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Joint Medicaid Oversight Committee
February 16, 2023

Chairman Holmes, Vice Chairman Romanchuk, Ranking Member Ingram, and members of the Joint Medicaid Oversight Committee: thank you for the opportunity to discuss the state of Ohio's ambulance industry on behalf the Ohio Ambulance Association this morning. My name is Brian K. Hathaway, and I am the founder and CEO of Spirit EMS based in Greenville. I'm an Advanced EMT and have my fire certification. I work on the ambulance alongside my employees on a regular basis allowing me to see first-hand the challenges that Ohio's frontline medical responders face in their day to day work. Since 1999, I have worked as a dispatcher at the Darke County Sheriff's Office to help the community prioritize emergency and non-emergency calls and dispatch appropriate units. I also serve as a volunteer EMT/ firefighter for Union City Fire and Rescue answering calls on an as needed basis. Prior to opening Spirit, I served as the Captain of EMS for the department. I am a board member and the Education Chairman for the Ohio Ambulance Association and a member of the State Board of Emergency Medical, Fire, and Transportation Services at the Department of Public Safety's Division of EMS.

Believe it or not, my passion for EMS grew from my days of once being a newspaper reporter in the late 90's. Oftentimes, as the reporter, I would be the first on the scene, observe people in dire need of help, and all I could do was stand back and wait for help to arrive. That passion quickly motivated me to obtain my fire and EMS certification. A few short years later, I started Spirit EMS based on the need in my Darke County community, the need to get people moved from one hospital to another for more definitive care, to patients needing transported to doctors' appointments and to life-sustaining dialysis, to patients simply needing someone to take them to an emergency room. The motto of Spirit EMS is "Our Family Taking Care of Your Family" and we truly strive to embrace that ethos that compassion means everything in serving every single one of our patients. Spirit employs 115 people on a full and part-time basis and serves all of Western Ohio with stations in Greenville, Celina, Houston, Sidney, Van Wert, and Liberty, Indiana. My company contracts with joint ambulance districts, hospitals, nursing homes, and various hospice agencies to provide critical medical care and transport throughout Western Ohio. Between our ambulance and wheelchair division, which includes transporting more than fifty children to school every day, Spirit averages around 2,600 transports a month.

Our Association is a diverse organization of ambulance and medical transportation companies, nonprofits, and public providers. Our members provide EMS to cities, villages, and townships; certified Emergency Medical Dispatching for several of those communities; and critical inter-facility transports to hospitals & nursing facilities, including mobile intensive care units, nonemergency ambulance transports, and wheelchair vans. Spirit operates a fleet of more than

sixty vehicles which include forty ambulances, thirteen wheelchair vans, other regular passenger vans, and non-transport vehicles offering our customers a wide variety of transportation options to meet their needs.

911 Response and EMS interfacility transports are provided by both public and private ambulance providers throughout the state and are often the frontline infrastructure of the healthcare system. Our paramedics and EMTs respond to your constituents and our neighbors in their most vulnerable moments. Reponses include acute illness, heart attack, stroke, and trauma, patients who need to be treated onsite and transported to the nearest emergency department.

Essential interfacility transport and care is predominantly provided by the private EMS providers throughout the state. It is necessary for the most at risk patients needing higher care levels or specialized care. Public EMS providers are often unable or unwilling to provide these necessary interfacility transports as it has the potential to take critical resources from 911 services or cause vehicles to make time consuming transports outside their district. However, these ambulance resources are absolutely necessary to assure patients receive the right treatment at the right place at the right time, especially those with a time critical diagnosis. Essential transports include patients needing advanced specialty care such as cardiology, neurology, neonatal, burn units, trauma surgery, or higher-level treatments not provided by the hospital that initially received the patient. Particularly, in rural areas there is a great risk of accessibility issues and the need for rapid and reliable mobile healthcare services to transport patients from community-based hospital ERs to hospitals with higher levels of care for services not commonly provided by community hospitals. Most essential interfaculty care patients also need ambulance services to safely discharge them to their long-term care or rehabilitation facilities.

Our services also include scheduled transports, that while they may not be a transport to lifesaving care, are equally important to keep the continuum of care and achieving successful healthcare outcomes. These can include routine healthcare appointments such as dialysis, specialty physician follow-up visits, and outpatient services not able to be brought to one's home or nursing home such as MRI's, CT scans, and/or radiation and chemotherapy treatments.

Quality reliable ambulance services are essential to transporting critically ill and injured patients regardless of their geographic location. The highly trained professionals in our industry need flexibility to respond to the needs of each individual patient in a timely and oftentimes expeditious manner.

Our patients are not just treated in a traditional healthcare setting. We are much more than a taxi cab or ride share service providing curb to curb transport. Our employees enter residences and other facilities to literally pick up and drop off patients, in all weather, while providing, oftentimes, lifesaving medical care in a moving vehicle. It should also be noted, under the current Medicaid pay structure, ambulance providers are not reimbursed for care provided when no transport is rendered. The care our employees provide is not provided in a vacuum. Our services rely on other healthcare providers to ensure smooth operations. As workforce issues and

caseloads grow across the field, it compounds ambulance issues— our crew may arrive to a scheduled transport to find that the nursing home is not ready for the patient to be transported or may arrive at a specialized facility to find that there is no bed available for the patient they have transported. Ambulance providers are also facing a rising number of psychiatric transports. For many populations, 911 is used as the default or a catch all when any level medical care is needed.

Most private ambulance companies in Ohio experience a payor mix that is 80% public payors. Given that revenue stream, the ambulance industry cannot practice the cost shifting that many other providers are able to engage in to offset below cost public reimbursement.

Further, private insurance does not pay at substantially increased rates from the public. Insurers are unwilling to negotiate rates with ambulance providers and Fair Health data indicates that Ohio commercial insurers are paying in a grouping of 100-150% of the Medicare allowable rates.

Ohio's balance billing regulations created additional hurdles for privately insured patients. Ohio's balance billing law prevents balance billing for emergency ambulance transports. While other providers can check in the insurer prior to providing a service, it is unconscionable not to mention impracticable that patients would be asked for their insurance card prior to emergency ambulance services being rendered. Unlike most healthcare providers today, we don't collect insurance deductibles and co-pays at the bedside, or when calling for an ambulance we can't ask, "Will this be Master, Discover, or Visa" today. Nonetheless, when the patient doesn't pay or is one of those in the 80% public payer mix, our ability to collect is either impossible because they are a Medicaid recipient, or very unlikely because of the patient already being on a fixed income. This leaves no opportunity for ambulance providers to check to see if they are in network and avoid below cost reimbursement for these transports for out of network patients. It further has created additional confusion for patients who have seen informational campaigns that they should not receive a bill for emergency ambulance care, making patients unwilling to pay co-pays or deductibles and leaving companies to fruitlessly try to enforce appropriate payment.

The Government Accountability Office has twice found Medicare rates to be below cost for ambulance providers. Since the implementation of Medicare Advantage patients, patient deductibles have increased and this has led to great difficulty for providers trying to collect, thus reducing reimbursement in this category even further. Pre-pandemic, Congress realized EMS was not being paid effectively and commissioned the ambulance cost collection process to evaluate Medicare Ambulance reimbursement. The collection of this data has been delayed due to the pandemic, but we are hopeful that the findings will result in a push to bring rates into a more realistic and fair alignment with ever escalating costs.

Ohio's Medicaid rate is at 33% of Medicare. When coupled with the revelation that Medicare itself is far below cost reimbursement, this statistic should be alarming. *Ohio ranks in the bottom 15% of states in Medicaid ambulance reimbursement.* For perspective, the base rate for an

emergency transport in a basic life support ambulance is $120 from Ohio Medicaid. Medicare reimburses this at $406.67 and National Fair Health Allowed in Network Median rate is $482. Fuel for this transport is reimbursed at $2 per mile by the state while Medicare's rate is $12.81 for the first 17 loaded miles and $8.71 for every loaded mile thereafter. Our border states of Indiana and West Virginia recently moved their ambulance reimbursement expressly to Medicare rates while Michigan's base rate for this BLS transport is 104% higher and Pennsylvania's is 171% higher than Ohio.

Further, crossover payments for Medicare/Medicaid patients were eliminated in the 2013 biennial budget, reducing what ambulance companies can recover for these patients. The Kasich administration authorized Ohio Medicaid to reimburse only up to the Medicaid maximum for all remaining non-institutional providers, not including physician services. Then, Director McCarthy stated this provision would save $97.2 million ($35.9 million state share) from non-institutional services and $40.0 million ($14.8 million state share) from dialysis clinics over the biennium. However, dialysis clinics were granted a policy exemption from the Director after the budget went into effect, while ambulance services continue to be prohibited from these payments creating additional downward pressure on these already low rates.

Many states, including Pennsylvania and Tennessee provide reimbursement for "treat without transport" service, where care is rendered but no transport to an emergency department occurs. There is currently zero reimbursement in Ohio when a patient receives treatment on site, but is not transported to a hospital. In some cases, like an opioid overdose, a patient may be stabilized or treated and then refuse a transport, or in the case of an emergency, diabetic treatment a patient may receive care and no further medical attention is necessary. Other states have recognized that the system can greatly benefit from the savings from avoiding large emergency room bills and reducing the overloaded ERs themselves through this program.

Managed care has created additional issues in this space. MCOs are unwilling to negotiate with ambulance providers. Just last year Caresource issued notices that it would pay 60% of Medicaid rates to out of network providers, while actively seeking to contract with providers, but refusing to negotiate contracts with ambulance providers that would reimbursement them at 100% of Medicaid.

Currently, every stage of patient services is delayed due to shortages in ambulance resources and funding, creating backlogs in our healthcare system which are detrimental to patient care. Similar to other health care providers, we are facing an increase in turnover, burnout, and competition for employees. Due to the high stress and low pay, we are often times unable to compete. In addition, our training pipeline has not returned to the pre-pandemic levels. We are experiencing a workforce shortage, along with rising fuel costs and inflation, but all of this has been caused and greatly compounded by chronically underfunded Medicaid reimbursement.

Roughly 20% of all EMS revenue in Ohio comes from Medicaid reimbursement rates. The Medicaid population continues to grow and take up a larger percentage of our payor mix. EMS has become the primary care provider and first point of contact for these Medicaid patients when they are in need of care. Currently these dangerously underfunded rates cannot be negotiated by EMS providers and severely undervalue the current operational costs of quality, responsive healthcare.

Our last reimbursement increase came in the 2019 biennial budget, before the pandemic turned the healthcare industry upside down. We were and continue to be extremely grateful for that much needed increase. However, prior to that, the industry had gone over a decade without an ambulance rate increase, leaving an ever-widening gap between cost and reimbursement for services that a $20.4M increase in each fiscal year over all medical transportation services, not just ambulance services, still cannot adequately bridge.

A survey commissioned by the Division of EMS found staffing shortages in EMS are moving towards a critical level. The annual turnover rate of paramedics and EMTs is now roughly 35%-40% statewide. Over the past three years these healthcare providers have been working harder than ever, however, scarcity in state funding has led to shortages in staff due to the inability to offer competitive wagers. This has forced many in the field to look for higher paying, less stressful employment opportunities elsewhere.

Current ambulance reimbursement rates do not take into account a 50% increase in wages over the past 5 years. Unfortunately, even with these increased wages, competition for these workers has created an unsustainable annual turnover rate of Ohio paramedics and EMTs. Across the state, EMTs are being paid about $19/hr. The Division's report concluded that paramedics, AEMTs, and EMTs are not being paid an hourly rate that provides a living wage for most people living in Ohio. It also found the typical hourly rate Ohio EMS agencies pay paramedics with 1-5 years of experience is nearly 58% less than the "realistic" hourly wage desired by students preparing to enter the profession. Further, the data uncovered demonstrated that 60% of EMS practitioners certified, but not working, indicate poor compensation as one reason they are not working for an EMS agency.

Our staff puts themselves at risk everyday— risk of injury from carrying patients, transporting psychiatric patients, entering dangerous and uncertain circumstances at the scene of an emergency. More and more healthcare providers are seeking to hire EMS personnel because they are attainable at a lower cost and more available, giving our staff an opportunity to work regular hours inside a comfortable facility. Our companies find themselves competing with organizations that we never had to compete with before, dipping into our pool of people to replenish theirs. Hospitals and nursing homes, who have received greater influxes of COVID relief payments, are able to pay better wages and employees don't have to deal with weather, unpredictable hours, loading and unloading, entering a stranger's home, and responding on site to emergencies.

While citizens rely on emergency transportation, transportation providers rely on fuel. The average ambulance requires over 2,300 gallons of gasoline per year. From April 2020 to 2022, gas prices in Ohio increased over 250%. With the rising price of gas and roughly 1,600 ambulances in Ohio, EMS operational costs have increased by roughly $8,500,000 in the past year alone. This has a singular impact on EMS providers in the healthcare industry. The extra cost per gallon of gasoline is adversely affecting our ambulance providers who require fuel to save lives, but are unable to offset the increased cost of gas due to the fixed Medicaid and Medicare billing rates. This means that this unique burden on EMS providers can impact the quality of care that Ohioans receive if action is not taken to offset the rising price of fuel.

Over the past two years, the Consumer Price Index for the Ohio region increased 9%. This price increase on everyday goods and services we use to save lives has not been reflected in the Medicaid rates. As EMS providers, we must continue to safeguard our community, but with the increased cost of equipment, it is becoming increasingly difficult to do so. Ambulances are becoming increasing difficult to purchase, the wait time to purchase a new or refurbished ambulance is anywhere from 18-36 months, depending on the manufacturer. This does not even speak to the cost of the ambulances skyrocketing due to unmet demand. Five years ago, I bought a cookie-cutter van-style ambulance for $65K. This past Christmas, for that same ambulance, I paid $110K. A larger box-style type ambulance, that I paid $130K for two years ago, was quoted to me last week at $322K. The cost of a power cot is on the rise to $60K in 2023. Two years ago, I bought the same, exact power cot for $41K. These are just a few of the big ticket items that are necessary to provide our services to the public; ambulances must be kept fully stocked with basic and specialty medical equipment, supplies, and medications that have greatly increased in cost without an accompanying growth in our revenues.

At the height of the pandemic, ambulance providers were, in most cases, the first point of contact in the healthcare system for those severely afflicted by COVID-19, and were the only transportation option for patients with appropriate isolation protocols. In addition to this heightened risk of exposure for their employees, ambulance companies have experienced increased costs associated with being COVID response ready. These costs included PPE that increased nearly 35% for masks, gowns, and face shields for employees and patients; additional ventilators and decontamination equipment and supplies that increased 10%; each transport taking longer to decontaminate for COVID precautions; and some patients required transport to specific hospitals/nursing/dialysis facilities for COVID positive patients which were at times much farther away; workforce shortages throughout the health care system, increases the EMTs time for transport due to bed shortages or waiting on a patient to be discharged; and additional time to decontaminate the ambulance after each run.

Like all healthcare providers, ambulance providers have found differences between the policies of MCOs contracted with Ohio Medicaid difficult to navigate. Unique to medical transport however, many of the MCOs have engaged brokers that add another layer of bureaucracy that detracts from appropriate reimbursement. Our industry has struggled with MCOs and their

brokers engage in extremely slow reimbursement, burdensome, and confusing prior authorization standards, routinely ambiguous and questionable denials, and difficult and inconsistent appeals processes, while all varying wildly between each MCO. Maneuvering with each MCO, getting properly reimbursed at rates that are so below our cost, is an extremely time-consuming process that many of our small businesses struggle with while trying to also make sure our ambulances are in the field serving our communities. While some provider groups have benefited from centralized credentialing, ambulance providers have not been included in this Next Generation streamlining.

We are the frontline and gateway for healthcare for the state of Ohio. We have the potential to divert unnecessary ER visits and get patients out of a higher cost of care to a lower cost of care. We are not a transportation commodity, we are a healthcare provider that can help contain healthcare costs if given the resources to be able to continue to operate in the state.

We are very pleased, relieved, and grateful to hear that the Department intends to propose a reimbursement increase to transportation services in the FY24/25 budget. We are excited to hear the details of what this increase could potentially entail and look forward to working with the Department and the legislature as the budget makes its way through the process. We would beg for the focus to be on ambulance services— ensuring appropriate reimbursement for these services will have a trickle-down effect of relieving the negative impacts of reimbursement across lower levels of transportation and making sure that the most medically vulnerable get access to the care they need in a timely fashion. Our neighbors in Indiana and West Virginia just made great strides by bringing their Medicaid ambulance reimbursement to Medicare levels. Anything Ohio can do to follow in their footsteps and more closely align Medicaid to our costs will help to ensure that the ambulance industry in Ohio does not collapse. We are now on a dangerous precipice. If drastic action is not taken, our private ambulance companies will continue to shutter their operations, as we have recently increasingly seen happen across our state.

By increasing Ohio Medicaid ambulance reimbursement rates to match Medicare, Ohio's elected leaders will have supported and helped strengthened our healthcare industry and better protected our citizens and neighbors. Nearly all of the challenges currently facing the ambulance industry are part of a cycle created by our dangerously low reimbursement rates. Patients with critical time sensitive diagnosis need to be transported in a timely manner by well trained and equipped professional providers. Getting people home to recover, to mental health facilities in a timely fashion— facilities losing beds because patients can't be moved in a timely fashion, are all symptoms of this problem. The number one solution that will impact each of these issues, whether it is lack of timely transportation or workforce shortages, is a meaningful reimbursement increase that addresses the actual cost of providing these essential services