**

- Jerry Overton, International Academies of Emergency Dispatch, SLC, Utah

**Discipline (i.e., EMD, EFD, EPD, ECNS. If "Other" please explain):**

Other – Analysis of the payer mix (billed and collected) for Fee For Service (FFS) ambulance claims.

IRB Study Number: YYMM-Discipline-#

Date of Submission: 07/31/2019



INTERNATIONAL ACADEMIES OF EMERGENCY DISPATCH  
**INSTITUTIONAL REVIEW BOARD**

(IORG0005364 / IRB #00006450)

**Study/Protocol Proposal Submission Form**

**SECTION 1: TITLE PAGE**

**Study/Protocol Title:** Response Determinant Trend Analysis of High Performance EMS Systems

**Principle Investigator (PI):**

- Matt Zavadsky, MS-HSA, NREMT

**Institution:** Academy of International Mobile Healthcare Integration (AIMHI), 1420 New York Avenue NW, 5<sup>th</sup> Floor, Washington, D.C. 20005

**Co-Investigators and Affiliations:**

- Jerry Overton, International Academies of Emergency Dispatch, SLC, Utah

**Discipline (i.e., EMD, EFD, EPD, ECNS. If "Other" please explain):**

EMD



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# Commercial Insurance

- **Dollars paid impacted by:**

- Usual and Customary Rate (UCR)

- The average rate charged in the region evaluated

- “Allowed” amount

- What the commercial insurer chooses to pay
    - Sometimes loosely based on UCR

- Member deductible and co-insurance

- Often billed to the member/patient

- Who gets the money

- Ambulance agency vs. the member/patient

- MEDICAL NECESSITY

- Was an ambulance/medical care necessary to improve the patient’s outcome?



# Commercial Insurance - Challenges

- **UCR**

- Are the rates charged in the region relatively “standard”
  - Low fees impact the UCR (more on that later)

- **Allowed amount**

- \$1,000 fee, \$600 “allowed” (again, may be based on UCR)
- Insurance pays \$600, and the balance is billed to the patient

- **Deductible and Co-Insurance**

- Most insurance plans have an amount the member must pay before insurance kicks in
- To reduce insurance costs, high deductible plans “vogue”
  - Could be as high as \$10,000 annually

# Fair Health Database



Insurance Basics

Resources

Shared Decision Making

Quality

Glossary

About Us



Total Cost Related to

**Transportation, by ambulance, Advanced Life Support level 1 (Emergency, flat rate)  
Code A0427**

Colorado Springs, CO 80922

**Total  
\$1,503**

**Out-of-Network/  
Uninsured Price**

**Total  
\$1,011**

**In-Network Price**



See out-of-network Reimbursement



Search Again

## Primary Medical Procedure

**Transportation, Medical Equipment and Supplies**

Transportation, by ambulance, Advanced Life Support level 1 (Emergency, flat rate) **CPT Code: A0427**

**Out-of-Network/  
Uninsured Price**

**\$ 1,503**

**In-Network Price**

**\$ 1,011**

<https://www.fairhealthconsumer.org/>



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# Commercial Insurance - Challenges

- **Who gets the \$**

- Most ePCRs contain a clause that 'assigns' benefit payments to the *provider*
- Despite this AOB, the insurer pays the patient
  - The provider then has to try and get the patient to pay the provider

- **Medical Necessity**

- Impacted by the documentation on the ePCR!
- Part of YOUR documentation needs to establish that the patient needed YOU
- This is true for all medical professionals



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# Medicare

- **Fee for Service and Medicare Advantage**

- FFS

- Claims processed by Medicare Administrative Contractors (MACs)
    - Acts as the financial intermediary for the federal government

- Medicare Advantage – Beneficiary chooses a Managed Care Organization

- Premiums paid to the MCO
    - MCO processes the payment
    - Financial incentive for the MCO to reduce expenditures for members



# Medicare - Challenges

- **Fees paid based on a national fee schedule**
  - Regardless of what the provider 'charges'
  - Some regional adjustments based on cost of living
- **Generally below the cost of service delivery**
  - And way below billed charges
- **Payments generally 80% of 'allowed' amount**
  - 20% difference billed to the patient
- **Deductibles apply**
  - Generally only an issue early in the "plan year"
- **Medical Necessity**
  - Services must be medically necessary for reimbursement
  - Failure to comply = Pre-pay review / claw-back / banned / imprisonment



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# Medicaid

- **Fee for Service and Managed Medicaid**

- FFS

- Claims processed by the state

- Managed Medicaid – Beneficiary chooses a Managed Care Organization

- Premiums paid to the MCO
    - MCO processes the payment
    - Financial incentive for the MCO to reduce expenditures for members
    - Members can change plans – frequently (even month-to-month)



# Medicaid - Challenges

- **Fees paid based on a state fee schedule**
  - Regardless of what the provider 'charges'
- **Generally (way) below the cost of service delivery**
- **No balanced billing to the recipient**
  - Must accept what Medicaid pays as payment in full
- **Some Medicaid patients can be high-utilizers**
  - Medically challenged
  - Economically challenged
  - Difficulty finding primary care or specialists that take Medicaid patients
- **Medical Necessity**
  - Similar rules to Medicare in most states
  - Subject to transportation managers / brokers (this can be negative or positive)

# A Word About “In-Network” Agreements

- **Basic premise =**
  - Provider agrees to lower FFS rate in exchange for higher volume (efficiency)
- **9-1-1 Providers**
  - Will generally NOT see an increase in volume due to in-network status
- **Reduced FFS revenue without increased volume...**
  - Means less revenue
    - Without the ability to balance bill
- **Payment directly to the provider NOT the patient**
  - Must weigh net collectability improvement vs. loss from rate reduction

# Average Patient Charge & Revenue

	Res	NR	Resident				Non-Resident			
			Billed	Collected	Collection %	Cash/Trip	Billed	Collected	Collection %	Cash/Trip
<b>Trips</b>	3,411	1,208	\$3,867,235	\$1,853,841	47.9%	\$543.49	\$1,564,977	\$713,838	45.6%	\$590.93
<b>Gross APC</b>			\$1,133.75				\$1,295.51			

Overall			
Billed	Collected	Collection %	Cash/Trip
\$5,432,212	\$2,567,678	47.3%	\$ 555.89
\$ 1,176.06			

# Revenue Analysis by Payer

Date of Service	Trip #	Run #	Charges	Ins Pmt	Patient Payment	Patient Discount	Balance Due
5/5/2020	0042-A	38271	\$ 1,046.00	\$ 303.71	\$ -	\$ 742.29	\$ -
5/7/2020	0077-A	38912	\$ 1,680.00	\$ -	\$ -	\$ -	\$ 1,680.00
5/12/2020	0184-A	40363	\$ 1,575.00	\$ -	\$ -	\$ -	\$ 1,575.00
5/12/2020	0112-A	40291	\$ 1,031.00	\$ 296.09	\$ -	\$ -	\$ 734.91
5/13/2020	0155-A	40620	\$ 1,046.00	\$ 303.71	\$ -	\$ 742.29	\$ -
5/16/2020	0227-A	41527	\$ 1,545.00	\$ -	\$ -	\$ -	\$ 1,545.00
5/16/2020	0042-A	41305	\$ 1,256.00	\$ 410.39	\$ -	\$ -	\$ 845.61
5/17/2020	0128-A	41679	\$ 1,575.00	\$ 492.46	\$ -	\$ -	\$ 1,082.54
5/23/2020	0180-A	43433	\$ 1,560.00	\$ 471.00	\$ -	\$ -	\$ 1,089.00
5/23/2020	0276-A	44650	\$ 1,500.00	\$ -	\$ -	\$ -	\$ 1,500.00
5/29/2020	0044-A	45008	\$ 1,590.00	\$ -	\$ -	\$ -	\$ 1,590.00
		<b>179</b>	<b>\$ 248,684.00</b>	<b>\$ 138,290.23</b>	<b>\$ 16,337.14</b>	<b>\$ 11,013.16</b>	<b>\$ 83,043.47</b>

**Average**    \$    **1,389.30**    \$    **772.57**    \$    **91.27**    \$    **61.53**    \$    **463.93**



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# Social Isolation Reality

How LONG is this social distancing thing supposed to last? My husband keeps trying to come into the house.

People are scared of getting fined for congregating in crowds. As if catching a deadly disease and dying a horrible death wasn't enough of a deterrent.

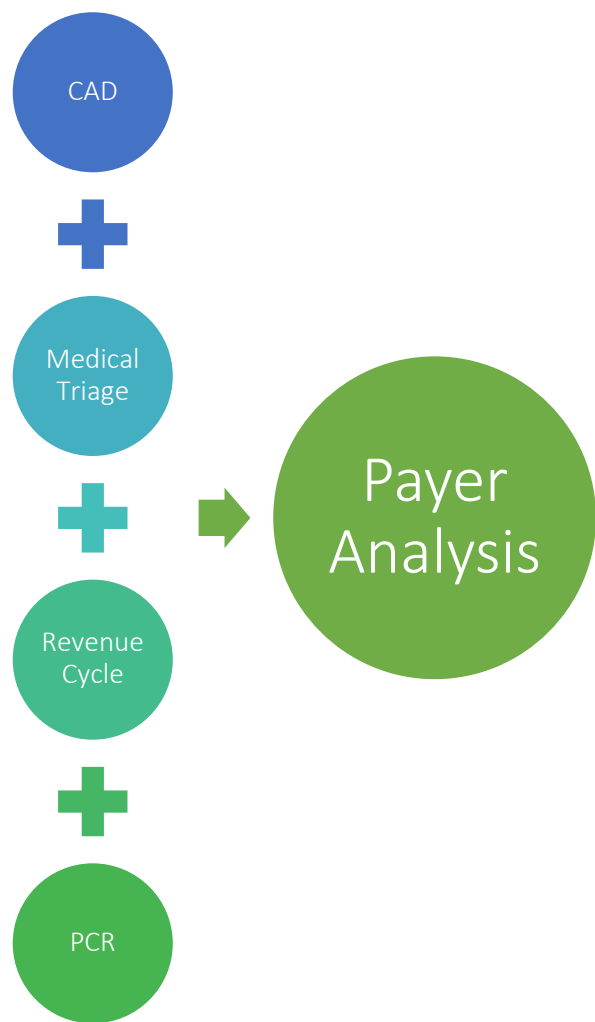


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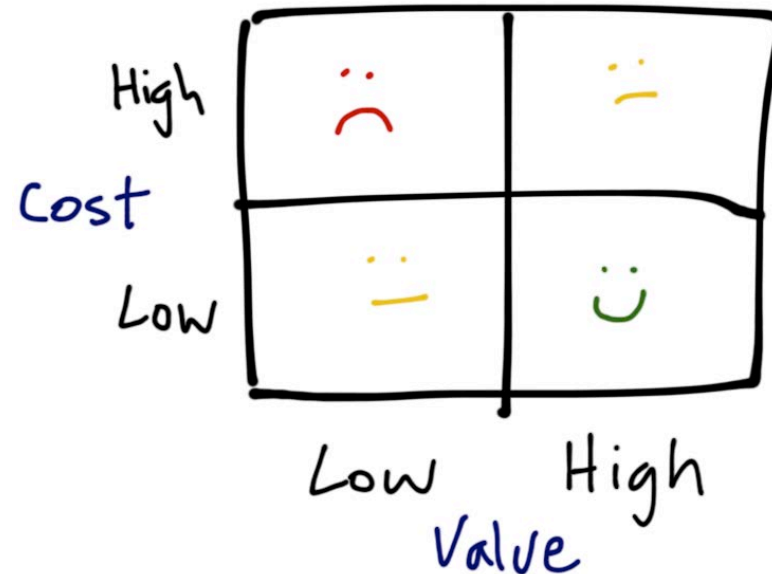
# Revenue Analysis by Payor by Presumptive Code



- EMS version of common healthcare pricing & reimbursement analysis
  - Analysis by CPT & Dx code
- Reimbursement trends by specific payor rather than payor class
- Payment based on acuity as categorized by triage determinant & PCR
- Delicate & controversial in 911 systems

# Summary: High Performance ➔ High Value

- Why the focus on *value*?
- Who do we need to prove *value* to?
- What do they consider *valuable*?





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# Free Summary & Full Report!



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Executive Summary

## 2018 Member Benchmarking Study

Download the Full Benchmarking Report Free at [www.aimhi.mobi](http://www.aimhi.mobi)!

The AIMHI benchmarking studies perform a fundamental service to EMS by providing tools through which we can continue to learn about the successes and opportunities of today's emergency care system, ensure its progress and growth, and work to expand the reputation and efficiency of EMS nationally and internationally. The 2018 study is the latest addition to the body of knowledge required for effective service delivery and improvement.

Since the first study in 1998, AIMHI has developed valuable evidenced-based studies to share clinical, response-time, and economic data across EMS systems serving diverse geographic and demographic communities. Our ultimate goal is to provide AIMHI members and the EMS community with tools, data, and outcomes to continue research that demonstrates the value of mobile healthcare as the initial point of entry to, and the safety net of, the healthcare continuum.

High Performance, High Value Systems Surveyed	
Emergency Health Systems (EHS) Nova Scotia	Primary Service Area
Emergency Medical Services Authority (EMSA) – Eastern Division	Halifax, Nova Scotia
Emergency Medical Services Authority (EMSA) – Western Division	Tulsa, Oklahoma
Mecklenburg EMS Agency	Oklahoma City, Oklahoma
Medic EMS	Charlotte, North Carolina
MedStar Mobile Healthcare	Davenport, Iowa
Metro EMS (MEMS) – Little Rock Ambulance Authority	Fort Worth, Texas
Niagara EMS	Little Rock, Arkansas
Northwell Health Center for Emergency Medical Services	Niagara-on-the-Lake, Ontario
Pinellas County EMS Authority/SunStar Paramedics	Syosset, New York
Regional Emergency Medical Services Authority - REMSA	Largo, Florida
Richmond Ambulance Authority	Reno, Nevada
Three Rivers Ambulance Authority (TRAA)	Richmond, Virginia
	Fort Wayne, Indiana

### What Is High Performance/High Value EMS (HP/HVEMS)?

High Performance/High Value EMS systems share key features of system cost-effective systems. Characteristics may include:

- Sole provider: Exclusive medical services are provided by a single agency.

VISIT [WWW.AIMHI.MOBI](http://WWW.AIMHI.MOBI) TO DOWNLOAD THE MEMBER BENCHMARKING SURVEY!





# Questions & Thank You!

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