EUGENE CITY COUNCIL
AGENDA ITEM SUMMARY

Work Session: Eugene Fire & EMS Department
Ambulance Service Area Realignment

Meeting Date: April 17, 2013
Agenda Item Number: D
Department: Eugene Fire & EMS
Staff Contact: Randall B. Groves, Chief
www.eugene-or.gov
Contact Telephone Number: 541-682-7115

ISSUE STATEMENT

In keeping with Recommendation #5 in the 2009 Joint Elected Officials Ambulance Transport Task Force Report, Eugene Fire and EMS entered into a 2011 IGA with the Lane Rural Fire/Rescue District (LRFR) to create more of an urban/rural split between Ambulance Service Area #4 (Eugene) and #8 (LRFR). The IGA was signed on August 21, 2011. LRFR subsequently created a functional consolidation with Lane County Fire District #1 and now operates as the Lane Fire Authority (LFA). Following a favorable evaluation period, both Eugene Fire & EMS and the LFA have submitted a joint request to Lane County, which has statutory authority for assigning ASAs within the County, to reconfigure the boundary between ASA #4 and #8 to codify the change. The majority of this area is within ASA #4, Zone #3.

BACKGROUND

The first Joint Elected Officials Ambulance Transport Task Force meeting convened on April 6, 2009. During the next two years, the ATS JEO Task Force decided on seven recommendations. Recommendation #5 stated that the ASA boundaries should be reconfigured to the west of Eugene's Urban Growth Boundary and the western-most contract fire protection districts served by Eugene Fire & EMS. This boundary change will provide a number of benefits for the constituents and ambulance service providers. First, it will greatly reduce response times for emergency calls occurring in ASA #4, Zone #3. Zone #3 extends from just west of Eugene's urban growth boundary (UGB) to a point between Walton and Mapleton (See Attachment #1). With a redeployment of an LFA ambulance into the area, ambulance response times were reduced by an average of seven minutes and 14 seconds during the evaluation period. Second, the shift in boundaries allows Eugene ambulances to remain within ASA #4 and be available more often for response within the metro area. Third, this move has helped preserve some badly needed capacity within Eugene's ambulance system. Fourth, the boundary change would allow for growth of the LFA ambulance service, both geographically in service area as well as in terms of a revenue base. Additionally, it better aligns with the first response service area of the newly consolidated LFA organization. The change will also pave the way for a future placement of an LFA ambulance in the City of Veneta area which would decrease response times further. However, it must be recognized that deployment decisions in this area will ultimately be made by the provider agency.

In order to change the boundary permanently, the departments must meet with the Lane County Health Authority which is in charge of Chapter 18 of the Lane County Ambulance Service Area Plan. The meeting will be held on, April 9, 2013. It is expected that the proposed changes will be accepted and forwarded to the Lane County Commissioners for adoption.

RELATED CITY VALUES
City of Eugene Goal #1: Safe Community
City of Eugene Goal #4: Effective, Accountable Municipal Government
City of Eugene Goal #5: Fair, stable, and adequate financial resources

ELECTED OFFICIAL OPTIONS
This is informational only to provide an update about the proposed ASA changes.

CITY MANAGERS' RECOMMENDATION
None. This is an informational work session only.

SUGGESTED MOTION
None. This is an informational work session only.

ATTACHMENTS
A. Lane County Ambulance Service Area Map
B. Memorandum (November 25, 2009) – Report and Recommendations
C. Memorandum (May 24, 2012) – Report and Recommendations

FOR MORE INFORMATION
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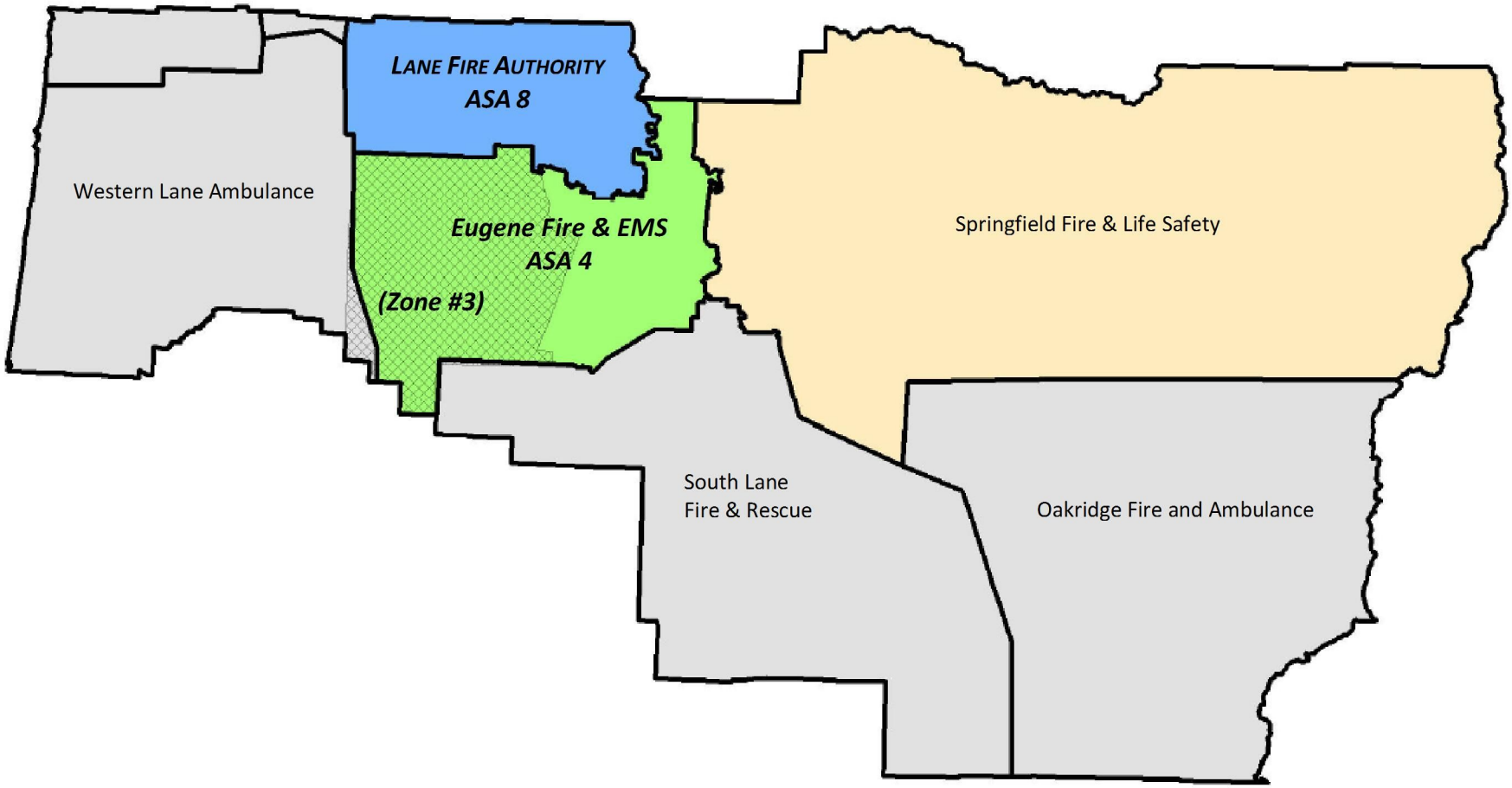
Staff E-Mail: randall.b.groves@ci.eugene.or.us

ATTACHMENT A

Lane County Ambulance Service Area Map



ATTACHMENT B

MEMORANDUM

November 25, 2009

TO: Mayor Kitty Piercy and Eugene City Council Members
Mayor Sid Leiken and Springfield City Council Members
Commission Chair Peter Sorenson and Lane County Commissioners
President Larry von Moos and Lane Rural Fire/Rescue Board Members

FROM: Ambulance Transport System Joint Elected Officials Task Force (Mike Clark, Andrea Ortiz, Dave Ralston, Hillary Wylie, Rob Handy, Larry von Moos, and Kevin King)

SUBJECT: REPORT AND RECOMMENDATION

SUMMARY
In view of negative revenue experiences and projections for the ambulance service providers in central Lane County (Eugene Fire & EMS Department, Springfield Fire & Life Safety Department, and Lane Rural Fire/Rescue District), which were brought on by reduced Medicare reimbursements and a number of other economic factors, our Task Force was charged earlier this year to study the problem and develop a recommendation, or set of recommendations, to provide for long-term financial stability for this service, without compromising the high quality of prehospital emergency medical care that our constituents expect and deserve.

We acknowledge that the provider departments – and their governing bodies – have already expended substantial effort to address this critical public concern, both by taking extraordinary steps to reduce expenditures and by passing extraordinary increases in user fees to offset decreasing revenue, but these measures have served only to slow, not stem the fiscal bleeding. Efficiencies within the scope of each agency's control have been or are now being implemented. This task force was formed because a solution to this crisis is beyond the capacity and authority of

any one provider agency acting unilaterally. It is vital that the possible solutions recommended by this task force immediately be addressed at a regional level and given the highest possible priority for allocation of time and resources.

Having studied this issue and the range of available options, having engaged the public at a series of community forums and online, and having worked in concert with stakeholders including local fire and ambulance service professionals, hospitals, and firefighters' unions, we recommend as follows:

1. That all three jurisdictions remain prepared to allocate a level of General Fund support as necessary for the continued high-quality provision of this core service.
2. That the Eugene and Springfield City Councils authorize initial steps toward merger of their fire departments.
3. That exploration begin immediately of more sustainable public funding options.
4. That marketing of FireMed subscriptions be enhanced and expanded in an effort to generate additional revenues to lessen reliance on general fund tax support.
5. That the City of Eugene and Lane Rural Fire/Rescue analyze the possibility of reconfiguring the boundaries of the county's Ambulance Service Areas so as to provide for an urban-rural split between Eugene and Lane Rural Fire/Rescue; and, if conditions appear favorable, that the Lane County Board of Commissioners be asked to enact such reconfiguration.
6. That work proceed as rapidly as possible regarding provision of a regional mobile health care system, featuring tiered levels of response (and cost) available to patients depending on the nature of the emergency with a report to elected officials by the end of calendar year 2010.
7. That public ambulance service provider agencies continue to lobby the Oregon legislature and U.S. Congress for larger-scale long-term solutions.

BACKGROUND

Throughout our region, the majority of patients transported are covered by Medicare. Before the implementation of the Ambulance Fee Schedule on April 1, 2002, ambulance suppliers received payment from Medicare on a "Reasonable Charge Basis." Medicare would pay 80 percent of the allowable amount and the remaining balance was the responsibility of the patient. This allowed transport providers broad flexibility in setting rates and assured recovery of costs.

The Balanced Budget Act (BBA) of 1997 added a new section 1834(1) to the Social Security Act which mandated the implementation of a national fee schedule. This section also required ambulance providers and suppliers to accept the Medicare allowed charge as payment in full; there was no longer the ability to bill the patient or another insurance provider for the balance of the reasonable charge.

The new fee schedule took effect in 2002 and was phased in over a five-year period, with full implementation on January 1, 2006. Year one (4/1/02-12/31/02) provided a blending of 20 percent fee schedule and 80 percent reasonable charge. The reasonable charge portion was then reduced by 20 percent in each of the four subsequent years, so that as of 2006 only the fee schedule amount was payable.

Put simply, the new national fee schedule, which covers 60 to 70 percent of all transports, does not allow most ambulance providers to recover the cost of providing the service. Instead, where we once had the ability to collect the full reasonable charge (which has risen over the years from $535 to $1,600 per transport), we are now reimbursed between $200 and $400, depending on the type of call. Medicaid, the state of Oregon's health insurance program, reimburses similarly.

While Medicare and Medicaid reimbursement reductions are the primary reason that emergency medical transport in our region has become a revenue-negative enterprise, two national trends are also contributing to the problem. One is the growing number of individuals eligible for Medicare. The other is the economy generally, as the provider agencies – which do not refuse transport because of inability to pay – are being forced to write off more and more bills as uncollectible.

The Eugene Fire & EMS Department has taken many steps to try to keep the ambulance service self-sustaining including increasing the transport rates; reducing ambulance coverage for non-peak times; and cutting costs for administrative staff, materials and supplies. The department has also worked closely with City Finance staff to identify the appropriate cost split between the Ambulance Transport Fund and General Fund to ensure the ATF is not supplementing General Fund services.

In addition, with Eugene's ambulance system capacity very thin, the department elected to subcontract much of its non-emergency transport work to a private provider through an RFP process as a cost avoidance strategy. With inadequate revenue to increase the number of advanced life support ambulances on the street, the department elected to privatize this portion of the service and match a more appropriate level of resource with particular non-emergent call types.

Springfield Fire & Life Safety staff has focused on maximizing existing revenue sources for all three providers through the joint FireMed program and development of new revenue sources through Mobile Health Services research and design.

However, none of these adjustments individually or in whole has created a sustainable fund during any 6-year financial forecast period. Eugene's Ambulance Transport Fund reserves have decreased from $1.1 million in FY07 to $165,000 in FY09. The financial goal is to maintain a reserve equal to two months' operating expenditures. For Eugene, this total for FY10 is $1.16 million. At this point, the projections show the fund will be out of reserves by the end of FY10. Additionally, for FY10, the fund is unable to support its medic unit replacement reserve resulting in lengthening the time for fleet replacement.

Springfield's Ambulance Transport Fund reserves were depleted as of FY09. The City Council allocated up to $500,000 in General Fund support, of which approximately $300,000 was needed. An additional $300,000 in support is allocated for the current fiscal year.

The Lane Rural Fire/Rescue District was granted an Ambulance Service Area (ASA) encompassing the northwest portion of Eugene's ASA in 2001 and in 2002 began providing emergency medical transport in addition to fire and rescue services to that area, resulting in a reduction of ambulance transport revenue as well as FireMed membership revenue for Eugene. As a pre-existing taxing authority, Lane Rural has been able to augment its overall revenue with ambulance fees and FireMed revenue, but not to the extent that the ambulance service is fully self-

supported; instead, the district annually levies funds as necessary to provide all of its services, in effect providing some support to the ambulance service with general tax monies. For FY09 this requirement is estimated to be between $400,000 and $500,000 or approximately one-third of the district's total revenue.

The entire problem will be further exacerbated next calendar year. A temporary increase in the fee schedule provided in the Medicare Modernization Act of 2003 is scheduled to sunset December 31, 2009. Also, for the first time, providers will not be allowed an annual inflationary adjustment in the fee schedule. The calendar year 2010 impact of these two factors alone is estimated at $400,000 for Eugene and $300,000 for Springfield.

In February of this year, at the conclusion of a Joint Elected Officials summit regarding this issue, the formation of our Task Force was authorized.

EXPLANATION OF RECOMMENDATIONS

1. **General Fund Support**
   In Eugene and Springfield, since the cities assumed responsibility for providing ambulance service in 1981, it has been established public policy that the service is to be self-supporting through fees collected (including FireMed membership fees). This, with the benefit of occasional fee increases, was sufficient until the Medicare reimbursement reductions took effect.

   Facing those reductions, the provider agencies took all steps available to them to continue to provide service on a self-sustaining basis. However, the crisis worsened as Oregon's Medicaid program enacted similar reductions, as the federal reductions became more severe, and as the national economy deteriorated.

   Lane Rural Fire/Rescue already supplements its ambulance fee and FireMed revenue with general tax revenue as necessary. In Eugene and Springfield, this has been required to a limited extent in recent years, and fiscal projections indicate that the need for General Fund support is escalating at an alarming rate.

   The elected bodies could choose to make General Fund support the permanent solution to the problem before us. However, the Task Force believes that, for the sake of preserving other local government services to the greatest extent possible, General Fund support should be viewed only as a short-term solution. In the long term, the public will be better served if ambulance and fire services are supported by a combination of fees for service, FireMed membership fees, and some form of dedicated tax support.

2. **Fire Department Merger**
   During the time that our Task Force has been studying and deliberating on the ambulance funding issue, the Portland consulting firm ESCI was commissioned by the cities of Eugene and Springfield to prepare a report regarding the possible benefits of

further collaboration between Eugene Fire & EMS and Springfield Fire & Life Safety, beyond that already occurring.
The ESCI report, which has been presented to the two City Councils, concludes that merging the support functions of these departments would save the cities an estimated $850,000 per year through the elimination of redundant positions (via retirements and normal attrition). The consultants recommended such a merger.

This proposal happens to align well with our other recommendations. With an intergovernmental agreement merging these departments as an initial step, not only will significant General Fund savings be realized immediately, but also, and more importantly for the long term, the transition to a district will be a smaller, more manageable step. For these reasons our Task Force is in support of working toward the recommended merger.

3. **New Form of Taxation**
This recommendation is based on our belief that continued and growing General Fund support for ambulance service is unsustainable, and that all other revenue-raising and cost-cutting measures combined are not sufficient to resolve this issue.

Fire District – In most of Lane County, and increasingly throughout the United States, fire and ambulance services are provided by special-purpose districts. The growth in emergency service special districts in areas traditionally served by municipalities may be attributed to greater competition among public services for increasingly scarce resources, given these districts show a higher degree of success historically to secure public willingness to pass tax measures to fund high-quality fire, rescue, and emergency medical services.

A general fire service district, including ambulance service, offers a significant public safety advantage over a district that provides ambulance service only, because – as is the case now in all three of our jurisdictions – ambulances can be staffed by cross-trained firefighter/paramedics who can, as necessary, supplement non-ambulance fire and rescue efforts. In a multi-unit response, the availability of these additional firefighters can make a life-saving difference.

Health District or County Service District – A new limited special-purpose district could be formed in the region, or the region could annex to an existing health district, to provide ambulance service. Such a district would be governed by an elected board of directors. Alternatively, a county service district could be established. This type of entity would be governed by the Lane County Board of Commissioners. Under either of these options, any boundary could be drawn, as long as it did not overlap another district providing the same service. Either option would require an affirmative vote of the electors within the proposed district.

Appendix H is an overview of district-related options for ambulance service funding, prepared in June by Lane Council of Governments. The Task Force also reviewed a full LCOG report regarding districts that was commissioned by the Lane County Fire Defense Board.

In planning for formation of, or annexation to, a special district, many further, more specific decisions will be needed. Boundary issues, revenue requirements, and the possibility of tax rate compression will need to be addressed. An election will be required. Because implementation of these options even at best speed will take a considerable period of time, we recommend the immediate formation of an intergovernmental staff team to fast-track the study of the feasibility of implementing this solution.

Local Option Levy – We are identifying this option only as a temporary means of reliving the General Fund of the ambulance service funding burden. We believe it may meet with voter acceptance initially, but we have serious concerns about this form of funding due to its need for renewal in perpetuity.

4. **Enhance FireMed Marketing**
Since its inception in 1985, the FireMed ambulance membership program has been marketed primarily as a form of protection against personal liability for an ambulance bill. While the program does serve that purpose for households, the revenue generated has become essential to the continued provision of high-quality service.

   More and more in recent marketing, this latter fact has been mentioned, but the support-for-the-service theme has always been subordinate to the cover-your-family theme. We believe the time has come to reverse this.

   In marketing for the FY11 membership year, we propose that FireMed advertising focus on the opportunity to contribute to a safe community, and to a lesser extent, but still overtly, on the private benefits of membership. Staff analysis has shown that a significant percentage of members already subscribe on a public-support basis, and we believe more might do so if they saw the opportunity in that light.

   We are also recommending, for the upcoming campaign, a greater reliance on endorsements as a supplement to paid advertising. Toward this end, we are developing a program whereby endorsing organizations will be able to offer FireMed memberships at a group rate below the new rate proposed for the upcoming enrollment campaign.

5. **Reconfigure Ambulance Service Area Boundaries**
This recommendation can be adopted or rejected independently of the two above. We propose analysis of the possibility that the Ambulance Service Area (ASA) assigned to Lane Rural Fire/Rescue be extended to the south so as to abut the Cottage Grove ASA, reducing the territory of the Eugene ASA such that it includes only those areas within the Eugene Urban Growth Boundary plus special districts now served by Eugene Fire & EMS. **(See ASA map, Appendix D.)**

   This boundary change would have a twofold purpose. First, it would greatly reduce in-service times for a percentage of ambulance calls now handled by Eugene Fire & EMS, as Eugene's ASA currently extends west to a point between Walton and Maple-

ton. This would preserve Eugene rescue and transport resources for emergency availability in the more immediate Eugene metro area.

Second, the boundary change would allow for growth of the Lane Rural ambulance service, both geographically and in terms of revenue. It also would pave the way for possible placement of a Lane Rural ambulance in the Veneta area, although that deployment decision would ultimately be made by the provider agency based on further analysis.

The above objectives would not be achieved without some revenue impact to Eugene Fire & EMS, which would be transferring an estimated 850 calls per year to Lane Rural. This represents revenue estimated at $500,000. That figure, however, represents raw revenue only. It should be recognized that, in expanding its service territory, Lane Rural would incur additional operating expenses that would offset the revenue to a great extent; conversely, Eugene's actual net loss of revenue would be smaller because rural calls cost more operationally than urban ones, and also because fewer Eugene-based calls will need to be handled by other agencies. Actual calculations of the net effect would depend on deployment configurations subsequent to an ASA boundary change, and also on actual call experience under that scenario.

6. **Mobile Health Care System**
   A Mobile Health Care (MHS) system links prehospital emergency medical services with several types of non-emergency medical care in a network of 24-hour healthcare. In Central Lane County, these would include fire/paramedic first response fire engines and ambulances, a private non-emergency ambulance contractor, wheelchair transport vehicles, and a mobile primary care provider known as Med Express.

   The MHS system is designed to triage phone calls from the public for help on illness and injury and match the level of response more closely with the level of care needed. The responding caregiver determines if the patient can be safely treated and released without further care or needs additional care. If additional care is needed, the caregiver determines whether the patient must be seen immediately or later and whether the patient needs transportation to a doctor's office, clinic, or emergency department.

   The goal is to improve early access to advice and direct the patient to the most appropriate level of care to match the nature and severity of illness or injury. This is designed to improve the quality of care while lowering the overall cost.

   Currently, only the fire units and private non-emergency ambulance service are linked. Grant funding is being sought to link all other parts of the system and demonstrate the efficacy of the MHS network.

7. **Continue to Lobby Congress for Relief**
   From a national perspective, the effect of the Balanced Budget Act of 1997 on ambulance services has been very small in comparison to the effects on physicians, hospitals, and other health care providers. Nonetheless, ambulance associations and local

governments have had some limited success in pushing for increases in the fee schedule (an example being the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, which unfortunately is due to sunset on December 31 of this year). This lobbying should continue.

OTHER OPTIONS CONSIDERED

Continue to Raise Rates: Although this approach has been used in the past to forestall revenue deficits, our Task Force rejected it for simple mathematical reasons. Because the majority of patients transported are covered by Medicare with its capitated reimbursement schedule, and because a large percentage of the remaining patients are unable to pay, the full fee is seldom collected. Even an astronomical rate increase would result in only a minimal revenue gain, and would in all likelihood result in a negative patient care impact if cost became a deterrent to accepting transport.

Privatize the Service: The elected bodies to which we belong have identified ambulance transport as a core public service that should continue to be publicly administered. Therefore the option of privatization was not studied by our group, and was not identified to the public as a viable option. Eugene Fire & EMS has contracted with a private provider to handle some non-emergency transports, but assignment of emergency prehospital care to this or any other private provider is not being considered. Under full privatization, the public would not only relinquish quality control, but also the emergency response versatility afforded by the firefighter/paramedics now staffing local ambulances.

Market FireMed as an Alternative to Additional Taxation: This was suggested at one of the community forums. It is correct that, if a sufficient number of FireMed memberships were sold, that enhanced revenue stream could take the place of General Fund support. However, FireMed and fire service professionals have countered, and we as your Task Force believe, that this type of marketing would probably result in unfortunate public perceptions and could lead to a backlash. Further, continued service would become dependent on adequate FireMed sales from one year to the next. Having said that, we are recommending enhanced marketing of FireMed, but with a positive approach.

PUBLIC PARTICIPATION

During our process, we directed staff to engage the public regarding this issue. We published an op-ed column in The Register-Guard explaining our charge, and nine community forums were organized within the three jurisdictions. The forums were announced via paid advertising, earned (unpaid) media (newspaper, television, and radio), and online. There were also presentations made to the Eugene City Club, Eugene Chamber of Commerce, and Springfield Chamber of Commerce. In addition to the community forums, we set up an online survey providing the same information and options as were provided at the public forums.

Documentation can be found in Appendices A through F, including a full transcript of written public comments received.

In summary, the combined responses from the community forums and the online survey showed the most support for the formation of a general fire service district, while General Fund support

(at the expense of other public services) was the least favored option. Numerical details regarding the responses are given in the appendix. Altogether, 116 responses were received and recorded.

We recognize that this is not a statistically valid sample, but it does represent the views of those interested enough to participate. We considered the public response in the same light as public testimony received on any issue, and we are confident that the full elected bodies will do the same.

CONCLUSION

With the political will already expressed to continue emergency medical transport as a core public service, and with the existing revenue streams no longer adequate, there is little question that additional tax support will be required. The only questions are as to the form and magnitude of that additional tax support.

Some of the measures recommended above can provide a degree of financial relief and/or service improvement. To directly address the larger and more critical central issue, however, we are compelled to report that General Fund support will probably be required to bridge the gap over the short to mid-term, and we conclude further that some new form of general tax support is the best solution for the long term, both from a fiscal and service standpoint. We recommend that further analysis of that option begin without delay.

Please contact any member of the Task Force, or staff in the respective fire service agencies, if you have questions or would like any additional information.

APPENDICES

A. Media clippings
B. Flier announcing public forums
C. Factsheet and ballot provided at public forums
D. ASA map
E. Financial graph presented at public forums
F. Public input results and comments
G. LCOG overview of district alternatives

ATTACHMENT C

Eugene Fire & Emergency Medical Services
Springfield Fire & Life Safety
Lane Rural Fire Rescue

City of Eugene
City of Springfield

MEMORANDUM

DATE: May 24, 2012

TO: Mayor Kitty Piercy and Eugene City Council Members
Mayor Christine Lundberg and Springfield City Council Members
Commission Chair Sid Leiken and Lane County Commissioners
President John Baxter and Lane Rural Fire/Rescue Board Members

FROM: Fire Chief Cities of Eugene & Springfield Randy Groves
Fire Chief Lane Rural Fire District Dale Borland

ON BEHALF OF: Ambulance Transport System Joint Elected Officials Task Force: Eugene City Councilor Andrea Ortiz, Eugene City Councilor Mike Clark, Springfield City Councilor Sean VanGordon, Springfield City Councilor Marilee Woodrow, Lane County Commissioner Jay Bozievich, Lane Rural Board Vice President Pete Holmes, Lane Rural Board Member Jim Drew

SUBJECT: REPORT AND RECOMMENDATION

SUMMARY

The Joint Elected Officials Ambulance Transport Task Force (ATTF) recognizes ambulance transport as a core service that is accessible to the residents and visitors of central Lane County regardless of ability to pay. Seen as a regional system, Eugene Fire & EMS Department, Springfield Fire & Life Safety Department, and Lane Rural Fire/Rescue District provide ambulance transport for a majority of Lane County citizens. Rural Metro Ambulance, a private ambulance service providing select non-emergency transports, and LifeFlight, air ambulance transportation for the most critical patients, augment the system. The three governmental providers continue to experience a financial crisis attributed largely to the federal government's decline in Medicare and Medicaid payments and the economic recession resulting in an increase in utilization by those underinsured and uninsured. All three regional providers are projecting annual financial deficits beginning in FY13.

Provider departments and their governing bodies have already expended substantial effort to address this critical public concern by taking steps to reduce expenditures and increase revenues including passing extraordinary increases in user fees, FireMed memberships fees, and implementing initiatives recommended by the 2009 initial Joint Elected Officials ATTF. None of these adjustments individually or in whole has created a sustainable revenue source during any 6-year financial forecast period. The Task Force was re-established in 2011 to continue the discussion of finding a permanent funding source offering stabilization for this vital service.

The 2011 ATTF has developed the following options:

1. **Do nothing.** Jurisdictions would remain responsible for providing and funding ambulance transport within its assigned Ambulance Service Areas (ASA). Under this option, jurisdictions recognize stabilizing the fund could require additional fee increases, continued reduction in expenditures, change in service levels, and/or on-going General Fund support for the continued high-quality provision of this core service. The elected bodies could choose to make General Fund support the permanent solution to the problem. However, the Task Force believes that, for the sake of preserving other local government services to the greatest extent possible, General Fund support should be viewed only as a short-term solution. Further, residents who do not live in the city limits but reside within the ambulance service area will not be contributing to the support of the service under this scenario.

2. **Privatize.** The Cities of Eugene and Springfield currently contract with a private provider for non-emergency transport. Under this contract, the Cities remain responsible for the service provided within the ASA. Under full privatization, the public would not only relinquish quality control, but also the emergency response versatility afforded by the firefighter/paramedics now staffing local ambulances. The goal would be to find the equilibrium point between these two ends of the public/private partnership spectrum. For this option, a feasibility study would be required including a review of costs to each jurisdiction to maintain fire response for medical calls in the event the ambulance transport system is contracted to a private provider in its entirety. For example, jurisdictions would need to maintain contracts for a supervising physician, which are currently funded by individual Ambulance Transport Funds. Additional considerations include payment for first response by the private provider and the financial stability of a private provider to ensure long-term, high quality service.

3. **Form Ambulance Transport District.** A new limited special-purpose district could be formed in central Lane County, or the region could annex to an existing health district to provide ambulance service. These options require governance by an elected board of directors. Alternatively, a county service district could be established. This type of entity would be governed by the Lane County Board of Commissioners. Forming a district requires an affirmative vote of the electorate within the proposed district.

   Attachment B is an overview of district-related options for ambulance service funding, prepared in June 2011 by the Lane Council of Governments (LCOG). The Task Force reviewed a full LCOG report regarding districts that was commissioned by the Lane

County Fire Defense Board. The ATTF also reviewed a high-level presentation on projected costs and estimated rate for the regional service.

In planning for formation of, or annexation to, a special district, a feasibility study highlighting proposed district legal boundaries, changes to the Metro Plan, sustainable tax revenue requirement, and taxing issues such as uncollectible percent and compression, both a reduction to gross tax revenue would need to be completed. Because implementation of district options will take a considerable period of time, we recommend the immediate formation of an intergovernmental staff team to fast track the study of the feasibility of implementing this solution.

BACKGROUND

Throughout our region, the majority of patients transported are covered by Medicare. Before the implementation of the Ambulance Fee Schedule on April 1, 2002, ambulance suppliers received payment from Medicare on a "Reasonable Charge Basis." Medicare would pay 80 percent of the allowable amount and the remaining balance was the responsibility of the patient. This allowed transport providers broad flexibility in setting rates and assured recovery of costs.

The Balanced Budget Act (BBA) of 1997 added a new section 1834(1) to the Social Security Act, which mandated the implementation of a national fee schedule. This section also required ambulance providers and suppliers to accept the Medicare allowed charge, which includes the patient's co-payment, as payment in full and transport agencies were no longer able to bill the patient or another insurance provider for the balance of the reasonable charge.

The new fee schedule took effect in 2002 and was phased in over a five-year period, with full implementation on January 1, 2006. Year one (4/1/02-12/31/02) provided a blending of 20 percent fee schedule and 80 percent reasonable charge. The reasonable charge portion was then reduced by 20 percent in each of the four subsequent years, so that as of 2006 only the fee schedule amount was payable. Since 2006, jurisdictions have received small, incremental increases in reimbursement. However, current reimbursement levels remain well below the cost of the service.

Put simply, the national fee schedule, which covers 60 to 70 percent of all transports, does not allow ambulance providers to recover the cost of providing the service. Instead, where we once had the ability to collect the full reasonable charge (which has risen over the years from $535 to $1,600 per transport), we are now reimbursed between $200 and $400, depending on the type of call. Medicaid, the state of Oregon's health insurance program, reimburses similarly.

While Medicare and Medicaid reimbursement reductions are the primary reason that emergency medical transport in our region has become a revenue-negative enterprise, two national trends are also contributing to the problem. One is the growing number of individuals eligible for Medicare. The other is the economy. Ambulance transport providers in our region do not refuse transport because of inability to pay and are being forced to write off more and more bills as uncollectible.

The Eugene Fire & EMS Department has taken many steps to try to keep the ambulance service self-sustaining including increasing the transport rates; reducing ambulance coverage during non-peak times; and cutting costs for administrative staff, materials, and supplies. The department has also worked closely with City Finance staff to identify the appropriate cost split between the Ambulance Transport Fund (ATF) and General Fund (GF) to ensure the ATF is not supplementing General Fund services as well as to identify needed GF support on a one-time basis to balance the ATF in 2010 and 2011.

In addition, Eugene's ambulance system capacity is very thin. With inadequate revenues to increase the number of advanced life support ambulances on the street, the department elected to privatize select non-emergency calls for service, which matches a more appropriate level of resource with particular call types to a private provider as a cost avoidance strategy.

Springfield Fire & Life Safety staff has focused on maximizing existing revenue sources for all three providers through the joint FireMed program by increasing the membership fee and by increasing participation in the JobCare program. In FY12, the FireMed program managers focused on decreasing administration and advertising costs of the program. However, it has been noted that even with the recent adjustments to the program, FireMed, in itself, will not garner enough revenues to balance the Ambulance Transport Funds.

Springfield Fire & Life Safety has taken several steps toward keeping the ambulance transport system self-sustaining including increasing transport rates and reducing costs for administration. Springfield Fire & Life Safety also contracts with a private provider for inter-facility, non-emergency transports. In FY11, the Ambulance Transport Fund accumulated reserves totaling $251,605. These reserves are forecasted to be depleted by the end of FY13.

The Lane Rural Fire/Rescue District was granted an Ambulance Service Area (ASA) encompassing the northwest portion of Eugene's ASA in 2001 and in 2002 began providing emergency medical transport in addition to fire and rescue services to that area, resulting in a reduction of ambulance transport revenue as well as FireMed membership revenue for Eugene. As a pre-existing taxing authority, Lane Rural has been able to augment its overall revenue with ambulance fees and FireMed revenue, but not to the extent that the ambulance service is fully self-supported; instead, the district annually levies funds as necessary to provide all of its services, in effect providing some support to the ambulance service with general tax monies. Currently, this requirement is estimated to be at least $400,000 annually.

None of these adjustments individually or in whole has created a sustainable revenue source during any 6-year financial forecast period. All three Ambulance Transport Funds continue to see annual deficits and depleting reserves. Another unobtainable goal is to maintain a reserve equal to two months' operating expenditures. As projected in the current 6-year financial forecasts, no jurisdiction will meet this goal. Additionally, all three jurisdictions have relied on contributions from their general funds to balance in recent fiscal years.

In 2009, the initial Joint Elected Officials Ambulance Transport Task Force was formed because a solution to this crisis was determined beyond the capacity and authority of any one provider agency acting unilaterally. After studying this issues and the range of available options, having

engaged the public at a series of community forums and online, and having worked in concert with stakeholders including local fire and ambulance service professionals, hospitals, and firefighters' unions, the taskforce recommended the following:

1. That all three jurisdictions remain prepared to allocate a level of General Fund support as necessary for the continued high-quality provision of this core service.
2. That the Eugene and Springfield City Councils authorize initial steps toward merger of their fire departments.
3. That exploration begin immediately of more sustainable public funding options.
4. That marketing of FireMed subscriptions be enhanced and expanded in an effort to generate additional revenues to lessen reliance on general fund tax support.
5. That the City of Eugene and Lane Rural Fire/Rescue analyze the possibility of reconfiguring the boundaries of the county's Ambulance Service Areas so as to provide for an urban-rural split between Eugene and Lane Rural Fire/Rescue; and, if conditions appear favorable, that the Lane County Board of Commissioners be asked to enact such reconfiguration.
6. That work proceed as rapidly as possible regarding provision of a regional mobile health care system, featuring tiered levels of response (and cost) available to patients depending on the nature of the emergency with a report to elected officials by the end of calendar year 2010.
7. That public ambulance service provider agencies continue to lobby the Oregon legislature and U.S. Congress for larger-scale, long-term solutions.

Several of these recommendations have been implemented including continued General Fund support as needed per jurisdiction to keep programs viable. All three providers recognize General Fund support is considered one-time and, at this time, is not a sustainable solution. The merger initiative continues to make positive steps toward a fire district, which could ultimately provide needed funding for ambulance transport. However, it is projected that forming a district is a long-term goal and will not address the immediate funding need of the ambulance transport service. As previously stated, increased revenues for the enhanced FireMed program have been determined that the program cannot in itself, garner enough funding to stabilize the system. The City of Eugene has moved forward with recommendation #5 by contracting with Lane Rural Fire/Rescue District to provide rural ambulance transport services west of the urban growth boundary. This agreement has resulted in decreased response times for the constituents being served. This recommendation has had minimal impact on the Eugene workload issue but does not address the financial stability of either ambulance transport system. Finally, regional providers continue to actively work with the United Front at the State and Federal levels for developing larger-scale, long-term solutions.

CONCLUSION

With the political will already expressed to continue emergency medical transport as a core public service, and with the existing revenue streams no longer adequate, there is little question that additional tax support will be required. The only questions are as to the form and magnitude of that additional tax support.

As shown, some of the measures recommended provided a degree of financial relief and/or service improvement. However, to address the larger and more critical central issue, General Fund support will probably be required to bridge the gap over the short to mid-term, and we conclude further that some new form of general tax support is the best solution for the long term, both from a fiscal and service standpoint.

Please contact any member of the Task Force, or staff in the respective fire service agencies, if you have questions or would like additional information.

ATTACHMENTS

A. ASA map
B. LCOG overview of district alternatives
C. Media clippings

Attachment A
Ambulance Service Area