EMS System Valuation for Colusa County

by

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Executive Summary

The County of Colusa is a rural county located in Northern California. The county is bordered on all sides with similar rural counties. Within the County of Colusa are several smaller cities and large unincorporated areas that primarily focus on agriculture and recreation as the primary industries. The County lacks an "in county" trauma center and some specialty centers; however, they do enjoy a reasonably robust hospital system both within the county and their neighboring counties. This lower population density in Colusa and their neighboring counties and communities in turn creates higher per capita health care costs as there are fewer patients over which to spread the overall healthcare system costs. This is also true when discussing the emergency ambulance system. The County's ambulance system, and more specifically the transportation volume, is low when compared to the cost per transport/patient. In high performance systems, as are often found in urban or more metropolitan areas, a reasonable annual transport rate would be roughly 3,500 transports per unit; however, in Colusa County, the total transport volume is significantly less at nearly 1,014 including non-emergency and inter-facility transfers (IFT). From a transport to revenue perspective, the system is financially unsustainable at the current volume.

An even greater challenge is the issue of capacity. In a more urban system that has greater call volume, there are generally more units in a service area to cover for units that are assigned to incidents. There are times when an ambulance is on a call and another call comes into the dispatch center requiring an outside response into the system. There are also incidents which may have more than one patient that requires transport to an alternate emergency facility, such as a trauma center. This capacity issue is among the most complicated aspect of the Colusa ambulance delivery model. In review of the last several years of data provided by Enloe, the low call volume results in a lower overall transport revenue that is challenged to support a single unit, much less the multiple units needed to service the area and provide a more robust system. Over the last several years, the ambulance provider maintained 1.5 units in the system with a single full-time 24-hour unit and a second unit operating during peak hours of the day. As costs increased and revenue decreased, the operator was forced to reduce the total daily coverage to a single 24-hour unit. While this was a necessity from a financial standpoint, it has

created what this consultant would describe as a dangerous scenario for the community at large. As emergency services providers, regardless of being public or private, the issue is not the emergency at hand but the emergency that develops prior to the completion of the first incident. The loss of the second peak unit has eliminated (at the most), or severely diminished (at the least), the ability to provide rapid ambulance response during times of multiple incidents at the same time. In turn, this also impacts the surrounding counties as automatic or mutual aid is needed to manage these multiple incidents as they occur and is one of the primary reasons for this study.

Revenue is the life blood of any Fee For Service (FFS) emergency ambulance system. The intent of a traditional FFS system is to match volume, cost, and capacity against revenue to create a non-subsidized system. The larger the system, the greater the opportunities to maximize efficiencies, lower cost, and improve the margin to sustain and maintain the overall health of the system. Because the call volume is not likely to increase significantly, there are very few methods to increase revenue and those few are typically confined to either raising the service rates or lowering the cost of the system. Raising rates can provide additional revenue, but on a limited basis, as the majority of patient contacts are within the Medicare and Medi-Cal population. This population group, and the coverage they enjoy, has a cap on the benefit that does not cover the actual cost of the system. The raising of rates, therefore, must be cost shifted to the commercially insured population. As this demographic of the transport volume is generally smaller, the impact to the system revenue is not a dollar for dollar equation. In other words, a 10% increase in rates does not generate a 10% increase in revenue.

Sustainability in the long term for Colusa County will likely be found in a combination of many factors. These include modifications to the system rates, aggressive billing and collection practices, and a system redesign that will help provide for increased federal reimbursements, and ultimately greater capacity and delivered services. It is the opinion of this consulting firm that the potential for a FFS-based emergency ambulance provider to meet the demands of the system, along with generating a profit, will be a significant challenge. Thus, the overall goal may be better focused on meeting costs with the end result of breaking even as the new baseline. This may be best achieved through innovative approaches such as more cost effective deployment models, greater community involvement, alternate funding solutions, public

education, and cost sharing on a multi-county regional approach that brings a greater economy of scale. The positive aspects of this approach will be that Colusa will be able to create a more stable system, but in the long term may be better positioned to deal with the future changes in health care and transitional financial changes that take place, such as the current COVID-19 crisis.

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Understanding Health Care Financing

Understanding health care financing and the principles that go along with it can be a very daunting task. With the mixture of Medicare, Medicaid/Cal, private commercial insurance, second and third party payers, workers' compensation, private payers, auto insurance, travelers insurance, ACA, Covered California, co-pays, deductibles, and the $100 dollar Tylenol, it stands to reason that the average local government administrator may feel out of his or her comfort zone. Although the overall industry is very complex, the actual processes for functioning within this system are not as complex as one may think. Remember, health care is the largest civilian industry in the United States. Every day, millions of dollars are billed and collected within the health care finance industry. A majority of the transactions taking place are from the small doctor offices and medical groups that serve the vast majority of Americans' needs. Most of America's health care billing and collections are done "in-house" through these small offices and medical groups. Although smaller and often narrower in the billing categories compared to the larger medical groups or hospitals, these smaller health care providers use the same 70,000+ billing codes to complete the day-to-day billing process as do the larger health care organizations.

When billing for ambulance services, either by a public provider or private provider, there are typically very few billing codes compared to general health care billing. This amounts to less than ten with four to five being most common, with the most common being "emergency advanced life support (ALS) and basic life support (BLS) transports," "non-emergency ALS and BLS transports," "mileage," and "oxygen." Because of the relatively small number of coded items for ambulance services, the Centers for Medicare and Medicaid Services (CMS) has requested and prefers a "bundled billing" approach. In simple terms, this means that while an itemized bill for services was the norm in the past, CMS understands that in most cases the basic line items listed above result in maximum benefits being paid out. Therefore, to streamline the process and reduce costs in coding, CMS has requested that bills be submitted in a "bundled" invoice. This approach also saves time and cost by not requiring billing agents to prepare more detailed billing claims. This same approach also applies to those who have commercial insurance as most, if not all, commercial insurance plans also prefer a simple bundled billing approach to transport claims.

With a more streamlined approach to billing and collections, a common question asked is "if there is really no difference or secrets in the billing process, why is there a difference in the collection rate?" This is one of the most misunderstood parts of the billing and collection process. The simple answer is "policy." To the greatest degree, the provider's billing and collection policy determines the reimbursement rate. As an example, two ambulance providers respond to the same patient and provide the same treatment and services. Both charge a common rate of $1,600. Ambulance Provider A waives the co-pay and deductible of $200 and collects the insurance payment of $1,400 as payment in full. Ambulance Provider B accepts a compromise offer of $100 for the co-pay and deductible and collects the $1,400 insurance payment. Provider A has a collection rate of 87% of the billable amount while Provider B has a collection rate of 94%. Without knowing the billing policy, one could be led to believe Provider B has the better billing company because of the higher collection rate. In reality, both providers have the same billing company but different collection policies.

Determining the Value of the System

There are numerous factors that impact the value of an Emergency Medical Services (EMS) system. The monetary value of the system essentially refers to how much money, in terms of revenue, can be garnered from the system. There are no special or secret methods for collecting revenue from an EMS system. There is a fixed amount of money available to all providers regardless of their public or private status; this is often referred to as the cap. The reason there is disparity in the revenue collected amongst various providers is attributable to two main areas, billing and collections. Some agencies are better at procuring monies in these areas than others. Often times an agency bases its success on its collection rate, but this is not an accurate representation of their effectiveness. Collection rates are just one aspect of the successful management of a system. The key factors affecting the success of billing and collections are billing policy, collection policy, transport rates, documentation, billing contractor's level of effort, and understanding the payer mix.

Billing Policy

Establishing a billing policy is one of the primary steps a provider needs to accomplish in

order to get the most monetary value from the system. When a service is provided, there is an assumption that there will be a charge for that service. There are numerous factors that will determine what is included in the patient billing policy. The more aggressive the billing policy, the more potential there is to collect. There are, however, areas that do have a fixed rate attached and this alone will create a fixed cap on the maximum potential collections that are available within the system. There will also be a set number of calls for service in a given time period; therefore, adding additional ambulances in the system does not equate to being able to run more calls and transport more patients. The expectation is that all the patients who request to be transported, or whose medical condition requires it, will be transported. There will be fluctuations in the call volume, but significant or seasonal changes in call volume are fairly predictable. Based upon the last four years of transport data from the current provider, the transport rates have remained relatively consistent. Unless there are significant changes in the County's demographics, this trend should continue. This consistent incident volume will help in a system redesign if the County goes in that direction.

Collection Policy

The collection policy is the most significant aspect of the collection process affecting the revenue stream. Federal regulations which control billing require that every patient receive a bill for services rendered in order to prevent what is known as "cherry picking," where only specific groups of patients are billed. How aggressive a provider is with the collection of those bills is a matter of business philosophy. Many private ambulance companies, and hospitals for that matter, have very aggressive collection policies, while many public ambulance providers tend to have lesser aggressive policies. The reason for this disparity is simple: private ambulance companies can only remain solvent when the cost and reimbursement are in alignment. Conversely, many public agencies, primarily fire departments, provide ambulance transport as an "added value" to their suppression services. Because many of these public agencies have other sources of revenue, they typically end up subsidizing the transport from the general fund. In this scenario, many public providers actually attain lower collections than their private counterparts. This is due to the political considerations and public relations concerns, as the vast majority of patients will also be taxpayers.

Transport Rates

It has already been discussed that there is a fixed number of transports that will occur in each period of time, but there is a subsection of patients whose medical condition will not require immediate transport. Obviously, the percentage of transports has a direct impact on the revenue received. Fewer transports results in less revenue. When a patient is not transported, there is a loss of revenue that results from these actions. As an example, if two Medicare patients per week were not transported for various reasons, this equates to roughly $50,000 per year in lost income to the provider. There will always be a percentage of calls that will not result in a transport due to circumstances. This is to be expected and can be projected as a percentage of the overall call volume. However, it is important to monitor transport volume to establish peaks and valleys through the course of the year.

Documentation

Documentation provided by a paramedic on the patient care report (PCR) also plays a significant role in the collection rate achieved by the provider. One area that is often overlooked is proper training of field units in the documentation process that accurately reflects the actual assessment and treatment provided on scene. These actions will then capture the correct reimbursement rate. Reimbursement, particularly through Medicare and Medicaid/Cal, is based upon the patient's needs and not reimbursed simply because they called for transport. Simply stated, many calls that should be billed and paid at an ALS rate are often reimbursed at the BLS rate, while some that should have been collected at either the ALS or BLS rates are not found to meet any reimbursement criteria and are left unpaid. Accurate documentation can result in a substantial increase in revenue in an area where the service is already being provided.

Billing Contractor's Level of Effort

The billing contractor or billing office also plays a major role in the collection rate. The level of effort demonstrated by the billing provider displays a direct correlation to the collections received. There are two common ways providers conduct billing for ambulance services. The first is to use an outside third-party billing company that conducts all billing on behalf of the

provider. Their ability to collect depends on several factors, the most significant being the billing and collection policy as previously discussed. A relaxed or vague billing and collection policy will result in less collection of revenue. Most billing companies base their fees on a percentage of the amount they collect. If the provider has a billing and collection policy that allows a reduced amount to be collected, then the biller will likely charge a higher percentage rate in order to meet their profit margin.

Another method of billing and collections is to conduct all billing in-house. There are the same challenges with doing billing in-house as with using third party billers. The single largest consideration in establishing in-house billing services versus using an outside billing company is measuring the cost effectiveness between the two methods. In smaller systems with lower billing volume, it may be more cost effective to use an outside company as opposed to the costs of personnel and benefits in doing billing in-house.

It should be understood that even though there is a fixed and finite amount of money that is available in the service area, there are numerous variables that influence a provider's ability to collect that revenue. Establishing policies, training of personnel, and close monitoring of the delivery system will pay forward in the collection of revenue. The advertised percentage of collections by billing companies is nearly irrelevant because it does not address all the facets of successful billing.

Understanding the Payer Mix

Reimbursement is based upon providing a service and billing the appropriate party responsible for the service provided. Within the health care industry, there are primarily four categories, or cost centers, for reimbursement: 1) Medicare, which is the primary health care coverage for persons over the age of 65; 2) Medicaid (also known as Medi-Cal in California), which is a component of the federal Medicaid program and is provided for certain qualified individuals and families (primarily low income at 138% of the federal poverty level); 3) commercial insurance, most commonly associated with benefits provided by employers to their employees, but also may be purchased independently; and 4) private pay, which is the term generally applied to those without insurance. Within these categories are numerous sub-

categories that are available and used for reimbursement but will not be discussed in this report. Sub-categories are predominantly workers' compensation, liability, and auto insurances.

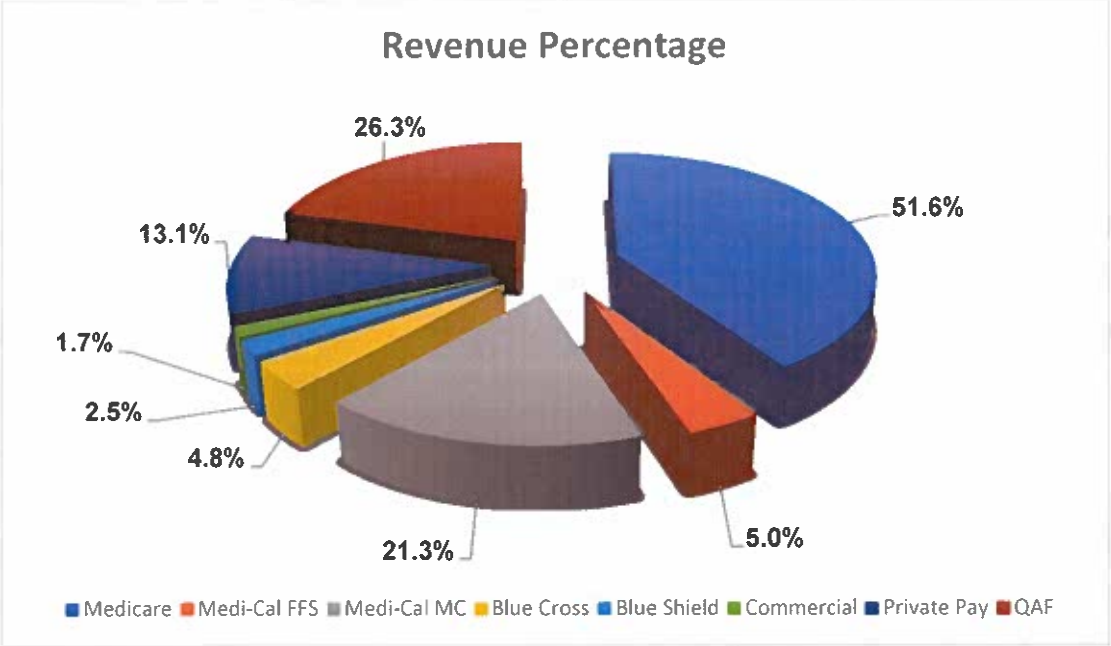
Each community will see differences in how the payer mix influences health care financing and reimbursements. As we are discussing ambulance revenue in this document, we must also understand that Colusa County has many different economic and population subsets. In order to begin to create a possible reimbursement scenario, it is necessary to understand the different ratios of the payer mix demographic.

In reviewing the data provided by Sierra Sacramento Valley EMS (SSV), we have a solid payer mix from the current provider. In order to create an estimate for the value of the EMS transport system, we will consider all transports including the emergency 9-1-1, interfacility, and non-emergency transport numbers.

Colusa County Payer Mix

Cost Center	Percentage %	Transports	Reimbursement	Revenue
Medicare	51.6%	523	$589	$308,047
Medi-Cal FFS	5.0%	51	$159	$8,109
Medi-Cal MC	21.3%	216	$174	$37,584
Blue Cross	4.8%	49	$3,152	$154,448
Blue Shield	2.5%	25	$4,112	$102,800
Commercial Insurance	1.7%	17	$2,740	$46,580
Private Pay	13.1%	133	3.5% of $648,508	$23,923
QAF*	26.3%		$220.35 "add-on"	$31,374
Totals	**100%**	**1,014**		**$712,865**

* QAF was not included in the overall calculations for Medi-Cal and separated out for clarity, as there is a tax that must be backed out of the supplemental revenue that is reported. The QAF program requires that a tax is applied to all transports. These tax monies are then used to leverage federal matching funds by the state. So while the total amount of the "add-on" supplemental revenue is roughly $58,833, the taxed amount of $27,459 must be backed out to determine the actual net amount of the QAF program at $31,374.



Because SSV provided the reported payer mix for 9-1-1 transports, we are in a position of validating the numbers as opposed to creating a potential valuation of the system. Regardless, the system payer mix and lower call volume are consistent with an unsustainable transport system.

The single biggest issue is the overall percentage of the Medicare and Medi-Cal cost centers. In both cases, Medicare and Medi-Cal have fixed revenue for transport. In the case of Medicare, the reimbursement is based on 80% of the covered benefit and the patient is responsible for the remaining 20%. Often, the patient's 20% is either waived or reduced based on the patient's ability to pay. In the case of Medi-Cal, the payment is astronomically low compared to their federal counterpart. Unlike Medicare, Medi-Cal does not allow balance billing of the unpaid bill. As a result, these two cost centers combined make up 78% of the total transport volume with average collections coming in at only 9% of the billed amount. When combined with the private pay cost center, the total transport volume of the three categories makes up 91% of total transports and collects only 8% of the billed amount with little to no option to collect more from these payers.

What has not been discussed is the balance of the 1,014 transports in the system. These other transports are the inter-facility and non-emergency transports. These transports are typically defined as transports from one facility to another, such as the patient who needs to be transported from the hospital's emergency department to one of the specialty or trauma centers out of the area, as mentioned above. Another is the patient who is non-ambulatory and needs to be transported back to a skilled nursing center. These transports, while not as critical as the emergency transports, are not only important to managing the county's overall patient movement, but also to providing additional revenue to keep the emergency fee for service system funded and operating.

Both Medicare and Medi-Cal have non-emergency rates established for these non-emergency IFTs. Commercial insurance rates can and do vary and are most often negotiated between the ambulance provider and the insurance company. The challenge in determining the revenue associated with IFT business is the diversity of the types of transport. Unlike emergency response and transport, IFTs can take on many different configurations. Examples would be BLS, ALS, and Critical Care Transport (CCT), which requires a higher level of care often provided by a nurse, neo-natal, gurney, and/or wheelchair van to name a few. Because each of these transports has a different reimbursement rate and cost associated with it, it is difficult to calculate the exact revenue without a detailed breakdown of the type of transport and the destination of the transport. Therefore, we will use a 25% reduction of the emergency transport revenue in order to arrive at a reasonable estimate of the total transport system. This would provide for total compensation of the transport system at $1,247,564. It is important to remember that this calculation could result in either greater or lesser revenue depending on the actual demographics of this component of the transportation system.

Cost Shifting

A standard practice in health care financing is to apply cost shifting to balance the lower payers with the higher payers. This practice is the standard in American health care. Simply stated, if a system has only four payers, one in each category, and the cost of transport is $500 per transport, total provider cost for all four transports would be $2,000. Assuming that Medi-Cal pays $100, Medicare pays $250, and private pay pays $50, the cap for those three are $400

combined. In order for the provider to break even, they need to charge each cost center $1,600 per transport.

Cost Shifting Table

Cost Center	Cost of Transport	Charges	Reimbursement	Collection %
Medicare	$500	$1,600	$250	16.6%
Medi-Cal	$500	$1,600	$100	6.25%
Commercial Insurance	$500	$1,600	$1,600	100%
Private Pay	$500	$1,600	$50	3.125%
Totals	$2,000	$6,400	$2,000	31.5%

The ability to cost shift is based on the percentages of the various payer mixes. As Medicare and Medi-Cal are fixed, and the ability to extract revenue from the private pay is minimal to nonexistent, all cost shifting takes place in the commercial insurance category. The greater the percentage of commercial insurance, the greater potential an increase in rates will result in more revenue. In the case of Colusa County, the current provider is at a rate that is approaching a maximum return. As we can see from the current provider's financials, there is a $528,635 shortfall between cost and reimbursement on the 9-1-1 side of the system ($1,237,631 - $712,865 = $524,996). Closing the gap would require cost shifting the amount to the commercial insurance categories, which account for only 9% of the transports, or 91, in total. To bridge this gap, we need to increase the new rate by an amount that takes into account not just the rate, but the insurance company's percentage of payment. As found in the provider's financials, the three insurance providers have an average reimbursement percentage of 51% of the amount billed. While not likely, we will assume that an increase in rates will still result in a 51% collection for illustration purposes.

Cost Center	Percentage %	Transports	Reimbursement	Revenue
Medicare	51.6%	523	$589	$308,047
Medi-Cal FFS	5.0%	51	$159	$8,109
Medi-Cal MC	21.3%	216	$174	$37,584
Blue Cross	4.8%	49	$9,148	$448,252
Blue Shield	2.5%	25	$9,148	$228,700
Commercial Insurance	1.7%	17	$9,148	$155,517
Private Pay	13.1%	133	3.5% of $648,508	$23,923
QAF*	26.3%	267	$220.35 "add-on"	$27,505
Totals	**100%**	**1,014**		**$1,237,637**
Providers' Costs				$1,237,631
Net revenue				**$6**

While the above scenario does show a breakeven business model, the reality is that this is still not a viable system for several reasons. First, to obtain a $9,148 insurance reimbursement would require a rate well above $15,000 per transport. This in itself is a non-starter. Next, the net income of $6 per year provides no hedge against the risk of providing the services. A good business practice would be to strive for a 10% margin and build a reserve fund for unexpected expenditures. And last, the system is still challenged with meeting demand via response time compliance.

It is important to remember that while we are attempting to create a sustainable system to ensure the timely response of an ambulance for emergency incidents, the IFT business is both an asset and a detriment from the perspective that placing an additional unit into the system adds additional capacity but at an additional cost that cannot be recovered under the current operations.

Federal Supplemental Reimbursement Programs - GEMT / QAF / AB 1705

Ground Emergency Medical Transport (GEMT)

In 2010, California began development of a federal reimbursement program known as Ground Emergency Medical Transport (GEMT). This program and similar programs are operating in several states and are in development in several more. These programs provide a substantial amount of money into government-based ambulance operations that are not available to the private sector. Although these types of programs have been in existence and operating across the country for more than 30 years, it has only been recently that these programs have been utilized by the governmental ambulance providers. There was much discussion on the future of these programs with many rumors projecting they would be gone by 2017; the reality is CMS is actively starting new programs across the country for ambulance providers. As health care is undergoing constant changes, any discussions concerning the future of ambulance reimbursement should be viewed as mere speculation at this point. Although these programs are an entitlement through the Social Security Act Title XIX, we strongly recommend that projected revenue from GEMT, inter-governmental transfer program (IGT), and Quality Assurance Fees (QAF) **not** be considered as part of the revenue stream for a stable system. We believe the best and logical direction for providing ambulance services should be in creating a stable Fee for Service (FFS) delivery system without supplemental or subsidized payments to the providers; however, due to the discussion above, it is paramount that providers in Colusa County take advantage of any and all supplemental programs to defray costs incurred in the system.

Quality Assurance Fee (QAF)

In 2017, SB523 was signed into law by the Governor. This bill created a Quality Assurance Fee (QAF), also known as a Provider Tax. It is applied to all ambulance providers in the State and charges a 5.5% tax on all transports. This tax is then used by the State to leverage federal matching funds from CMS and is redistributed back to the provider as an "add on" to the base rate for all Medi-Cal transports. The supplemental reimbursement is $220 per transport. This supplemental reimbursement was not shown in the current provider's revenue but included in the table above.

Public Provider IGT (AB1705 Bonta)

AB1705 (Bonta) was signed by the Governor and is now law. This program creates a public provider inter-governmental transfer (PPIGT) program that develops a single statewide rate for public providers that draws down supplemental reimbursement in the same manner as the QAF program. However, while QAF is a capped program with regard to the amount that can be transferred to CMS for matching funds, the PPIGT program has no limits other than the actual cost of providing the services by the public providers. Because this rate is based on the average cost of all public providers, the reimbursement rate is much higher. Estimated at $800 per Medi-Cal transport in addition to the base rate, the impact to the Colusa County revenue is tenfold to the QAF revenue at $213,600 compared to the estimated $31,374 of QAF. However, this supplemental revenue is not available in the current deployment model using a private provider.

Summary of Findings

The Colusa County operating area is listed as a "non-exclusive" county by the State EMSA identifying the system as open to any provider that desires to provide services. While this is an open invitation for business opportunity, the County's rural demographics, low call volume, and challenged payer mix makes the County a less than desirable location to operate a fee for service based ambulance business. The current provider has what appears to be a strong commitment to the community and continues to operate at a loss to the benefit of the County. The provider operates at an extremely low cost compared to the larger ambulance companies around the state whose costs are exceeding $1 million per 24-hour unit.

Upon evaluation of the data provided, we arrived at nearly the same value to the system as what is being reported by the current provider with a few small differences, such as the supplemental revenue they are receiving through the QAF program and potential revenue from treat no transport fees, understanding this provides minimal increase in overall revenue. Even a 10% difference between valuations would not remarkably change the financial challenges faced by the County. Regardless of the small differences, the value of the system is less than $1 million. As stated, there does exist a significant number of non-transport patient contacts that could yield additional revenue if these patients were transported. Transporting those patients would also add additional unit hour demand on the system that would logically require additional unit hours at an additional cost, resulting in what would more than likely be a greater loss

financially.

The County's current ambulance rates are on the higher side of many systems but not overly high for a rural system. Due to the low call volume and less than 100 insured transports per year, it is not feasible to increase rates to a level that will bring the system to a breakeven point for the provider. The provider's compliance times are below the desired level, but it must be understood that response times are directly related to the number of units in the system. With the low incident volume and reimbursement, the expectation of response time compliance in this type of system is realistically not possible across the entire county without driving up costs significantly.

The County's role in this system is clearly founded in state law (Lomita vs. the County of Los Angeles) and basically requires the County to provide or ensure that services are provided to the community. This places the burden on Colusa County should the system become unsustainable. When correcting a system that is out of alignment there are typically three options to bring the system back into position. 1) Decrease costs which usually involves reduction in unit hours. However, the current system is running on the thinnest of unit hours at this time and this is not a realistic option. 2) Increase rates. This has been discussed and due to the limited number of commercial insurance providers the increases needed to bring the system to a breakeven point is not realistic. 3) Increase revenue. Expanding services, as is currently being done through the IFT business, is not expected to bring in enough revenue to make the County solvent. It will, however, reduce the need for a subsidy. Should the system become unsustainable due to losses incurred by the current provider, the County should take advantage of every opportunity to capture maximum revenue, not just through a Fee For Service delivery model, but also by taking advantage of supplemental reimbursements that are afforded to public providers. This can be done through various methods, including using the current or new private provider under contract with a public entity to capture the federal reimbursement.

As health care changes, the costs of services will likely not be going down in the immediate future. This means the sooner the County can address the issues and develop a plan, the less chance there will be of an interruption of services and, more importantly, it will reduce the need for the County to subsidize the system. We would suggest the following recommendations be taken into consideration.

Recommendations

- The County should conduct a complete comprehensive system redesign study as quickly as possible. This should be the number one priority and include the bullet items listed below.

- The County should strongly consider the options for ambulance services and contract with a public provider to capture the PPIGT revenue of a quarter million dollars annually. This will reduce the potential (and possibly the amount) of the County needing to subsidize the system and will help stabilize the provider.

- Create a system that is driven by positive patient outcomes and not response times.

- Consider a tiered response to incidents to create capacity in the system without increasing system unit hours. This could include first responder response prior to ambulance dispatch, lower response code (Code 2 versus Code 3) to lower acuity calls with immediate redirect of the ambulance to higher acuity calls.

- Consider the use of BLS units when appropriate, reducing the need for paramedics which are in short supply currently (not intended to replace ALS capabilities).

- Engage the fire departments and consider using standby ambulances located throughout the County as surge for the primary units.

- To increase capacity, consider placing a "Low Acuity Assessment Unit" to respond in place of the initial ambulance dispatch to triage the patient.

In conclusion, there are no easy remedies to the challenges facing Colusa County and their EMS system. The County is responsible for all ambulance services within their borders and a non-sustainable system is not an option moving forward. The ability to provide a sustainable FFS system will require an innovative approach along with stakeholder and community involvement. AP Triton is standing by to assist the County with these challenges should the County like to consider options and a system wide redesign.