

Docket No. SA-530

Exhibit No. 4-F

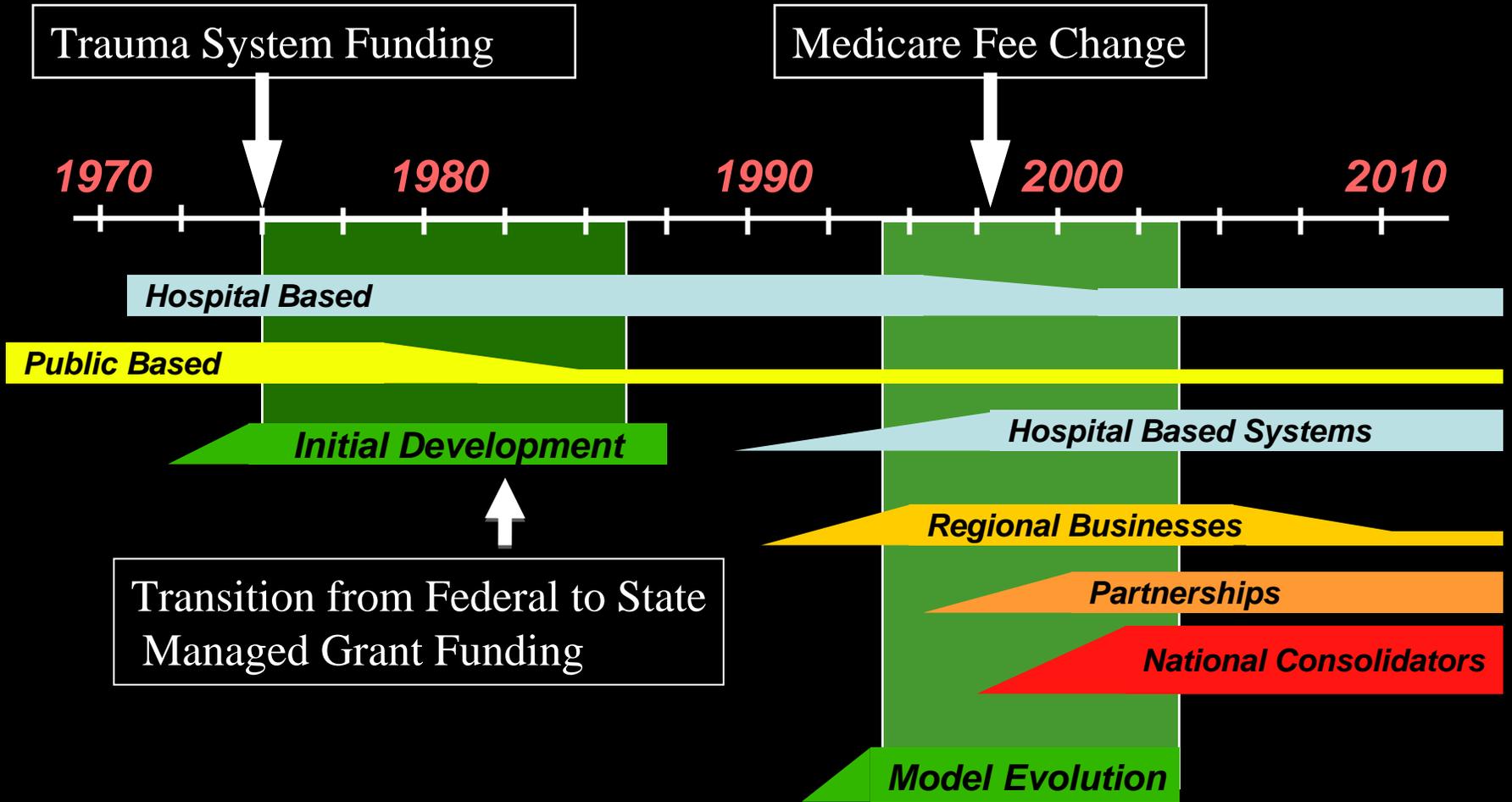
NATIONAL TRANSPORTATION SAFETY BOARD

Washington, D.C.

Panel on Current EMS Models and Reimbursement Structures
Presentation by Dr. Kevin Hutton

(7 Pages)

Reimbursement and Model Development Air Medical Transport in the US



Model Development Follows Funding

Why Growth is Occurring Now in the US?

- Rural level of care requirements
- Increased time dependent care
- Consolidation & critical care regionalization
- Increased patient destination legislation
- Limited or no rural ground transport capability
- Malpractice, decreased local specialty capability
- Growth & consolidation of providers, economies of scale
- More consistent reimbursement

Market Drivers



Understanding the US Insurance System

Fee Structure: *(Government dictates this)*

Base Rate: All fixed costs, 85% of costs are fixed

Loaded Mileage: Variable cost per transport

Issue: not paid for response / readiness, must transport patient

Insurance and other sources of payments:

Medicare: over 65, disabled, others

Medicaid: poor, extreme State by State variation

Tricare: military, dependants, & military retired

Commercial: auto, health insurance, etc...

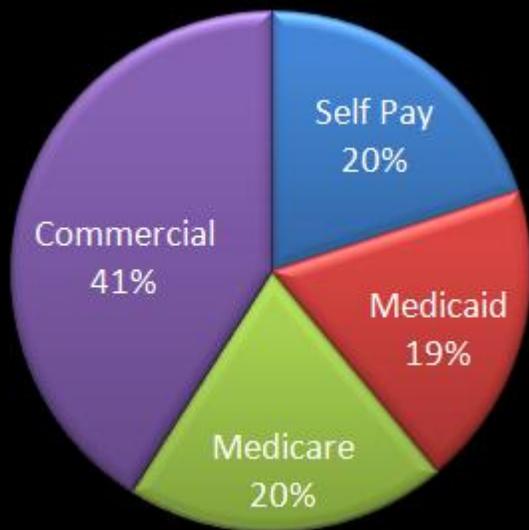
Self Pay: patient responsibility, charity care

Special Funds: administered by few States & Counties

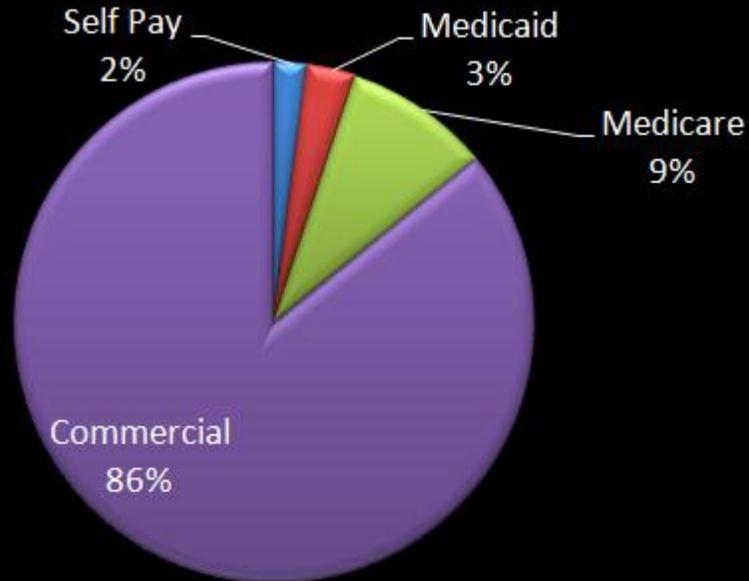
Legal Settlements: in some States

Air Medical Transport Patient Payer Mix & Payment Comparison

Patients by Payer Type



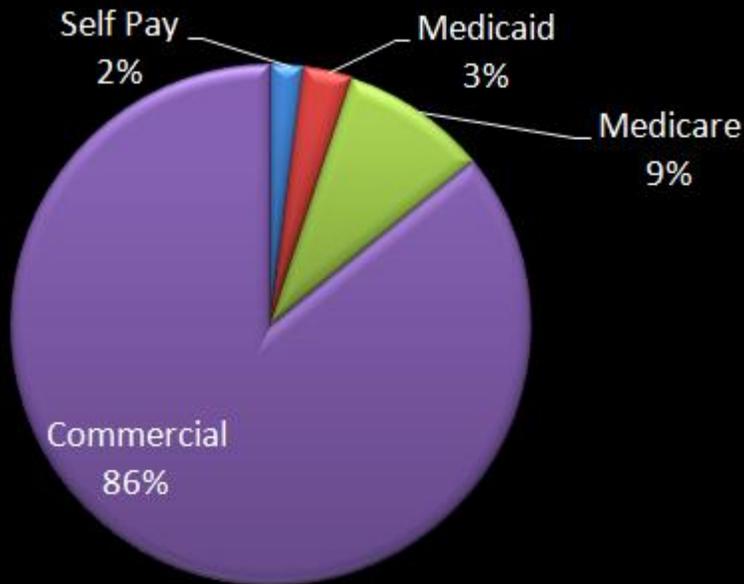
Payments By Payer Type



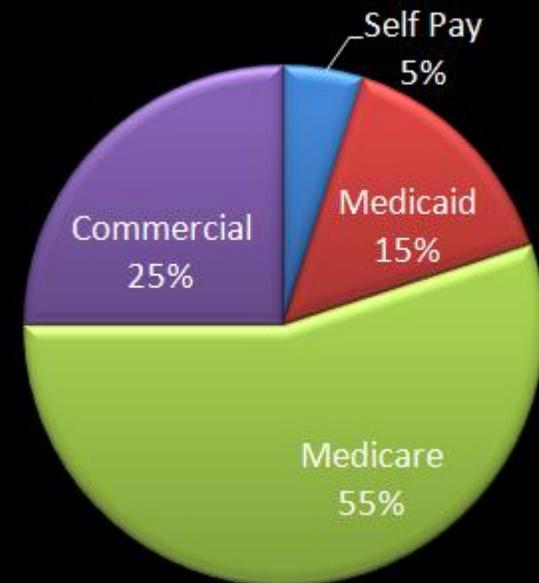
* Northern VA experience Golden Hour Data Systems, Inc

Payer Mix & Payment Comparison Air vs. Ground

Payments by Payer Type



Air *



Ground**

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** Richmond VA experience, Figure 2.2, EMS at the Crossroads

Air Medical Billing

- **Complex & Adversarial**
- **Error & Risk Filled**
- **Regulations NOT designed for AMT**
- **Non-specific Regs Increase Cost**
- **Labor Intensive**
- **Costly & Not Efficient**

- 45 % collections in 105 days is good