

# Who Will Answer Their Call?

## HOW NEW YORK STATE CAN PRESERVE RURAL ACCESS TO EMS

New York State Association for Rural Health

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### PURPOSE STATEMENT

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In order to preserve rural communities' access to emergency medical services, New York State government must act *now*. Due to inadequate reimbursement from Medicaid causing strained budgets, minimal provided incentive for volunteers, and lack of utilization of EMS capabilities, rural ambulance agencies are at risk of closing down or consolidating with other agencies. Fewer ambulance agencies will only increase response and wait time for emergency medical situations, putting rural New Yorkers at an even higher risk of serious medical complications. To amend this crisis, New York State can increase the Medicaid reimbursement rate for EMS, increase incentive for volunteerism by providing SUNY scholarships for volunteers and/or their children, and initiate community paramedicine programs in rural communities to ensure access to quality emergency healthcare.

### INTRODUCTION

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From a young age, we are taught to always call 9-1-1 in an emergency medical situation. Although an ambulance is *expected* to arrive in a timely manner, for many rural New York communities, this may not be guaranteed. In its birth, ambulances were simply a mode of transportation to the hospital. However, EMS now provides life-saving care on site and during transport. This is crucial for what is known in modern emergency medicine as the "golden hour," which is the maximum time between injury or emergency in which medical intervention is most likely to prevent fatality. If crucial changes are not made now, rural New Yorkers will continue to be at risk of increased wait time for emergency care, pushing the limits of the golden hour.

Access to emergency healthcare in rural communities is currently threatened by inadequate reimbursement from insurers, particularly from Medicaid, and the decline of volunteerism. Rural EMS has historically depended on volunteer staff but as numbers of volunteers continue to drop, agencies are forced to take on more paid staff. However, because of insufficient reimbursement for transport, budgets have little room for hiring new drivers, EMTs, and paramedics, often leaving stations understaffed and current staff overworked. Due to declining EMS financial health, paid rural EMS staff are many times paid less than employees

at fast food restaurants, despite working in a high-stress environment, completing required hours of training, and acquiring various levels of certifications.

So how can New York State help? To ensure that rural New Yorkers continue to have access to emergency medical services, the New York State Association for Rural Health (NYSARH) has composed a collection of recommendations that can support the first responders that are integral to a healthy community.

## REIMBURSEMENT MODIFICATIONS

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The most pressing matter New York EMS is facing is inadequate reimbursement, particularly from Medicaid. According to Steven Kroll, chief and executive director of Bethlehem-Delmar EMS, agencies are paid “less than a third of the cost of an ambulance delivery.” For upstate agencies, covering many rural areas, the mean cost of ambulance trips is \$304 according to the 2017 New York Department of Health Medicaid Ambulance Rate Adequacy Review Report.<sup>1</sup> This means rural upstate EMS is taking on an average deficit of more than \$200 per Medicaid patient. Mark Deavers, director of Gouverneur Rescue Squad, reports that Medicaid patients now make up to 40% of agency patient volumes. Even if a rural upstate agency only answered 100 calls a year, they would statistically lose at least \$8,000 annually to Medicaid calls.

Poor reimbursement impacts EMS agencies in multiple areas. In the most obvious form, poor reimbursement tightens budgets, leaving little room for competitive salaries for paid staff. Although it is now possible to make \$15 an hour at the local fast food restaurant, starting EMTs are not making nearly the same, despite hours of training, certification, and the stress and health risks that come with being an EMS provider. Alan Smith, longtime EMS provider and leader with the United New York Ambulance Network, says, “[Others making minimum wage], they don’t have to worry about climbing down over a bank thirty feet to pull a guy out... and have to carry up a stretcher that almost breaks your back. Those types of things... people weigh out today.” In a 2019 survey conducted by the New York State Emergency Medical Services Council, EMTs and paramedics were paid up to **222% less than** their first responder counterparts including firefighters, police, and registered nurses.<sup>2</sup> In the Albany-Schenectady-Troy region firefighters, police, and RNs are compensated by salaries at least 141% more than EMS providers.<sup>2</sup> In the Rochester area, this gap increases to a maximum of 194%.<sup>2</sup>

Poor reimbursement not only impacts compensation for EMS first responders, but also affects care and function capabilities. Alan Smith states that inadequate reimbursement “means [agencies] can’t update [their] defibrillators, means [agencies] can’t run new ambulances.” As agencies must make challenging decisions to keep afloat, updating equipment for life-saving care falls into a list of priorities along with employee compensation. Inadequate reimbursement directly threatens New Yorkers’ access to high quality emergency healthcare.

The 2017 Department of Health report suggests that Medicaid transition to a model utilized by Medicare in which the base mean cost of ambulance trips is adjusted by a Relative Value Unit (RVU) system, based on the characterization of the care provided by EMS (Figure 1).<sup>1</sup> This model would significantly improve reimbursement from Medicaid as it includes consideration for trips that are deemed emergency and non-emergency, which is currently not specified in Medicaid reimbursement.

Figure 1. Medicare RVU Model<sup>1</sup>

Care/Transport Type	RVU
Basic Life Support Non-Emergency	1.00
Basic Life Support Emergency	1.60
Advanced Life Support Non-Emergency	1.20
Advanced Life Support Emergency	1.90
Mean Basic Life Support RVU	1.30
Mean Advanced Life Support RVU	1.55

As shown in the figure above, reimbursement, in addition to mileage rates, can be adjusted based on care provided by EMS and immediacy of each scenario. By using a comprehensive model of care and services provided by EMS, Medicaid reimbursement could improve significantly. While not a perfect solution, as Medicare also underpays EMS, this model provides an actionable step towards significantly improving the poor reimbursement that cripple agencies statewide.

A supplemental change that can be made to improve reimbursement for EMS agencies regards private insurance. Many rural ambulance agencies report that although private insurers write checks that fully cover the cost of ambulance trips, these checks are made out to the patient only. Because these checks are not signed to the agency as well, patients have been known to use them for luxuries such as new TVs and boats. Mark Deavers reports that one patient in particular has received \$26,000 in checks from their insurance for ambulance trips over five years. His agency has yet to see any of this money. To avoid this issue, it is recommended to pass either a direct pay or dual-signed check policy. Direct pay policy would essentially cut out the middle-man, eliminating any chance of patients withholding checks from agencies. Dual-signed check policy entails checks written by private insurance to their customer to the ambulance agency, ensuring that the agency receives its intended full reimbursement.

## INCENTIVIZING VOLUNTEERISM

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The nationwide decline of volunteerism has particularly impacted EMS, resulting in a higher average age for volunteers. While this may not be an issue for other volunteer organizations, emergency medical service positions are often very physically demanding. Rural EMS agencies have historically depended on volunteers due to smaller budgets and a large number of community members working full-time outside of the local area. As discussed earlier, working as an EMT or paramedic is not an easy job—it requires hours of expensive

training and long hours at the station, both oftentimes a considerable distance from the volunteer's home. As the nation recuperates from the economic impact of the pandemic, many people (especially in rural America) have little time to dedicate to volunteering due to financial priorities. While New York currently offers a \$200 tax break for volunteer EMS, this has proven to be of little use against the trending decline of volunteers. We recommend that the legislature introduce a tuition discount at SUNYs for volunteer EMS or their children. Not only is this a competitive incentive with increasing college tuitions nationwide, it may also encourage generational volunteerism within EMS.

As volunteerism is considerably less accessible in rural communities and in today's economy, NYSARH recommends EMT/paramedic training to continue following a hybrid method. By delegating a portion of training to an online platform, volunteers may be less discouraged by driving and taking on gas expenses to attend classes. Donna Kahm, president and CEO of Southern Tier Health Care System Inc., believes the online format has "absolutely" made becoming an EMT more accessible, as Southern Tier has been able to hold larger EMT classes.

Consistent volunteerism is absolutely crucial for rural communities' continued access to emergency medical services. New York State providing a more competitive incentive such as SUNY tuition incentives for volunteers and their children will not only increase the influx of volunteers, but encourage multi-generational volunteerism, keeping rural EMS agencies going for years to come. In addition to incentives, ensuring EMT and paramedic training is as accessible as possible is crucial to keeping interest in EMS volunteer opportunities alive.

## COMMUNITY PARAMEDICINE

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To further increase rural New York's access to quality healthcare, we recommend introducing community paramedicine programs across the state. Community paramedicine is a novel healthcare model being utilized in rural communities across the nation. In this model, EMTs and paramedics act as a liaison between their community and primary care, health education, and other medical services. Focused on the unique public health needs of the community, this model is flexible and may look different across regions in the state. Community paramedicine supports rural communities in particular by increasing access to primary care, addressing medical concerns before they become life-threatening emergencies. This will also reduce non-emergency calls and transports. The community paramedicine model also presents an opportunity for a new stream of income for agencies, receiving compensation for any provided primary care either at a local clinic setting or via home visits.

Initiating the community paramedicine model in rural communities will not only increase revenue for EMS agencies, but also develop agencies' relationships with their communities and give rural New Yorkers access to more personalized and preventative healthcare.

In addition to improving EMS revenue stream with community paramedicine, NYSARH also recommends introducing an efficiency model used in Wisconsin created by Paul Anderson. Anderson's workbook guides rural EMS agencies through business complications and provides recommendations for improving practice.<sup>3</sup> Utilized by the state of Wisconsin, this innovative model has improved conditions for rural agencies and their communities.

## CONCLUSION

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The time to act is *now* for New York State to preserve and increase rural New York's access to emergency medical services. Government action is necessary to ensure a healthy and safe life for all constituents, especially those in rural areas. Emergency medical services have experienced unfair compensation for far too long, threatening both their businesses and the health of the communities they so passionately serve.

By

- increasing the Medicaid reimbursement rate and transitioning to the Medicare RVU model,
- passing private insurance direct pay or dual-signature check legislation,
- providing tuition discounts for EMS volunteers and their children as well as keeping training in an accessible hybrid model,
- and introducing community paramedicine programs across rural communities,

New York State can increase access to emergency medical services and improve public health for rural New Yorkers.

## REFERENCES

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