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These articles were published in *EMS World* under the byline of a senior subject-matter expert. I served as editorial lead and principal writer: pitching topics, partnering with the SME, and rewriting drafts to meet editorial standards. For the first piece, I provided editing support. The goal: secure national placements in a leading industry publication to expand reach and establish authority with EMS decision-makers.

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FEATURE STORY

Shock Advised: EMS Economics in Critical Condition

By Michael Brook, Senior Vice President, Digitech

05/14/2024

As our nation celebrates the 50th anniversary of EMS Week this month, a time when we're honoring the profession and celebrating our country's dedicated clinicians, there's something we don't seem to be talking about enough: our broken EMS reimbursement model. A model that's still tied to EMS' roots based on payment for transport, and classified by the Centers for Medicare & Medicaid Services (CMS) as a "Supplier of Services," like durable medical equipment, rather than a Provider.

EMS professionals are highly trained, delivering advanced medical care. Assessing and treating physically ill, critically injured, and mentally at-risk patients. They're more than a ride or a supplier of goods, and the outdated reimbursement model is failing private agencies and municipal EMS alike.

The good news is that key EMS organizations are working to change the broken system. The National Association of EMTs, the American Ambulance Association, the International Association of Fire Chiefs, and others are making efforts to influence key policy-makers.

Yes, it's complicated. The challenges with each payer are different. For Medicaid and Medicare, it's typically very low payments that come nowhere close to reimbursing agencies for the cost of care, supplies, and transport. Commercial insurance for ambulance service varies widely from policy to policy with the "allowable" amount typically arbitrary, often tied to some multiple of the Medicare ambulance fee schedule or an opaque "usual and customary" amount. Once the insurance company sets their "allowable," the difference between the charge and the "allowable" becomes stranded. This remaining balance ends up becoming the patient's responsibility. Patients are further punished because any stranded amounts are typically not credited against any deductibles or out-of-pocket maximums associated with their insurance policy. This dilemma is what's led to patient protective legislation such as the No Surprises Act (currently not applicable to ground ambulance services, but under review by the federal Advisory Committee on Ground Ambulance and Patient Billing). In the absence of federal rules, several states are taking action to pass legislation that protects patients. Washington, Indiana, Delaware, Maine, and Colorado have recently set up new protections from large ambulance bills.[1]

"For commercial insurance, the challenge is that some insurers will arbitrarily decide what they think is a fair payment for the service," explains Maxine D'Agostino, Vice President of Billing Services at Digitech, a provider of EMS billing and technology services. "This leads to agencies not getting full reimbursement for the services provided, and also leads to remaining balances that are billed directly to patients, which the insurance industry has successfully labeled as 'balance billing.'"

Jonathan Washko, MBA, FACPE, NRP, AEMD, Assistant Vice President of Northwell Health's Center for EMS and a subject matter expert notes, "Because EMS generates revenue, people believe we have a pot of gold and that we're reimbursed like healthcare. If they see a $5,000 ambulance bill, first there's sticker shock, and everybody thinks we collect that $5,000, but we don't. We may charge $5,000, but we may collect $500 if we are lucky."

To complicate matters, costs nationwide are rising dramatically for labor, vehicles, supplies, medications, and fuel, while reimbursement rates across the board are largely stagnating.

Washko says there's been an exponential rise in the expense of EMS services due to factors like labor shortages, COVID-19, and supply chain issues. "There's no leveling mechanism in Medicare that's appropriate to keep pace with expenses," he says. "Say there's a new drug that comes out that costs $1,000 per dose that's going to save somebody's life, there's no additional reimbursement that comes with that. If there's a new procedure or a new piece of medical equipment, there's no additional reimbursement. We get paid our base rate plus every mile we transport and that's about it."

No Transport, No Dollars

Today most EMS agencies report that up to 33% of calls do not result in transport. Even when the patient is thoroughly assessed

and receives medical treatment on-site, there are often zero reimbursements from most state Medicaid programs nor Medicare for these calls (and Medicare patients typically represent 40% to 50% of EMS calls).

Community paramedicine and mobile integrated healthcare (MIH) are smart, much-needed services in our country. These models are critical to a patient-centered healthcare system and will help serve the traditionally underserved. But we'll never get them off the ground nationwide unless EMS can get fairly compensated for this type of care.

"The sad part is that in many cases, the best thing for the patient is not to go to the emergency department," emphasizes Digitech's D'Agostino. "But EMS agencies are only compensated for the transport, and ironically the transport is to the most expensive part of the health system–the hospital ER."

What does it look like If agencies do not get fairly reimbursed? Eventually, if they're privately owned, they may go out of business, and it's happening at an alarming rate. Approximately 55 ambulance services have gone out of business since 2021, according to local and national media reports tracked by the American Ambulance Association (AAA) and the Academy of International Mobile Healthcare Integration (AIMHI).2 When an agency goes out of business, another entity is forced to step in and fill the gap. Or, worse, we end up with "ambulance deserts."

"When COVID hit, EMS was decimated," says Washko. "Even though we've been talking about the fragility of EMS for a long time, COVID brought more awareness to the funding gaps that exist. Today, many EMS systems across the country are literally failing and are having to shut their doors."

This frequently leads to public EMS services needing tax subsidies, so taxpayers foot the bill to keep emergency medical services alive.

"From a safety net perspective, ultimately a private provider may still continue its mission," explains Washko. "But it would have to be subsidized by the government."

The system is undeniably broken, and we're in dire need of a solution that protects patients and the ambulance services they depend on, as well as taxpayers.

How Can We Shock the System?

We should start with collaboration across the healthcare space to get to commonsense solutions that benefit the patient and provide them with healthcare at the right clinically appropriate timeframe, in the right place, at the right quality, and at the right cost. This requires all parties to agree on solutions. We all need to rally behind an aligned strategy from those national organizations that represent EMS, like IAFC, NAEMT, AAA, and others.

An education effort is needed at the national, state, and local levels as to what financial resources are needed to run an EMS system, and we all need to be transparent about costs.

A major stumbling block is that EMS systems vary widely and so do their costs. Some communities opt to outsource emergency services to private ambulance organizations. Those agencies historically have low pay structures and employ more EMTs vs. paramedics. Other communities provide service through their municipal structure, such as fire-based or third-service EMS, which typically employs paramedics who are paid union-negotiated wages, benefits, and pensions. The cost structure of a municipal-based system is typically much higher than a private-based system, so it's very difficult to define a fair cost structure across the entire industry. EMS providers would benefit from banding together to determine a baseline cost structure, and this collaboration would lead to more success in engaging with large payers.

Legislation on various levels will be a big part of any real, lasting solution. There is some hope on the horizon as several states are working to require commercial insurance companies to reimburse at locally approved or regulated rates. However, state legislation only covers state-regulated plans, and commercial insurance typically represents less than 20% of an agency's billing. The challenges with underfunding by Medicare and Medicaid still need to be addressed. Simply put, Medicare and Medicaid need to pay a fair amount and pay for all services.

Finally, there needs to be a solution to serve patients without insurance–who pays for them? It can't be a case of EMS agencies absorbing the cost (i.e., loss) unless other parties are willing to pay more to offset the uninsured.

In reflecting on the 50th anniversary of EMS Week, Washko first asserts that EMS is undeniably essential. "In places where it doesn't exist, morbidity and mortality rates are higher because of the life-saving work that EMS does. 50 years is not a long time and EMS is still in its infancy. We have a lot of work to do," he explains. "We've been focused on developing the delivery model, the framework, and the system. Not enough time, energy, or attention has been paid to how we get reimbursed," adds Washko. "It's going to take a lot of work on the federal level, on the state level, at the insurance level, and at the agency level in order to get EMS the funding it needs to last another 50 years. As of right now, I don't know that we'd last another 50 years as an industry in its current form."

With that in mind, let's celebrate EMS Week with a reckoning in this country. Let's agree that EMS is an essential part of our nation's continuum of care, one that has a growing role in serving our communities. There's tremendous value in having lifesaving services

available 24 hours a day, seven days a week, but there's also a real and rising cost of providing those services. Most EMS agencies are not looking to drive outrageous profits, they're simply trying to not lose money, pay their staff a living wage and benefits, and be part of a community healthcare solution.

1. https://www.axios.com/2024/03/27/surprise-medical-bills-ambulance-health-costs
2. https://icma.org/articles/pm-magazine/ems-economic-and-staffing-crisis-creates-opportunity-improved-system-design

Michael Brook has been in the EMS billing industry for 15 years in a variety of capacities, including both overseeing billing operations and managing client accounts. He currently provides leadership and support to Digitech clients, partnering with them to optimize revenue and navigate a changing marketplace. Michael would love to hear your thoughts and can be reached on LinkedIn.

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FEATURE STORY

Behind the Sirens: The Hidden Costs of EMS Readiness

08/21/2024

By Michael Brook, Senior Vice President, Digitech

You are the EMS Chief of a midsize Midwestern agency called “Any Town Fire & Rescue Department” or ATFRD. It's 2 AM, and the call comes in — a 45-year-old male with chest pain. Your crew jumps into action, the ambulance's red lights flashing through the deserted streets. This scene, a lifeline in moments of crisis, is repeated countless times across the country daily. But what does it take to keep this service available around the clock? The costs are staggering and often hidden from view. Let's delve into the actual price of maintaining emergency ambulance services and our financial challenges.

The Hidden Infrastructure of EMS

As the crew responds, consider the intricate web of readiness behind this response. Maintaining an EMS system capable of responding to emergencies 24/7 involves substantial costs. While the spotlight is often on the staggering costs of ambulance services for patients, there's less focus on what each EMS incident costs the provider. These expenses extend far beyond the visible efforts of our paramedics and EMTs and include the readiness of staff, facilities, equipment, and supplies.

At Digitech, we process bills for over 5 million EMS incidents annually and assist clients in reporting cost data to CMS. To provide a clear picture of the true costs of readiness, we analyzed 2023 data from 11 diverse ambulance service providers across six states, including Fire-based and EMS-only services. This analysis reveals the extensive financial demands of maintaining an EMS operation.

Breaking Down the Costs: Where Your Budget Goes

Understanding the detailed cost breakdown is essential for managing an efficient EMS operation. Here’s a comprehensive look at the categories involved:

Capital Costs – 2%

- Depreciation of buildings, vehicles, and operational equipment
- Leases, rental, and interest costs

Salaries – 57%

- Regular, overtime, vacation, and holiday pay for all EMS staff, including EMTs, paramedics, chiefs, 911 call technicians, dispatchers, and support staff

Benefits – 25%

- Employer-paid health and life insurance, retirement plans, payroll taxes, and tuition assistance

NOTE: While salaries and benefits are over 80% of an EMS agency’s costs, the industry still faces a staffing crisis; wages are simply not high enough to keep pace with the cost of living and pay in other competing fields. In New York City, EMT salaries start at $39,386 annually. That’s less than the pay for an app delivery worker making the new city minimum wage of $19.56 plus tips while working 40 hours a week.

Medical Supplies – 1%

- Non-capital medical supplies such as medications, monitors, and consumables

Fleet Maintenance – 3%

- Maintenance parts, labor costs, and fuel for vehicle upkeep

Other Admin – 12%

- Professional services, contracted labor, medical director costs, training, utilities, and communications

Case Study: Any Town Fire & Rescue Department

Let's zoom out to understand the broader financial picture. The average cost for ATFRD to run one ambulance trip is nearly $2,000. Most ambulances make multiple trips daily, so the cost of keeping an ambulance operational and ready to respond is significant.

Cost Per Transport Breakdown

Using the example from above, here's how the cost from ATFRD breaks down:

Accounting	$24.98
Administrative	$15.24
Ambulance Salaries	$8.61
Contracts for Equipment Service	$6.07
Contracted Services - Ambulance	$1.39
Dispatch Service	$128.55
Dues and Subscriptions	$1.05
General Insurance	$43.42
Housekeeping	$4.58
Legal	$1.19
Medical Supplies	$30.07
Minor Equipment	$37.59
Minor Medical Equipment	$2.45
Other A&G	$4.39
Other A&G	$3.02
Salaries	$1,124.59
Salaries (Fringe Benefits)	$458.22
Supplies	$34.61
Training	$9.77
Utilities	$14.85
Total	$1,954.60

The Financial Gap: Charges vs. Costs

Your ATFRD crew stabilizes the patient and transports him to the hospital. This vital service comes at a significant cost. The disparity between the transport cost and the patient's charge is substantial. In 2020, the average charge for an ALS emergency ground ambulance service was $758 (report), while the Medicare reimbursement for the same service was only $463. This leaves providers like ATFRD facing a significant shortfall for each transport unless they align fee schedules to costs, a decision with many downsides.

Moreover, for uninsured patients, ATFRD often recovers very little of the billed amount — not because the patients do not want to pay their bills but because they simply cannot. The collection rate for this "self-pay" group may be 5% or lower, meaning that if 1,000 uninsured patients are charged $1,000 each for an ALS transport, it would cost (ATFRD, for example) $1,955,000, and they may only recoup $50,000 on $1,000,000 invoiced.

Conclusion: Bridging the Financial Divide

As the patient receives definitive care at the hospital, your crew is already preparing for the next call. The cost of their service is the furthest thing from their minds — they are rightly focused on responding to that call and delivering high-quality pre-hospital medical care. However, for EMS leaders and administrators, understanding the true costs of EMS services is the first step towards bridging the financial divide. We must advocate for fair reimbursement rates that support our agencies and ensure sustainability. The math doesn't add up, and while the solution isn't simple, acknowledging and addressing these financial gaps is crucial for the future of EMS.

By shedding light on these hidden costs, we aim to foster a deeper understanding among our peers and drive the necessary changes to support our EMS providers. Together, we can work towards sustainable solutions that ensure our readiness and capability to serve our communities effectively.

The next call is just minutes away. Are we ready?

Michael Brook has been in the EMS billing industry for 15 years in a variety of capacities, including both overseeing billing operations and managing client accounts. He currently provides leadership and support to Digitech clients, partnering with them to optimize revenue and navigate a changing marketplace. Michael would love to hear your thoughts and can be reached on LinkedIn.

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FEATURE STORY

Death and Taxes: Sustaining the Lifeline of EMS Services

02/11/2025

By Michael Brook, Senior Vice President, Digitech

In our previous article, Behind the Sirens: The Hidden Costs of EMS Readiness, we explored the costs involved in maintaining 911 EMS readiness with a midsize Midwestern agency called "Any Town Fire & Rescue Department" or ATFRD. In this follow-up, we'll examine the funding sources that support municipal EMS systems.

The Life Behind the Lights

Late one stormy night in Some Town, a 9-1-1 dispatcher answers a call about a young mother struggling to breathe. Within minutes, EMTs from Some Town Fire & Rescue Department (STFRD) arrive, stabilize her condition, and rush her to the hospital. Behind this fraught moment lies a stark reality: EMS services depend on an intricate web of funding to ensure their readiness every day, every hour.

But who pays for this critical safety net?

This article delves into the urgent matter of EMS funding, illuminating the financial gaps that pose a threat to these life-saving services. It also presents potential solutions to bridge these gaps, underlining the need for immediate and concerted action.

The Costs of Readiness: Why It's So Expensive to Save Lives

Every EMS agency operates on two overlapping principles: readiness and response. Maintaining ambulances, equipment, medications, and staff requires funding, even when no emergencies occur. Yet readiness funding routinely falls short of covering its true costs.

In most municipal EMS systems, revenue comes from two primary sources:

1. Direct cost recovery: Revenue from billing insurers and patients for emergency transports.
2. Tax-based funding: Revenue from property taxes, municipal general funds, and special assessments.

However, these sources often do not sufficiently cover the needs. A staggering 80%–90% of EMS transports involve uninsured patients or those covered by fixed-reimbursement government payers, such as Medicare and Medicaid. The reimbursements tied to these transports often fall short of actual costs, leaving EMS agencies to fill the financial gap through taxpayer support.

Funding Breakdown: How Agencies Like STFRD Stay Afloat

Using publicly available data, we analyzed the funding mix for EMS agencies. Here's what we found:

- Direct billing revenue: Typically covers 20%–35% of total costs.
- Supplemental Medicaid payments: Provides additional funds in some states.
- Tax-based revenue: Fills the majority of funding gaps.

For example, at STFRD:

- 36% of EMS funding comes from property taxes.
- 22% comes from the municipal general fund.
- 11% comes from supplemental Medicaid payments.

Without the Medicaid program, funding gaps force STFRD to draw even more from property taxes, placing a heavier burden on the local community and forcing the municipality to make funding trade-offs.

Case Study: The Financial Gap at STFRD

Each ambulance transport at STFRD costs approximately $1,500, but they recoup just $490 per trip through billing. The remaining $1,010 must come from elsewhere—primarily from property taxes and supplemental funds.

This financial gap directly affects STFRD's operations, potentially leading to service cuts, increased tax burden, or the need for better reimbursement rates. Additionally, if state Medicaid programs aren't available, the same difficult decisions loom: raise taxes, cut services, or advocate for better reimbursement rates.

A Broken Model: Why EMS Funding Needs Advocacy

What if we viewed EMS funding like public utilities? Municipal water service requires an infrastructure (i.e., the storage, treatment facilities, pipes, and pipelines) to provide water to households and businesses at any moment; EMS readiness is an equally critical public service with infrastructure costs. Actual water usage fees apply to end-user usage. A household that consumes 1000 gallons of water pays a different amount on their water bill than those that use 100 gallons during the same period.

Following this analogy, taxes would cover the infrastructure of a 24/7 EMS service (like municipal water service infrastructure), and the cost of the actual ambulance transport would be covered by the patient receiving the service (like the water bill).

As water users pay based on consumption, patients and their insurers are expected to contribute to ambulance transports to fully cover the cost of any transport. However, when reimbursements are insufficient, the burden shifts to taxpayers, stretching municipal budgets already allocated to schools, infrastructure, and public safety.

The question is: How do we ensure sustainability without breaking the system—or the community?

A Way Forward: Transparency, Advocacy, and Solutions

Sustainable EMS funding requires a multi-faceted approach:

1. Transparency with taxpayers: Agencies must communicate funding needs and the actual costs of EMS readiness.
2. Fair reimbursement rates: A key pillar of sustainable EMS funding is the need for Medicare, Medicaid, and insurers to cover costs that truly reflect the actual expense of emergency transport. This fair reimbursement is essential to the financial sustainability of EMS services.
3. Community engagement: Residents must understand that EMS isn't just a service; it's a shared responsibility. Their active involvement and understanding play a significant role in sustaining EMS funding, empowering them to contribute to the safety of their community.

Conclusion: Beyond Death and Taxes

As STFRD prepares for its next budget meeting, its leaders must weigh impossible choices: service cuts, tax increases, or sustained advocacy. They—and every municipal EMS agency—face this truth: sustainable EMS funding is not an individual task but a collective effort that requires unity, collaboration, and the active participation of all stakeholders.

Michael Brook has been in the EMS billing industry for 15 years in various capacities, including overseeing billing operations and managing client accounts. He currently provides leadership and support to Digitech clients, partnering with them to optimize revenue and navigate a changing marketplace. Brook would love to hear your thoughts. Connect with him on LinkedIn.