

EMS Must Take the Lead on Reimbursement Reform, Leaders Say

EMS must take the lead on reimbursement reform or risk having change imposed by government regulators, EMS leaders say.

To lay the groundwork for reform, NAEMT collaborated with several of the nation's largest EMS agencies and national EMS organizations to develop a proposed framework for changing the way in which EMS is reimbursed. The framework calls for EMS agencies to begin moving away from fee-for-service reimbursement toward rewarding high-quality, cost-effective care, also known as value-based purchasing or pay for performance.

Specifically, EMS agencies that bill Medicare and Medicaid would agree to report cost, performance and outcomes measures to increase the accountability of EMS, and to better enable Congress to monitor how Medicare and Medicaid money is being spent. In exchange for the greater transparency, Congress would make the Medicare ambulance reimbursement "add-on" payments permanent, which is critical to the financial health of many EMS agencies.

"We need to lead the change, or change will come to us through regulation," says Asbel Montes, vice president of government relations and reimbursements at Acadian Ambulance Service in Lafayette, La. "We need to come together as an EMS industry and get ahead of this."

Acadian was one of three ambulance companies, including American Medical Response (AMR) and Superior Ambulance, that participated in developing the reimbursement reform framework in collaboration with NAEMT, the National Association of EMS Physicians (NAEMSP) and the National Association of State EMS Officials (NASEMSO).

Based on that framework, NAEMT's Advocacy Committee developed a position statement that was adopted by the NAEMT Board of Directors, urging the EMS industry to work with Congress on legislation that would bring the reimbursement reform framework into law.

"EMS reimbursement has not kept pace with changes in EMS. EMS is an essential, patient-centered public service," says NAEMT President Conrad "Chuck" Kearns. "It has proven to save lives in all types of emergency medical crises, such as trauma, cardiac arrest and stroke. It provides emergency care at all times, to every community in our nation. Moreover, it has increased efficiency and in many cases reduced in-hospital patient care costs. Reform should reflect advances in EMS."

EMS's History as a Transportation Provider

When modern EMS took shape in the 1960s, EMS was developed as an emergency *transportation* service that delivered the sick and injured to hospitals.

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The EMS practitioners of today, of course, do a lot more than pick up patients and drive. EMTs and paramedics provide lifesaving medical care for trauma, STEMI and stroke patients. They assess patients to determine the best place to take them for care, and are increasingly integrated into the larger healthcare system. With the addition of Mobile Integrated Healthcare and Community Paramedicine (MIH-CP), some EMS agencies are further expanding the services provided, offering health education, nurse triage of non-urgent calls, chronic disease management in the home and transport to alternative facilities.

Yet one aspect of EMS remains mired in the past – reimbursement. EMS agencies are still paid a fee that's based on an EMS practitioner driving a patient to the hospital.

“We began as part of the National Highway Traffic Safety Administration (NHTSA) responding to the epidemic of death on the interstate highway system,” says Dr. Brent Myers, director and medical director for Wake County EMS in Raleigh, N.C., and president-elect of NAEMSP. “The job was to take the trauma patient from the interstate to the hospital. You are part of the Department of Transportation, and you are paid for that based on how far it is... Today, my healthcare colleagues are shocked when I explain to them that we are still being reimbursed in that way. When I tell them that, I receive these blank stares.”



Photo: MedStar

Healthcare Shifts to Value-based Reimbursement

Even though EMS is stuck in a 1960s-era reimbursement scheme, the way in which the rest of healthcare is reimbursed is undergoing rapid change.

Instead of fee-for-service, which rewards *volume* of care – basically, the more medical services you provide, the more money you make – reimbursement is shifting toward payments for care based on quality and patient outcomes – that is, does the care actually help the patient, and is the cost justified?

Linking reimbursement to quality of care is called value-based purchasing, or pay for performance. The goal is to reward effective care, discourage ineffective care, and ultimately bring down costs while improving patient health.

Hospitals, physicians and other medical providers are increasingly subject to value-based reimbursement, including receiving penalties for unnecessary hospital readmissions, and incentives for reporting on measures pertaining to quality of care (such as following national guidelines for heart attack treatment and hospital-acquired infection prevention), as well as patient satisfaction, also called patient “experience of care.”

EMS so far hasn't had to report on similar quality measures. But many experts believe it's only a matter of time before CMS

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Getting paid: FAQs About Reimbursement and Cost Reporting

Q. Which U.S. Congressional committees consider Medicare reimbursement?

On the House side, it's the Committee on Ways and Means and the Energy and Commerce Committee. On the Senate, it's the Finance Committee.

Q. What would cost reporting entail?

Basically, cost reporting means providing information about all of an EMS agency's income and expenses, such as equipment, gas, supplies, personnel costs, taxes, and the cost of uncompensated care.

Q. Does EMS do any cost reporting currently?

Almost all EMS agencies, public and private, track costs for their own accounting purposes. Many fire departments and municipal EMS agencies report costs to their local jurisdiction, such as the city or county. Some EMS agencies also provide cost reporting to the state, which may help cover the cost of uncompensated care. But this information has never been shared with the Centers for Medicare and Medicaid (CMS) or Congress before.

(Centers for Medicare and Medicaid) and private insurers will expect EMS to fall in line with the rest of healthcare.

A 2013 report from the Office of Inspector General is widely viewed as a harbinger of changes to come. The report found a sharp increase in Medicare claims for transports, which rose by 34 percent between 2002 and 2011, even though the number of Medicare fee-for-service beneficiaries increased just 7 percent. Much of the spike, according to the report, was explained by questionable, non-emergency, dialysis-related transports.

“We need to make it clear to Congress that we are coming together as an industry to prevent fraud,” Montes says.

Protecting the Add-ons

There’s a practical reason for EMS to offer to do cost reporting, Montes says – providing data that justifies EMS’s need for the “add-ons,” or supplemental temporary payments first authorized in 2003.

The add-ons, which have been reauthorized periodically ever since, give ambulance providers a 2 percent increase in the base rate and mileage for transports in urban areas and a 3 percent bump in the base rate and mileage for transports originating in rural areas. Super-rural providers are eligible for a 22.6 percent bump, plus the 3 percent rural add-on.

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Asbel Montes, vice president of government relations and reimbursements, Acadian Ambulance Service in Lafayette, La.

The add-ons are set to expire March 31. The American Ambulance Association (AAA) has been lobbying for the add-ons to be made permanent, a stance that has almost universal EMS support. Doing so “would allow us to budget over the long-term for staffing, replacing equipment and ensuring we can continue to serve the communities that rely on us for medical care,” according to AAA’s website.

Yet given the current mood on Capitol Hill that may be a hard sell, Montes says.

All legislation receives a cost analysis for the Congressional Budget Office, and members of Congress have indicated that bills that will receive serious consideration are those that won’t cost the federal government additional money, he says.

“The attitude is, ‘We can’t just keep adding new programs and new expenses,’” Montes says. “If somebody proposes new legislation, they have to explain how they’re going to pay for it.”

Congress may be willing to extend the add-ons for another few months or even a year, he notes. But for add-ons to become permanent, EMS will need to show that it can pay for the add-ons. One strategy is cost-reporting that will document the need for the add-ons and help to root out fraud in non-emergency BLS (basic life support) transports.

Recognizing the Full Value of EMS

Cost and quality measures reporting would also serve another purpose – helping EMS have national data to show to CMS

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NAEMT Position Statement on EMS Reimbursement Reform

On January 23, the NAEMT Board of Directors issued a position statement urging the EMS industry to work cooperatively with congressional leaders to pass legislation that supports quality patient care, promotes the ability of pre-hospital EMS to provide that care, and ensures financial sustainability. The statement supports:

- Making the Medicare ambulance reimbursement “add-ons” permanent
- Paying for these add-ons through reductions in payments for non-emergent, repetitive BLS transports, considered vulnerable to fraud
- Cost reporting by all ambulance providers in a format that will demonstrate to congressional leaders and regulators that the industry is supportive of being held to the same measures as the rest of the healthcare system
- Incentivizing providers to begin reporting on performance and outcome measures
- Offering opportunities for providers to be reimbursed for innovations that improve patient care and reduce healthcare costs, such as mobile integrated healthcare and community paramedic programs, and referring or arranging for alternative patient care.

The full statement can be found at naemt.org/advocacy.

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Even for those who do qualify for home health, it can take 24 or 48 hours to get a patient certified to receive home health services. What happens in the meantime? Filling that gap between when the patient is discharged and when they are certified for home health could be one of partnerships between home health and EMS.

Q At the end of your talks, did you see a shift in attitudes toward MIH?

Yes, but we have a lot of relationship building and education to do.

At the local level, there's a need to prove over time to home health agencies that you walk the walk – you are not competing with them, you are facilitating filling a gap in services, and in some cases, you are identifying patients who would qualify for home health and referring them into home health. When you bridge those gaps at the local level, the objections tend to melt away.

But the national home health associations are still very apprehensive about MIH, in part because some EMS agencies in a few communities have not done a good job alleviating the concerns of home health agencies in their community. Those local home health agencies have shared their concerns to their state and national organizations.

Q How can NAEMT's "EMS and Home Health" resource document be used?

It serves as an educational piece for EMS leadership to explain the differences between MIH and home health care, so that when EMS has that first meeting, EMS can articulate those differences in a way that home health agencies can understand. The document can also be used as a leave-behind for further discussions.

For more information on mobile and home health care, visit the MIH-CP section of naemt.org.

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that by and large, EMS is not being overpaid for providing Medicare and Medicaid transports, but at best, is operating on razor-thin margins and at worst, is being significantly underpaid, Montes adds.

This kind of information could also help EMS going forward in advocating for reimbursement that more fully reflects the value of EMS to the community, says Dr. Craig Manifold, the American College of Physician's EMS committee chair, medical director for NAEMT's Principles of Ethics and Personal Leadership course, and EMS medical director for the San Antonio Fire Department.

"Our federal government is one of the largest payers, we need to look at a reimbursement structure that is different than a mileage-based fee," Manifold says.

Sharing information about quality and costs may pave the way for Medicare and Medicaid reimbursement for the types of services provided by MIH-CP programs, such as EMS doing post-hospital discharge follow ups, or taking patients to alternative facilities such as urgent care instead of the hospital emergency department.

"The federal government isn't just going to hand us a bunch of money to make these changes," Manifold says. "I think we have a tremendous opportunity to move this forward. But we need to demonstrate through gathering data and research that we are providing quality care, and we are doing it in a cost efficient manner in order to see this change in reimbursement process."

