



**CITY OF KIRKLAND**  
**Fire & Building Department**  
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## MEMORANDUM

**To:** Kurt Triplett, City Manager

**From:** J Kevin Nalder, Director Fire and Building Department  
Mark Jung, Lieutenant

**Date:** November 22, 2010

**Subject:** EMS Transportation User Fee

### RECOMMENDATION:

1. City Council receives the detailed staff report and recommendations on policy issues, financial issues, and operational issues for implementation of an emergency-medical-transport fee.
2. City Council gives staff direction on key program design questions, and authorizes a professional services contract with Systems Design EMS for billing services.
3. City Council directs staff to prepare an ordinance authorizing Emergency Medical Services (EMS) Transportation User Fees for consideration at the January 4, 2011 meeting.

### BACKGROUND:

Staff was directed at the November 1, 2010 City Council Meeting to return with detailed reports on key policy, financial, and operational issues for implementation of an EMS transport fee. These issues are presented in a sequential order below. The recommendations and discussion included in this memo have been reviewed by the City Attorney's Office and a discussion of questions of law is attached as Appendix A. Where appropriate, we have drawn examples and comparisons to peer agencies. These peer agencies all have established medical transport fees with one or more years of experience. They include:

#### King County:

- City of Bothell
- King County Fire District #43 (Maple Valley)
- Valley Regional Fire Authority (VRFA)

#### Snohomish County:

- City of Edmonds (Joined Snohomish County District #1 in January 2010)
- City of Everett
- Snohomish County Fire District #1 (South Snohomish county including Brier, Edmonds and Mountlake Terrace)
- Snohomish County Fire District #7 (South East Snohomish County including Clearview, Mill Creek, and Brier)
- City of Lynwood

### Recommended Service Commitment:

Ability to pay will never be a condition of emergency medical service or transport. Each issue below is considered with this overarching principle in mind. The Kirkland Fire Department will continue to provide exceptional emergency medical services to the community as part of the King County EMS System without regard for a patient's ability to pay user fees that may be assessed for emergency medical transportation. Further, policies and procedures regarding user fees for medical transportation will be fair, equitable, and consistent.

### Proposed Program Overview:

Emergency medical transport fees are legal, reputable, common and well established user fees that help defray the cost of providing and improving comprehensive EMS life and safety services. The vast majority of patients transported by the Kirkland Fire Department have some form of medical insurance, and they have already paid premiums to cover the cost of EMS transportation. Based on information gathered from billing services familiar with our region, we anticipate that over 90% of patients transported will have some form of insurance, and most of the remaining patients will be helped by the financial aid policy proposed below.

The idea of only billing insurance companies and waiving deductibles, copayments, or the entire fee for uninsured patients is appealing, but there are strict rules governing billing procedures (Appendix A: 3-6, 9). As a municipal ambulance company, there is some flexibility to waive deductibles and copayments for residents in consideration for taxes paid by those residents to support the service (Appendix A: 3, 5). Nonresidents must be billed for deductibles and copayments not covered by insurance, and the entire fee may not be waived for those without insurance, regardless of resident status, unless they can show indigence (Appendix A: 6). Figure 1, on page 3, illustrates the billing arrangement recommended by staff in flow-chart form.

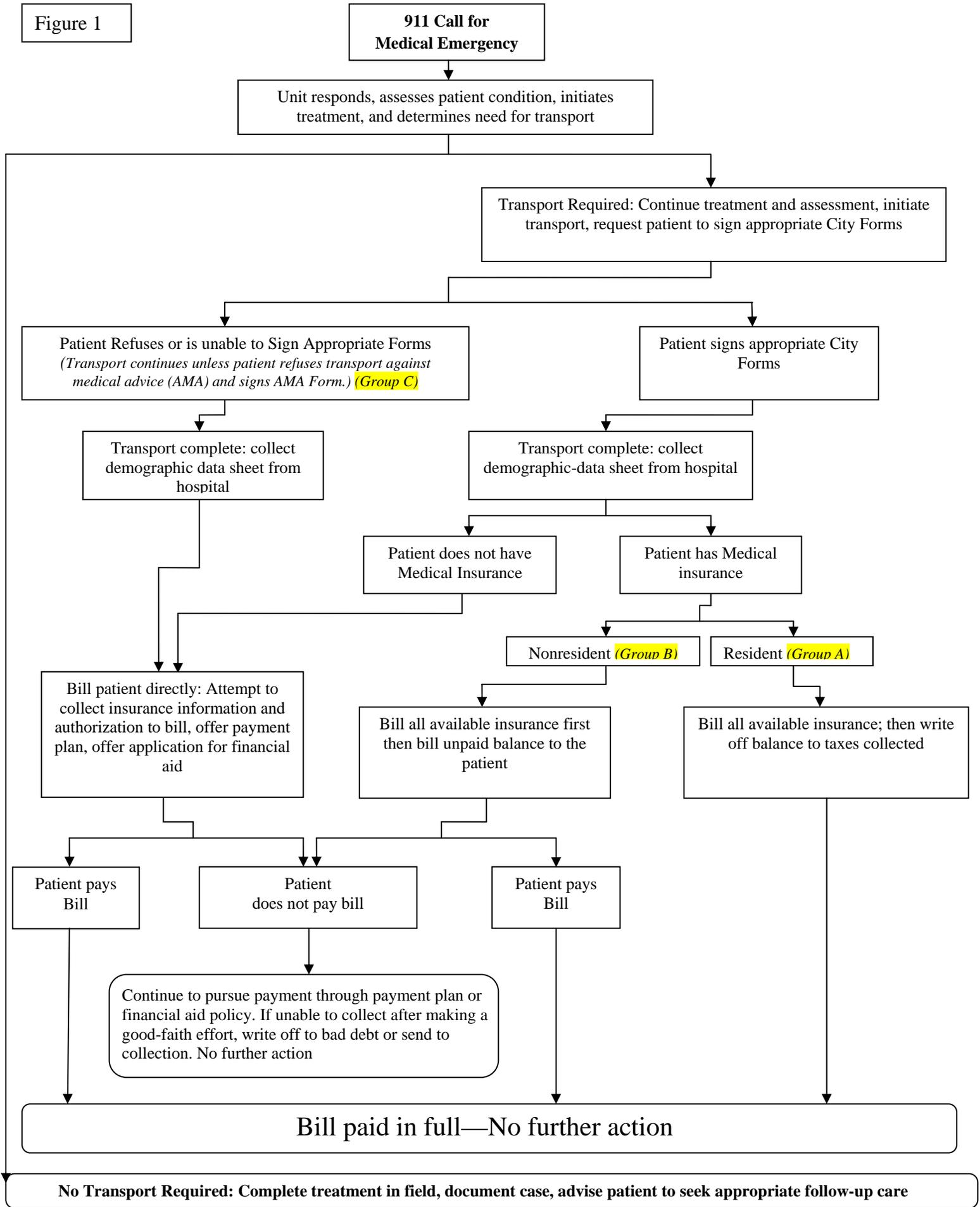
### Shall portions of the EMS transport fee, not covered by insurance, be waived for residents?:

To enhance fairness and equity of the user fee arrangement, Council may choose to waive uninsured portions of transport fees for residents of the City and King County Fire District #41. This approach will reduce the financial impact on resident users who have some third-party insurance. This includes Medicare, Medicaid, private medical insurance, supplemental-medical insurance, Labor and Industries industrial insurance, accidental injury insurance and or any other insurance payer that may be properly billed for emergency medical transportation. All of our peer agencies have developed policies that waive uninsured transportation fees for residents.

Waiving these fees for residents will have a significant effect on collection rate. Based on conversations with billers and data collected from our peers, writing off deductibles and copayments for residents decreases the collection rate by about 15%. **Staff recommends waiving the uninsured portion of transport fees for residents.**

# BILLING FLOWCHART FOR EMS TRANSPORTATION FEE

Figure 1



Definition of "Resident":

The Council has some discretion in defining who will be treated as a resident in the context of waiving uninsured transportation fees. Obviously, someone residing in the City is a resident, but the Council has discretion to extend "resident" status to employees of tax-paying businesses, employees of non-profit organizations, City Employees, other government employees working in the City and to tax-paying nonresidents as well. While allowable, it is unclear if there is a threshold amount of tax that would need to be paid to qualify as a tax-paying nonresident (see Appendix A: 3). There will also be some difficulty in efficiently documenting taxes paid by these nonresidents. This uncertainty and complexity is probably the reason none of our peer agencies have extended resident status to tax-paying nonresidents. Most of our peers limit resident status strictly to residents, but some have included employees at work within their jurisdictions as residents as well. This choice will have a smaller, but additional negative effect on collection rate. **Staff recommends including employees at work within the City and Fire District #41 as residents, but not including tax-paying nonresidents.**

Financial Aid:

While any financial aid policy that contains uniform procedures and standards for identifying those eligible for aid is acceptable, staff recommends implementing a policy that is consistent with WAC 246-453-001 through 246-453-060 "Hospital Charity Care." The WAC establishes Federal Poverty Guidelines as the standard and defines procedures for determining eligibility.

<b>The 2010 Poverty Guidelines for the 48 Contiguous States and the District of Columbia</b>				
<b>Persons in family</b>	<b>100% Charity</b> 100-133% of Poverty	<b>50% Charity</b> 134-166% of Poverty	<b>25% Charity</b> 167-200% of Poverty	<b>0% Charity</b> >200% of poverty
1	\$10,830	\$14,512	\$18,086	\$21,661
2	14,570	19,524	24,332	29,141
3	18,310	24,535	30,578	36,621
4	22,050	29,547	36,823	44,101
5	25,790	34,559	43,069	51,581
6	29,530	39,570	49,315	59,061
7	33,270	44,582	55,561	66,541
8	37,010	49,593	61,807	74,021

For families with more than 8 persons, add \$3,740 for each additional person.

Collecting Delinquent Accounts:

Only one of our peer departments has a policy that sends delinquent accounts to a collection agency. Their collection rate (53%) is in the middle of the range (41-68%) and near the median (54%). Billing companies report that they have very good success when they contact patients with a full range of options. They can help patients by gathering missing insurance information, offering financial aid, or a payment plan. Some departments, not among our peers, have collection policies that send only the most noncompliant accounts to collection—accounts owing more than \$200 for example. The City Attorney has concluded that the City can meet its

obligation to make a bona fide attempt to bill and collect unpaid fees without sending these debts to collection (Appendix A: 6). The most common practice among our peers is to write off accounts as uncollectable after making a good faith effort to bill and collect from the patient for 90 days. **Staff recommends against sending delinquent accounts to a collection agency**, however, Council may choose to send all delinquent accounts to collection, or choose some threshold criteria for sending accounts to collection.

#### User-Fee Groups:

With discussions of resident status, waiver of uninsured fees, and financial aid complete, billing procedures can be broken in to four groups. These groups have been noted on Figure 1 where appropriate. **Staff recommends accepting the following user groups and billing procedures as a framework for developing billing policies that are fair, equitable and consistent:**

Group A: Residents of the City and District #41 who sign a City-approved form that contains an assignment of insurance benefits to the City, together with an appropriate release of medical information.

Billing procedure: All bills are sent to the patient's insurance carrier(s). Resident status permits that portion of the fee not paid by a primary or secondary insurer, supplemental insurer, third-party insurer, Medicare, Medicaid, or any other insurance or medical benefits available to the patient to be deemed as having been paid by taxes already collected by the City of Kirkland.

Group B: Nonresidents who sign appropriate forms.

Billing Procedure: Bills are sent to the patient's insurance carrier(s). A bill will be sent monthly to the patient for any unpaid balance. If no payment is received after 30 days, the biller will send a letter explaining our financial aid policy and offering an interest-free payment plan. If no payment is received after the City has met its obligation to make a bona fide attempt to bill and collect, the unpaid fees will be written off as uncollectable.

Group C: Patients who, regardless of resident status, refuse to sign or are unable to sign appropriate forms, refuse to provide insurance information, and/or state they have no insurance.

Billing Procedure: All bills will be sent monthly to the patient's residence along with a letter attempting to resolve any issues with billing the patient's insurance. If the patient does not have insurance, a letter will be sent explaining the financial-aid policy and offering an interest-free payment plan. If no payment is received after the City has met its obligation to make a bona fide attempt to bill and collect, the unpaid fees will be written off as uncollectable.

Group D: Without first reaching a legal agreement with our mutual aid partners, patients transported, by the Kirkland Fire Department, from outside the boundaries of Kirkland and King County Fire District #41 will not receive a bill for emergency medical transportation service. (Appendix A: 7)

Rates:

**Staff recommends charging \$600 plus \$14 per mile for emergency medical transportation.** Four approaches were used to arrive at the recommended rate.

- The cost of providing service;
- Reimbursement maximums by Medicare, Medicaid, and Washington State Labor and Industries;
- Fees being charged by our peers and private providers; and
- The recommendation contained in the Management Partners feasibility study

Cost of Providing Service: An average-cost-per-call approach<sup>1</sup> was calculated to determine the direct and indirect cost of providing EMS for 2009<sup>2</sup> (\$9,978,625). Then the average cost of a response requiring transport was determined along with the average cost of a non-transport response. Finally, knowing that every transport response has a non-transport component<sup>3</sup>, the average non-transport-response cost is subtracted from the average transport-response cost to arrive at the marginal cost of transport, \$1,359. (Appendix B includes the detailed calculation) The cost of providing the transport clearly exceeds user fee recommended.

Reimbursement Maximums: Medicare, Medicaid, and Washington State Labor and Industries impose maximum amounts they will pay for transports. Medicare and Medicaid are important to consider because they define the lower end of reasonable and customary fees. The maximum payment from Medicare is \$362.51 + \$6.87 per mile. Medicaid is \$115.34 + \$5.08 per mile. Because Medicare and Medicaid don't recognize local economic conditions (only the difference between urban and rural), it is useful to consider Washington State Labor and Industries maximum payment as a local indicator of usual, customary and reasonable (\$554 +12.84 per mile).

<b>Payer</b>	<b>Base Rate</b>	<b>Mileage</b>
Medicare	\$362.51	\$6.87 / mile
Medicaid	\$115.34	\$5.08 / mile
WA L&I	\$554.00	\$12.84 / mile

Peer Provider and Private Rates: There are currently only three agencies charging user fees for EMS transportation in King County. Although Maple Valley (District #43) and VRFA are distant and don't match Kirkland perfectly in demographics or transport volume; they are included

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<sup>1</sup> The mix of EMS versus Fire emergencies has remained stable for the past several years at 70% EMS and 30% Fire. To simply accept this ratio as a basis for allocating the program costs of EMS and Fire ignores that fire responses are often more complex, resource intensive, and frequently take hours, and sometimes days, to complete. While the costs of providing EMS and fire services are deeply intertwined, and allocating costs based solely on the mix of EMS and fire responses is not ideal, fire and finance staffs agree, for this exercise, it is acceptable.

<sup>2</sup> 2009 is the last year where complete data is available. Projected call volume and budget data could have been used from 2010 but the data sets don't appear to be materially different, so complete-year data was chosen over projected.

<sup>3</sup> The process of responding, contacting the patient, patient assessment, beginning treatment, and making a treatment plan is the same on every EMS call regardless of the decision to transport.

because they are part of the King County EMS System and their EMS structures are similar. We have also chosen providers in Snohomish County because of their proximity and similar demographics.

Peer Jurisdiction	Base Rate	Mileage
King County Average	\$571	\$8.87 / mile
*Excluding Bothell	\$656	\$13.31 / mile
Snohomish County Average	\$487	\$14.61 / mile
Average of all peers	\$523	\$12.17 / mile
*Excluding Bothell	\$544	\$14.17 / mile
Average of 3 local private	\$694	\$16.10 / mile
*The city of Bothell charges substantially less than any of our peer providers (\$400) and they do not charge a per-mile fee.		

Consultant and Staff Recommendation: Management Partners recommended \$600 + \$14 / mile in their report based on their analysis of peer agency rates, rates charged by local provides, and rates charged nationwide.

Revenue:

Three variables determine revenue: the number of transports, the fee (if accepted by Council), and the collection rate (total receipts / billed).

Number of transports: The Kirkland Fire Department typically responds to just over 5,000 medical emergencies each year (5,251 projected in 2010), and about 40% of those responses (2,210 projected in 2010) result in a Kirkland EMS transport to a local hospital for evaluation and treatment in the emergency department. In previous reports staff has indicated the typical number of transports is near 3,400. This was due to an error interpreting our transport-unit report. The code "no unit" was interpreted as a transport where a unit was not reported for the transport, but it actually indicated no transport at all. This error has been corrected and the 2009 and 2010 data, reported below, has been checked against transport data provided by NORCOM Dispatch.

Call Data	2009	2010 (projected)	2011 (projected)
Total Responses	7,318	7,057	7,469
Fire	2,178	1,806	1,911
EMS	5,140	5,251	5,558
<b>-Transport</b>	<b>2,164</b>	<b>2,210</b>	<b>2,431</b>
-Non Transport	2,976	3,041	3,127

Collection rate: Decisions Council makes about how much the fee will be, writing off deductibles and copayments for residents, broadly defining resident status, collection policies, and the financial-aid policy will affect the collection rate.

Charging a fee much higher than the Medicare maximum will reduce the collection rate because Medicare Part-B ambulance services are required to accept the payment from Medicare and not bill the patient for the uncovered balance. Each time Medicare pays only a fraction of the billed amount, it drives the collection rate down. That is not to say that it drives revenue down. Setting a low fee could lead to a very high collection rate but low revenue. Bothell, for example, reports an impressive collection rate (68%), but their rate is \$400, just above the Medicare cap of \$362. The reported range of our peer agencies is 41-68% with a median equal to 54%. Not surprisingly, the extremes of the range belong to the highest and lowest fees charged by our peers.

Based on conversations with billers and data collected from our peers, writing off deductibles and copayments for residents decreases the collection rate by about 15%. The range is 5% to 19% for our peers, but again, setting a low fee reduces the impact of the write off. When the outlier, 5% reported by Bothell, is removed the range of our peers becomes 12-19% with a median of 15%.

The financial aid policy recommended by staff is not likely to affect the collection rate significantly. The people helped by the financial aid are highly unlikely to be able to pay even if the debt is not forgiven and written off.

**Staff recommends assuming a collection rate of 53%.** This is based on the policy choices recommended by staff and collection rate data gathered about our peer departments. Our fee is recommended near the high end of the range indicating a slightly lower than average collection rate, but our other policies are very similar to our peers. This rate is the same as the rate recommended by Management Partners in their feasibility study for Kirkland, and just one percentage point higher than the national average (52%) published JEMS in their 2009 "200 City Survey" article.

Using the recommended billing rate of \$600 + \$14 per mile, a collection rate of 53%, and 2,431 EMS transports, annual gross revenue is projected to be \$845,210.

Revenue	
Transports Provided	2,431
Fee including 4 miles at \$14 / mile	\$656
Expected Collection Rate	53%
--Expected Total Revenue	\$845,210

Overhead:

Billing Service: The annual cost of billing services is projected to be \$50,905 based on 2,431 patient care reports (PCR) at \$20.94 each. Staff recommends initially entering into a professional services contract with Systems Design EMS to expire no later than December 31, 2012 for billing services at \$20.50 per PCR plus postage. If billing begins on March 1, 2010, the contract cost is projected to be \$42,677. Municipal-ambulance billing is a specialized area of medical billing. Systems Design EMS is a Western-Washington company that has extensive experience providing ambulance-billing services for Washington fire departments. They provide

billing services for more than 60 Washington fire departments including five of our seven selected peer agencies. Staff has spoken directly with our peer agencies using Systems Design EMS, and all were satisfied or very satisfied with their experience.

Systems Design was selected by the City of Everett as the provider of ambulance billing services after a formal RFP process that netted multiple bidders. Staff recommends utilizing the cooperative-purchasing language contained in the Everett RFP to “piggy back” on that contract. Time is critical right now as we move the implementation along, but, after billing begins and the program is established, the City should initiate an RFP process to select a vendor for 2013 and beyond.

Supplies, printing and public education: Staff anticipates the cost of printing required forms and public education materials, plus incidental supplies (mostly paper), to be \$1,250.

Additional Workload: The addition of billing creates additional work in three areas, Fire Operations, Fire Administration, and Finance Operations. **Staff recommends adding a significant initial investment in management and oversight beyond what was outlined in the Management Partners feasibility study.** While developing the implementation plan, conversations with our peer departments, experienced change managers, and the local IAFF Leadership indicate that implementing a transport fee will require persistent attention and leadership as new processes and procedures are inculcated in the daily operation of the Department. Managing this change will require, not only support from the entire Senior Staff, but also a dedicated IAFF staff officer committed to program development, quality assurance, training, and program monitoring.

Our peers in Snohomish County have integrated this workload in their EMS management and oversight structures. On average, they dedicate 3.0 FTE’s to management and oversight of their EMS programs, but these departments provide advanced life support (ALS) service in addition to operating a basic life support (BLS) service. In King County, departments that operate ALS services<sup>4</sup> have similar overhead dedicated to EMS, but departments operating only BLS services, have EMS organizational structures that have evolved organically with limited and extremely decentralized command and control. Although this structure has been very efficient in Kirkland, the Department currently lacks capacity to provide the essential management, leadership, and administrative activities required to support billing for EMS transportation without adding staff.

Figure 2, below, illustrates the comparative differences between the Kirkland-proposed EMS structure after implementing EMS transport fees, and our peers. Bothell and Maple Valley have managed to implement EMS billing programs without adding an administrative officer, but they are smaller. Each Department bills fewer than 1,000 transports per year and they commit more than 0.5 FTE per/1000 PCR’s—twice the average of our peers. VRFA initially implemented EMS transport billing without adding an administrative EMS officer, but later reorganized assigning an administrative captain to oversee the EMS transport billing program.

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<sup>4</sup> King County EMS is responsible for all ALS service in King County (except Seattle). They provide the service directly in South King County and contract with Bellevue, Redmond, and Shoreline Fire Departments to provide service to the remaining area.

Department		Structure	Transports Billed/Year	Management and Oversight of EMS Program Minus Supervision			Admin Support for Transport Billing
				DC/MSA	BC/MSO	Captain	Admin Assistant
<b>Kirkland (proposed)</b>		<b>BLS</b>	<b>2,431</b>	<b>0.125</b>	<b>0.25</b>	<b>1.00</b>	<b>0.50</b>
King County							
Maple Valley (KCFD#43)		BLS	950	0.125	0.25	-	0.50
VRFA		BLS	600	0.125	0.25	1.00	0.25
Bothell		BLS	725	0.125	0.25	-	0.50
King County Total			2,275	0.375	0.75	1.00	1.25
Snohomish County							
Everett		ALS/BLS	3,800	1.00	2.00	-	0.75
Lynnwood		ALS/BLS	1,950	1.00	1.00	-	0.50
Sno 1		ALS/BLS	5,400	1.00	3.00	-	1.00
Snohomish County Total			11,150	3.00	6.00	-	2.25
Total			13,425				Total 3.50
Admin Support/1000 Transports							
All peer departments			0.26				
Kirkland (proposed)			0.21				
Average King County			0.55				
Average Sno. County			0.20				
Management & Oversight/1000 Transports							
All peer departments			0.83				
Kirkland (proposed)			0.57				
Average King County			0.93				
Average Sno. County			0.81				

The proposed staffing plan includes 0.57 FTE's dedicated to management and oversight per 1,000 PCR's; less than the average of all of our peers (0.83 FTE/1000) and also less than the average of our King County BLS peers (0.93 FTE/1000).

Fire Operations and Administration: Staff recommends adding a program administrator, at the rank of IAFF Captain<sup>5</sup>, to develop, implement and manage the operations and projects of the EMS Transport Billing program. This position is central and critical to program success. Thorough knowledge of EMS operations, highly developed administrative skills, credibility with EMS staff, and authority within the EMS chain of command are essential attributes for the person in this position. Initially the program administrator will continue to move the implementation process forward developing the necessary elements required to begin billing by the March 1, 2011 target date. These activities include:

<sup>5</sup> The IAFF has formally requested to bargain the impacts of the EMS transport billing program and representation of the new work identified above as "program administrator." In initial negotiations the IAFF has indicated they believe the work is at or above the level of IAFF Captain.

- Coordinating development of an ordinance with the City Attorney's Office for Council Approval
- Developing new policies and procedures
  - Fire Department standard operating procedures for EMS staff
  - Health Insurance Portability and Accountability Act (HIPAA) compliant policy and procedure for storage and flow of protected health information
  - Policy and procedure for communicating billing information to the billing vendor and tracking payments with finance staff
- Finalizing vendor contract
- Continuing to pursue acquisition of provider identification numbers and authorizations to bill various insurance carriers
- Developing and acquiring a supply of forms for collecting field information, patient authorizations, and public information
- Developing and delivering training for EMS staff
- Coordinating with finance staff to develop initial accounting procedures
- Developing initial program evaluation tools, reports, and reporting schedule
- Developing and delivering public information tools to introduce the EMS transport billing program and address anticipated questions and concerns

Skillful program development and implementation is critical to future success. Delays and missteps will be costly considering the projected-program revenue is more than \$70,000 per month and each 1% reduction in collection rate amounts to nearly \$8,500 in lost revenue annually. The implementation plan must continue to be moved forward seamlessly by the program administrator and the implementation team to reach the target date.

The workload will obviously be initially demanding as the program gets up and running. To overcome the initial workload, shift coordinators will be recruited from the company officer ranks in the Operations Division to assist with training and issues in Fire Operations, and temporary staff positions are recommended in Fire Administration and Finance Operations. The demands of managing change will likely wane as the first year of billing draws to a close, but the workload will continue as program evaluation and improvement processes move forward. The ongoing duties of the program administrator include but are not limited to the following:

- Facilitates and monitors program objectives
- Develops and monitors program budget
- Gathers and analyzes information pertaining to program efficiency and effectiveness, including overall program evaluation
- Makes recommendations regarding program policy
- Maintains familiarity with relevant EMS and EMS-transport law
  - Develops compliant program components
  - Implements program changes to comply with changes in law
- Initiates, develops and evaluates requests for proposals (RFPs)
- Implements and ensure compliance with contract requirements
- Coordinates and facilitates contract(s)
- Develops and monitors data collection systems

- Ensures documentation of all applicable licensure, certification and/or accreditation requirements for all medical personnel.
- Establishes and maintains quality assurance (QA) program
  - Maintains QA records
  - Implements and evaluates QA initiatives
- Acts as Health Insurance Portability and Accountability Act (HIPAA) Compliance Officer

Staff recommends a temporary position in fire administration to assist with routine administrative activities as the program administrator focuses on program development, evaluation and improvement during the first year.

Fire Administration: Staff recommends adding ½ FTE Office Technician (one year temporary funding). Our peer departments indicate, on average, they are allocating 0.26 FTE per 1,000 / PCR's at the administrative assistant level to complete routine administrative tasks associated with EMS transport billing. The staff recommendation amounts to allocating 0.21 FTE/1000 PCR's. These tasks include:

- Data entry, scanning PCR's and demographic data sheets
- Transmit billing data
- Follow up on issues/questions on PCR's and routine communications with billing vendor
- Follow up on issues/questions on demographic data from local hospitals
- HIPAA compliance auditing and reporting
- Track PCR's to account for all records issued (internal audit of numbered reports)
- Provide batch data to Finance staff for reconciliation
- Managing EMS billing records in TRIM Context software and moving paper records to secure offsite storage.
- Assist with data collection and reports as requested by the departments, City Manager and Council.

Finance Accounting: Staff recommends adding ¼ FTE Accounting Support Associate. Sound financial practices require separation between billing and accounting of revenue. The final ¼ FTE in the complete overhead package will allow the finance department to commit staff time to the following accounting issues:

- Daily deposit of insurance and patient payments submitted by billing agency
- Deposit of any direct patient payments made to the City/Reconciliation of such payments with billing agency
- Track outstanding accounts, establish collection agency account or work with payment plans
- Reconciliation of payments to bank reconciliation
- Reconciliation and payment of vendor contract
- Establish, review and update internal policy on billing, charges, write-offs and delinquent pursuits in a formal City policy
- Assist with data collection and reports as requested by the departments, City Manager and Council

Staff is committed to efficient operation with minimum overhead. Procedures will be designed and refined to utilize technology and minimize the impact on finance staff and the demand for

routine administrative tasks. A work analysis will be conducted late in 2011, when the program has some history, to identify the ongoing administrative needs beyond the Captain in 2012.

Total annual overhead is estimated at \$202,954 (staff) plus \$52,155 professional services contract and supplies = \$255,109.

	Annual Overhead	2011 Overhead		2012 Overhead Excluding Temporary Staff
Additional Staff	\$202,954	\$193,605		\$165,828
Professional Services	\$50,905	\$42,677		\$50,905
Supplies	\$1,250	\$1,250		\$1,250
--Total Overhead	\$255,109	\$237,531		\$217,983

Net Revenue:

The Management Partners report projected ongoing annual net revenue at \$1,010,240 and total overhead at \$150,900 for annual net resources of \$859,340. The revised ongoing net revenue is projected to be \$845,210 with total overhead of \$255,109 which results in net annual resources of \$590,101. The table below summarizes the relative changes in estimates.

	Management Partners Study	Revised Estimates	Difference
Net Revenue*	\$1,010,240	\$845,210**	(\$165,030)
Overhead Costs	\$150,900	\$255,109	(\$104,209)
Net Resources	\$859,340	\$590,101	(\$269,239)

\*Gross revenue less uncollectible.

\*\*Revised estimate due to reduction in number of transports from 3,400 to 2,400.

2011 revenue may be substantially reduced due to three issues:

1. Projected March 1, 2010 start date eliminates 59 days of revenue.
2. Approximately 60 days will be required before revenue starts coming in.
3. Council may choose not to implement EMS transport fees in the district until June 1, 2011 annexation date. This amounts to reducing transport revenue by 48% for 92 days after starting in the City, a reduction of \$102,259. Staff does not know of any official objection being asserted by the King County Fire District #41 Commissioners, and the City is not legally required to obtain approval (Appendix A: 8). **Staff recommends not delaying the start date in Fire District #41.**

Net revenue for 2011 is projected to be \$332,117 with a concurrent start date in District #41, or \$230,954 if billing doesn't begin in District #41 until June 1, 2011. The 2012 estimates shown below assume that the administrative support in Fire Administration is one-time and will be eliminated as an ongoing cost. The IAFF Captain and the Finance support is assumed as ongoing.

Net Annual Revenue		
	2011	2012 (minus temp staff)
Gross Annual Revenue	\$845,210	\$845,210
Total annual Overhead	-\$255,109	-\$217,983
--Net annual Revenue	\$590,101	\$627,227

		2011 Net Revenue
Gross Annual Revenue	\$845,210	
Total 2011 Overhead	\$-237,531	\$607,679
Start 3/1/2011	\$-136,623	\$471,056
<b>60 day payment lag</b>	<b>\$-138,939</b>	<b>\$332,117</b>
Start District 6/1/2011	\$-102,259	\$229,858

**\*\*City Manager's Note\*\***

Budgetary Impacts of Revised Estimates:

During the Council budget deliberations, the EMS Transport Fee was specifically identified as a revenue source to help restore the overtime dollars needed to avoid rolling "brownouts" in the Fire Stations for 2011-2012. The revenue necessary to avoid brownouts in 2011 (assuming no other changes to the budget or operations) would be \$582,000. The revenue necessary in 2012 would be \$760,000. The difference is based on the Council's budget decision to "frontload" \$180,000 from the overtime reserve in 2011 to avoid any brownouts in January, February or March.

2011 One Time Funding and 2012 Gap:

As mentioned above, with the staffing levels we believe are necessary to effectively implement the program in 2011, the net revenue for a full year of collections would be \$590,000. However, since the fee will not be implemented until March, the estimated 2011 revenue is \$333,000.

**To avoid rolling brownouts for the 2011 and to adequately resource the implementation of the fee, staff is proposing to fund the approximately \$250,000 gap in 2011 with one-time dollars to be identified by Finance for Council consideration in early 2011.**

If we assume the 2011 staffing levels are continued in 2012, the net revenue for 2012 would be \$590,000. This would leave a gap of approximately \$170,000 for 2012 if no changes are made to staffing and operations and overtime use meets projections. Clearly the City would need to take some additional action to address this gap. Further study is recommended regarding the ongoing need for staffing beyond the Captain.

Conclusion:

Staff has presented a detailed report on several key policy, financial, and operational issues where Council direction is needed prior to drafting a resolution authorizing EMS Transportation User Fees and moving forward with implementation. Council Direction is needed specifically on the following questions:

1. Shall portions of the EMS Transport Fee be waived for residents?
2. How broadly will "resident" be defined?
3. Is the proposed financial-aid policy acceptable?
4. How will delinquent accounts be treated?
5. Does Council accept the proposed billing framework?
6. Is the proposed fee acceptable?
7. Does council authorize the professional services contract with Systems Design EMS?
8. Does the Council have questions regarding the need for the staff to manage and implement the Transport Fee and an understanding of potential ongoing costs?

With direction from Council, staff will continue with the implementation plan and return in January with additional requested information and, if appropriate, an ordinance for Council's approval in January 2011.

1. May the City of Kirkland charge a fee for transporting patients after responding to a call for emergency medical services?

Pursuant to RCW 35A.11.020, code cities like Kirkland are granted very broad powers to adopt ordinances relating to and regulating its local and municipal affairs and appropriate to the good government of the City. In addition, "the legislative body of each code city shall have all powers possible for a city or town to have under the constitution of this state, and not specifically denied to code cities by law." 35A.11.020. One such power was delegated to towns in 35.27.370 and provides there in subsection(15) that: "The council of said town shall have power . . . To operate ambulance service which may serve the town and surrounding rural areas and, in the discretion of the council, to make a charge for such service. . . . Consequently, the City may charge a fee for transport.

2. Does the King County EMS levy prohibit the City from charging a fee for transport?

Upon review of the ordinance proposing the levy, the ordinance adopting financial policies for the fund created by the levy and the Medic One/EMS 2008-2013 Strategic Plan, there is nothing there that indicates the levy funds should be used to pay for transport costs. To the contrary, the Strategic Plan arguably contemplates that only ALS providers will use these funds for transport.<sup>1</sup> The Plan further reveals that only 14% of the revenues needed by BLS providers like Kirkland will be covered by the levy.

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<sup>1</sup> "The levy provides partial funding to BLS providers to help ensure uniform and standardized patient care and enhance BLS services. Basic Life Support services are provided by 31 local fire departments and fire districts. A BLS Subcommittee was formed to help determine the financial needs of regional BLS agencies. A model to estimate the total costs of providing BLS services for fire departments in King County was developed and completed by 20 out of 31 agencies. Costs for the remaining 12 agencies were interpolated based on agencies that were close to them in terms of both operational and geographic characteristics. It was determined that in 2004, the BLS allocation covered approximately 14% of the costs of providing BLS services.

This process was useful to determine a desired increase in the total BLS allocation. It was decided to tie the 2008 BLS allocation to the cost of BLS responding to the most critical of ALS calls. **After extensive review, this was defined as the number of calls requiring ALS transport since BLS provides critical services for these calls by being first on the scene and stabilizing the patient.** The KC EMS Fund is structured to allow increases to the total BLS allocation at CPI each year, and along with a revised allocation formula, now guarantees that each agency will receive at least a small increase each year."

(Emphasis added.) Medic One/EMS 2008 - 2013 Strategic Plan, Revised, November 200, pg 68 – 69. This suggests to me that ALS providers cannot charge a fee for transport because this levy seems to include that as something it was contemplated ALS providers would do for the levy money received. It further suggests to me that BLS providers can charge a fee because it appears the levy was only intended to fund them to show up and take care of the patient until ALS could arrive and transport if necessary.

Clearly, charging a fee for transport services will not be replicating any revenue already being received for such services.

3. May the City allow a waiver from collection for the portion of the transport fee that is not paid for by private insurance, Medicare or Medicaid?

Under Medicare and Medicaid, the city will only receive payment of 80% of the transport fee. Private insurance may also pay only a portion of the entire fee. The balance would have to be paid by the patient unless that portion can be waived. The Office of the Inspector General (OIG) has jurisdiction to provide advisory opinions as to the practices, and those who receive the benefits, of Medicare. The question presented here has been reviewed by OIG in Advisory Opinion 01-11 dated July 20, 2001 where it stated.

However, there is a special rule for providers and suppliers that are owned and operated by a State or a political subdivision of a State, such as a municipality or a fire district. CMS Carrier Manual section 2309.4 provides that:

a [State or local government] facility which reduces or waives its charges for patients unable to pay, or charges patients only to the extent of their Medicare and other health insurance coverage, is not viewed as furnishing free services and may therefore receive program payment.

CMS Carrier Manual section 2309.4; see also CMS Intermediary Manual section 3153.3A. Notwithstanding the use of the term "facility", the Centers for Medicare and Medicaid Services ("CMS") – formerly the Health Care Financing Administration – has confirmed that this provision would apply to a State or municipal ambulance company that is a Medicare Part B supplier.

Accordingly, since the Medicare Program does not require the Fire District (a municipal company) to collect copayments or deductibles from residents, we would not impose sanctions under the anti-kickback statute or section 1128A(a)(5) of the Act where the waiver is implemented by the Fire District categorically for bona fide residents of the Fire District.

OIG Advisory Opinion No. 01-11, July 20, 2001. What this has been interpreted to mean is that, so long as the unpaid balance is owed by a resident of the city, the city can waive collection because that unpaid portion would be deemed to be paid by the taxes the city collects. OIG went on to extend the determination of residency to employees of property tax paying businesses within the city and sales tax paying nonresidents within the city.<sup>2</sup> Regarding the latter, the advisory opinion that granted

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<sup>2</sup> "CMS has also confirmed that this provision would apply to waivers of cost-sharing amounts for employees of taxpaying businesses who need emergency ambulance transportation while working on

it was given in the context of a proposal to waive the unpaid fee for a tourist who had paid sales taxes staying in a hotel within a tourism destination city. The significance of the amount of the sales tax being paid, the fact that the fee was going to the general fund rather than a special purpose fund and that the city was a tourist destination is unknown.

Because of these and other questions around extending the waiver to those who pay sales tax, limiting the waiver to property tax payers and their employees would provide a clear bright line. Further, drawing a distinction between these two funding sources is reasonable because of these same questions.

4. Can the waiver be extended to nonprofit institutions exempt from paying property taxes and their employees?

Equal protection provides Officers and employees of nonprofits, if similarly situated to their counterparts at for profit entities, should be treated alike. It seems to me these employees are similarly situated and should therefore be treated alike. Too, because receiving equivalent health care services from the government may be an important right, maybe even a fundamental right, more than a rational basis for treating them differently will be required. Under such facts, the OIG should recognize a municipality would need to extend the waiver to the officers and employees of nonprofits, too. Consequently, I believe the waiver can be extended to this class of employees as well.

5. Even though the OIG allows cities to waive the portion of the fee not paid by Medicare, Medicaid or private insurance for residents, wouldn't that be a gift of public funds for patients that are not "poor" as contemplated by the Constitution?

While it is true many of those transported will not be poor, waiving the fee is not a gift of public funds because those being transported are infirm. This is significant because the aforementioned prohibition does not apply if the money is being spent, or in this case waived, in aid of the poor or infirm.

6. May the City waive the entire fee for the uninsured without losing the ability to bill Medicare and Medicaid?

In Advisory Opinion 01-11 cited above, the citation to the CMS Carrier Manual provides as follows:

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business premises." OIG Advisory Opinion No. 03-09, April 17, 2003. "CMS has also confirmed that this provision would apply to waivers of cost-sharing amounts for taxpaying nonresidents who need EMS within the City limits." OIG Advisory Opinion No. 05-10, June 9, 2005.

a [State or local government] facility which reduces or waives its charges for patients unable to pay . . . is not viewed as furnishing free services and may therefore receive program payment.

Consequently, the City can waive the fee and still receive payments from Medicare and Medicaid if the uninsured patient is indigent. Of course, due diligence would be required in reaching the conclusion that the patient was truly unable to pay. For those who can afford to pay the fee, the City would have to make reasonable efforts to try and collect. In Advisory Opinion 97-04, the OIG stated that:

Reasonable collection efforts are those efforts that a reasonable provider would undertake to collect amounts owed for items and services provided to patients. These efforts should include a bona fide attempt to bill and collect from the patient if the patient's insurer refuses to pay.

What constitutes a bona fide attempt is not defined by OIG. Merriam-Webster defines such an attempt as one that must be "made in good faith without fraud or deceit." Being prepared to ultimately send it to a collection agency, if necessary, would certainly constitute a bona fide attempt to collect. However, I think it is also reasonable to conclude that City would be acting in good faith if it chose not to pursue collection where the cost of pursuing would exceed the amount the City could recover or the City believes the patient is immune from execution of a judgment because he or she has insufficient non-exempt assets.

7. May the City charge the fee for transport of residents from another jurisdiction?

The City could charge the transport fee from residents of another jurisdiction. However, if the primary EMS provider from that jurisdiction does not charge a transport fee from residents of the City when it transports, the City could elect not to charge that fee of them as well. This would comport with the current practice of not charging for responses into other jurisdictions for fire or EMS services.

8. May the City charge the transport fee from residents of the area being served by Fire District #41 before the effective date of the annexation?

The City currently provides all of the fire protection and EMS services to the District. The agreement between the City and the District by which these services are provided does not prohibit charging this fee. Consequently, the City could charge the fee of the residents of the District even before the effective date of the annexation. However, because it is currently in another jurisdiction, the same rationale that allows us to not charge residents of another jurisdiction could apply. Whether it should or should not be applied seems to be a policy question.

9. What can the City do if the patient refuses to assign their insurance benefits to the City?

The City would either initiate a lawsuit to collect the money or refer it to a collection agency.

<b>Appendix: B</b>			<b>2011 Preliminary</b>
<b>Direct Costs</b>	<b>2009 Actual</b>	<b>2010 Budget</b>	<b>Budget<sup>1</sup></b>
Suppression (org key: 0109202220)	13,237,963	13,080,640	13,180,133
Training (org key: 0109202240)	577,057	520,999	526,428
Subtotal Direct Costs	13,815,020	13,601,639	13,706,561
<b>Indirect Costs</b>			
Department Overhead	409,986	403,793	424,329
City Overhead	820,313	857,900	911,481
Subtotal Indirect Costs	1,230,299	1,261,692	1,335,810
<b>Total Costs for Fire Suppression and Training</b>	<b>15,045,319</b>	<b>14,863,331</b>	<b>15,042,371</b>
Less: EMS Levy Revenue <sup>2</sup>	838,397	866,231	838,197
<b>Net Allocable Costs</b>	<b>14,206,922</b>	<b>13,997,100</b>	<b>14,204,174</b>
<b>Call Data for 2009</b> (from Mark Jung's email)	<b>7,318</b>		
Fire	2,178		
EMS	5,140		
-Transport	2,164		
-Non Transport	2,976		
<b>Average Cost Per Call</b>	<b>\$ 1,941</b>		
<b>EMS Call Time</b>	<b>Hours</b>	<b>Percent of Total Hours</b>	
Transport (average 1 hour*2,200 calls)	2,164	59%	
Non Transport (average .5 hour*2,940 calls)	1,488	41%	
<b>Total Estimated Cost of Service</b>		<b>EMS Cost Per Call</b>	
Fire	4,228,297		
EMS	9,978,625		
-Transport (based on percent of call time)	5,883,854	2,719	
-Non Transport (based on percent of call time)	4,045,829	1,359	
<b>Marginal Cost to Transport</b>		<b>1,359</b>	