

To: Center for Medicare and Medicaid Services
Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014
Date: September 6, 2013

The National Association of Emergency Medical Technicians (NAEMT) appreciates the opportunity to comment on the proposed rule regarding collection of data for Medicare reimbursement.

NAEMT is the nation's only organization solely dedicated to representing the professional interests of all EMS practitioners, including paramedics, emergency medical technicians, emergency medical responders and other professionals working in prehospital emergency medicine. NAEMT members work in all sectors of EMS, including government service agencies, fire departments, hospital-based ambulance services, private companies, industrial and special operations settings, and in the military. We have over 40,000 members and train over 60,000 students annually.

Prehospital Emergency Medical Services (EMS) originally developed as an emergency transportation service to deliver sick and injured patients to a hospital. Reimbursement models were created in response to this historical role. Since its early years, however, EMS has evolved into an essential, patient-centered public service. Quality EMS is proven to save lives in all types of emergency medical crises — from trauma, to cardiac arrest and stroke.

In every community of our nation, EMS is expected to deliver quality emergency medical care to their residents on a 24/7 basis, as part of a continuum of health care services provided to all patients suffering with emergency medical conditions. EMS is very often a patient's entry to the health care system, following an acute care episode. High-quality prehospital emergency medical care is essential in improving patient outcomes, increasing efficiency, and reducing costs for patients with expensive medical conditions. The federal government funds a large portion of the EMS provided to Medicare, Medicaid and CHIP beneficiaries, and thus has a strong interest in ensuring high quality and cost-effective emergency medical care.

Unfortunately, the financial reimbursement model used by our federal government is based on the 1960's model of emergency transportation – rather than today's EMS model of delivering patient care. Using an old model for reimbursement will inhibit our country's further evolution of EMS into a mobile integrated healthcare system that supports improved patient outcomes and lower costs. In short, the current reimbursement model does not support effective medical care.

When people need medical help and do not have a primary physician, they turn to their local ground EMS agency. In our current healthcare system, the EMS agency is placed in the role of "gatekeeper." When called, our EMS personnel have no choice but to take their patients to an

emergency room — regardless if the patient is suffering from a true medical emergency or simply a lack of primary care. In some cities, local wait times for EMS patients are 45 minutes or longer (referred to as “wall time,” which is the time a paramedic spends leaning against a wall, while the patient on a stretcher waits for an emergency room bed). Without an alternative approach to this system, such as treatment in the home (data shows this improves patient care and well-being), we will continue to misuse our nation’s hospital emergency departments and cost our healthcare system billions of dollars.

We believe that the implementation of the Patient Protection and Affordable Care Act can be supported and enhanced through better utilization of our nation’s EMS systems. EMS brings a valuable medical culture that can improve patients’ lives and reduce the cost of healthcare to the patient and the system.

We believe the time has come to develop a new strategy — which reimburses EMS agencies for patient care, rather than patient transport. As the national voice for thousands of EMS practitioners, we respectfully request the Center for Medicare and Medicaid Services to establish a national task force, comprised of national, state and local stakeholders to:

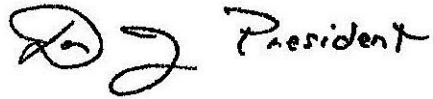
1. examine how emergency medical care is currently delivered,
2. review the many examples of innovative ways that communities are utilizing EMS in the delivery of mobile integrated health care,
3. develop a reimbursement model that is based on the current and future delivery of mobile health care, and reimbursed for outcome-based patient care - which may not include transportation to a hospital, but focuses on improved patient care and a reduction of unneeded emergency room care and/or hospital admissions.

We believe that CMS, working collaboratively with all stakeholders, can identify a new reimbursement strategy that 1) reimburses for patient care, 2) is less costly, 3) includes outcome-based targets, and 4) promotes the “right patient care, at the right time, and in the right setting.” Numerous studies recently published by AHRQ, NCSL, RAND, UC-Davis and JAMA support our request.

The EMS community understands the need to develop and implement new models of healthcare delivery – which improve patient outcomes and reduce costs – and is committed to develop real solutions for our country’s healthcare challenges. Community-based paramedics, participating in CMS-funded innovation grant programs, are making a difference in their select cities by treating patients and ensuring that they are directed to the most appropriate healthcare facility. These innovations can be extended nationwide with the support of an appropriate reimbursement model.

Thank you very much for your consideration of our request. We look forward to working with CMS on this, as well as other important health care issues. If you have any questions, please feel free to contact me or NAEMT's Executive Director, Pamela Lane at (800) 346-2368.

Sincerely,

A handwritten signature in black ink, appearing to read "Don Lundy", followed by the word "President" written in a cursive, handwritten style.

Don Lundy
President, NAEMT