



## NAEMT/AIMHI Webinar Q & A: Your Questions Answered

On August 20, 2019 NAEMT and AIMHI conducted the first in a series of webinars designed to educate EMS professionals about the economics of EMS. We had many great questions on the first webinar, so many that we could not get to all of them during the webinar. Here are the responses to the questions Chip and Matt did not have time to answer live during the webinar.

### **Medical Necessity**

*What about those cases when the patient really did not need to go the hospital via ambulance? Maybe they are a frequent abuser, or simply have a very low acuity condition. Providers are required to accurately document, but in some cases, medical necessity is tough to explain when it's really absent.*

This is a real conundrum. Many patients may not exhibit life-threatening medical conditions, but there still may be medical necessity for medical monitoring during transport. The patient's condition could deteriorate, necessitating the need for medical intervention. Payers have historically used what's often referred to as a "prudent layperson" standard for an 'emergency medical condition.' Often, this standard is reasonable, based on dispatch information at the time of the medical call. For example, a 55-year old male with a severe headache could be having a stroke and we handle the response, as from a pre-hospital perspective, on a stroke being one of the possible differential clinical diagnoses of the patient's condition. Once they are assessed at the hospital, it may be determined that his headache is from a caffeine deficiency, but EMS had no way of knowing that without more robust diagnostics. Most insurers would cover that ambulance use, since it is reasonable that a prudent layperson may have presumed the patient may be experiencing a stroke at the time of the ambulance call.

Now, in some cases, no matter how well you document, it may be hard to demonstrate medical necessity. We use the recent case of a patient who called 9-1-1 for blisters on her feet and she did not want to walk to the bus stop to go to the clinic. The patient had no medical history (diabetes, or other conditions related to the blisters on her feet that might need medical intervention). She simply wore shoes that did not fit properly. This transport will in all likelihood be rejected by an insurer due to lack of medical necessity. We have to accept this fact and try to find system approaches for dealing with low/no acuity medical calls, perhaps such as nurse triage in the communications center, alternate destination and transportation options, etc. It's a bad practice to try and go overboard on creative documentation to try and demonstrate medical necessity when none exists.

*Who pays for a return trip to a nursing home for a non-medically necessary trip, after hours to the nursing home which doesn't provide a van or wheelchair van service so the facility uses the ambulance as a taxi to bring them back after discharge?*

The balance here is medical necessity vs. being a good partner for your community's healthcare system. The best approach here is to try and develop a resource that can be appropriately used. Some agencies implement, or contract for, stretcher or wheelchair van services as part of their service offering. Another option is to see if the facility can wait until business hours for those services being available. Another strategy could be working with the facilities to have them become a 'payer of last resort' when the transports are denied, either for lack of medical necessity, or even lack of payer source. This simplifies the transfer process for the requesting facility (no need to get pre-authorization to arrange for payment in advance), and if they get a lot of ambulance bills for transports that did not meet medical necessity, they may work with you to find other resources!

*What can be done for doctors that are setting up interfacility transports based on their convenience not the patient's billing requirements.*

This is another example for the use of payer of last resort agreements. If you have a physician who does this repeatedly, see if they are willing to enter into that agreement. You can explain the challenge to the doc, or if the patient is going to a healthcare facility for the physician's services, then perhaps approach the sending or receiving healthcare facility for the payer of last resort agreement. The facility may be able to work with the physician to better manage transportation resources.

If the patient is coming from a facility (skilled nursing, LTAC, etc.), another option could be to educate the sending facility on resources that may be able to come to them. There is a growing market for mobile services such as x-ray, lab, even mobile urgent care who could come to the facility as opposed to sending the patient out.

### **Rates & Reimbursement:**

*When speaking to your charges are you also taking into account operational expenses?*

Financing the EMS system must take into account **all** expenses - operations, capital purchases (including refreshing existing capital such as vehicles) and even amounts put to operating reserves. In our webinar example, Above Average EMS has total expenses of \$2 million, including capital and debt service. They do 3,000 annual transports, so that means their 'fully allocated' cost per transport is \$667. To cover this cost, they would need revenue per transport of at least \$667, which can be covered with fees for service, tax subsidy or a combination of both. If the system's desire is to not use tax dollars, the agency would need to charge an amount that nets them the required \$667 per transport.

*Is it better to itemize bills, or use flat rates?*

It's been surmised that itemized billing could yield a higher rate, and potentially higher reimbursement. In some cases, that may be true. However, we find that in general, most payers pay based generally on three allowable charges, base rate, mileage and oxygen. It's probably better to try and consolidate the items you may bill for separately (such as night fees, supplies, medications, etc.) into an appropriate base rate.

*Regarding commercial payers, do either of your systems have contracts with commercial payers to obtain guaranteed payment?*

Boy, wouldn't that be the bomb! No, we have not generally seen payment arrangements with commercial insurers that guarantee anything. Medical necessity is generally the most important determiner for coverage. Even if there is 'coverage', whether or not you actually get paid is a totally different matter. Things like deductibles, co-insurance and other factors may limit the amount you get paid, even when the service provided meets coverage eligibility. Now, that said, the arrangement described on the webinar that the commercial insurer pays a 'capitated amount' (a fixed amount per member, per month) could be considered a 'guaranteed' payment, however, those arrangements are not without risk to the ambulance providers in terms of excess utilization and need to be evaluated very carefully.

*What about expanding a 911 EMS services' ability to transport to other appropriate facilities, such as detox, crisis centers and urgent care?*

EMS' ability to transport to alternate destinations is dependent on three key things. First, is it permissible in your service area? Some states have statutes and/or regulations that don't permit this to occur. Second, do you have locations to transport to other than an ED? Are urgent care or detox centers available? Do they want to be an ambulance receiving facility? Finally, will you get paid for the transport to that alternate destination? Medicare (before ET3) will generally not pay for an alternate destination transport – most other payers are the same. Once you have the answers to these three key questions, you'll be able to make determinations about whether or not alternate destinations are a viable option for your system.

## **GEMT and Supplemental Payments:**

*What does the acronym GEMT stand for?*

GEMT stands for Ground Emergency Medical Transportation Services (GEMT). It's a voluntary supplemental reimbursement program. It's generally a Certified Public Expenditure (CPE) based program which provides additional funding to eligible governmental entities that offer GEMT services to Medicaid beneficiaries. The Centers for Medicare and Medicaid Services (CMS) approves State Plan Amendments (SPA), authorizing the federal share of the supplemental reimbursement payments based on uncompensated costs for Medicaid fee-for-service transports.

*Could you tell us a little more about this GEMT thing? How does it work, and what states offer it?*

Great question! In short, it's complicated. Each state is a little unique, but generally, GEMT is a program that pays ambulance agencies a supplemental payment for Medicaid ambulance transports. Most Medicaid rates are below (some, WAY below) the cost of providing the service. The GEMT program pays ambulance providers a supplemental amount to help bridge this gap. In many cases, it's available only to public ambulance agencies because the states recognize that Medicaid's shortfall generally means a higher tax burden on local residents, if tax dollars are being used to subsidize the ambulance provider. There are variations of the GEMT, such as in Missouri and more recently, in California. All providers pay 'fee' per transport to either the state, or another funding mechanism. The revenue generated in this fund is then distributed to agencies who have a high rate of Medicaid ambulance use. In these cases, the supplemental payments can be made available to all types of emergency ambulance providers, public and private.

For example, California has a new GEMT-QAF program. Providers pay \$26.07 per transport to the state. In return, providers get a supplemental payment for any Medicaid transport of \$220.80. If you have a high percentage of Medicaid transports, that works for you. If you have a low Medicaid payer mix, it hurts you. Here's an example.

	<b>Transports</b>	<b>QAF Payment</b>	<b>Medicaid Transports</b>	<b>Supplemental Payment</b>
System A	9,000	\$234,630	1,704 (18.9% of payer mix)	\$376,243
System B	11,000	\$286,770	800 (8% of payer mix)	\$176,640

To make the California GEMT-QAF system work, and be budget neutral, ALL ambulance providers MUST participate and the supplemental payments are available to all providers, public and private.

Check with your state Medicaid office to see if GEMT, or some variation, is available in your state. We know of the programs in Texas, California, Colorado and Washington state, but there are likely more.

## **Billing Processes & Networks:**

*From an IFT company standpoint, is there any benefit to collecting co-pays before or at the time of transport?*

Interesting concept! Collecting the co-pays in this regard will most likely require you to set up the ability to a) know what the co-pay is going to be, and b) have a process to collect the fee. The latter, from a technical perspective, can be relatively easy with things like the 'square' for processing payments from an iOS or Android device. The former is a little bit more of a challenge – but we suppose you could find out what the co-pay is from the payer before the trip. The bigger limiter in the coverage would likely be denial and applicable deductibles. The co-pays are generally low (maybe as high as 20% of the covered amount). The time, energy, effort, training and angst that you may need to implement for the small reimbursement, may not make it worth it.

*How do IFT companies combat relationships with hospitals that have poor payer mixes?*

Well, to be successful, you may not want to consider it a battle. Partner with them. You both have aligned incentives – they want patients transferred, you want to be able to pay your employees. Find innovative partnerships – perhaps they will do the payer of last resort agreement we referred to earlier. Perhaps they provide you with all transports so that the revenue generated from all the transports (assuming you want them all) help cover the cost of the unfunded transports. Maybe form a non-profit joint venture organization that can apply for grants or other programs designed to help reimburse for uncompensated care? This may be especially attractive if the hospital received tax support to care for the uninsured. Finally, not all business is good business. Without some support, that hospital may not be a good fit for your organization.

*How do small, municipal volunteer services best function and thrive financially when the majority of patients are on Medicaid?*

Ah, the \$64 million question. Partnerships! Demonstrate the value you bring to different stakeholders and seek funding support. There are many volunteer agencies that receive tax subsidies from the communities they serve for exactly that reason. You could also apply for grants (although, generally not for operations, they can help fund equipment, training and other support). Find a benefactor – some agencies capitalize on relationships from philanthropist to assist with funding, even fund raising. Bill for your services – just because you're volunteer does not mean you don't have expenses – even if you send a "bill" to patients, that is really a letter explaining that it cost you \$XXX to respond to their medical call, and any offer they could make to help offset that cost will help assure the service is available for others in the community. Finally, NAEMT has been working with Congress on the funding for the recently passed SIREN Act – which makes money available for small and rural EMS agencies.

*Concerning the in and out of network billing, is there a discussion about engaging the fraud aspect of these bad actors that routinely use EMS and receive payment from the insurer with no intention of paying their EMS bill?*

Yes! In fact, in Texas, we met with the Texas Association of Health Plans several years ago on this very issue. Some of the insurers started making payments to the patient instead of the providers, despite the patients signing an assignment of benefits statement. We brought oodles of data that showed the amount of money the insurers were paying to the patients and what amounts were not being turned over to the providers. During the discussion, the concept that the payers were creating an environment that allowed consumers to engage in insurance fraud was brought up. We all mentioned that we 'might' be willing to refer their members to authorities for criminal prosecution. And, of course, the claims processors from the insurers may be called as witnesses in the cases (one agency had over 1,500 examples of members who were paid and did not turn over the payment). We're happy to report that the payer who was paying insurers directly, eventually ceased the practice.

*Is there a resource for "Payer of Last Resort" contract examples?*

Yes, we'll post one on this website below for download.

*Is the subscription plan EMS is charging monthly actually legal? To waive patient responsibility is cause for fines by OIG.*

Ambulance agencies take various approaches to billing and fees. There are many agencies that charge different rates for residents or non-residents. Others that choose to accept whatever insurance pays as payment in full for residents. And, still others that have a 'no collections' policy, meaning that they do not send any patients to collections if the ambulance bill – or a portion thereof – are not collected. Each state is different with regard to ambulance subscription programs. Most states allow them, while some consider them insurance and only able to be offered by insurance companies. The OIG has not determined that ambulance membership programs, nor the other billing arrangements listed here, violate any regulations.

*What are some grants that are available to EMS especially squads in lower income areas?*

There are numerous grants EMS agencies can apply for, some are national, most are local or regional. Some can be used for equipment, training, vehicles, or other special initiatives. Some equipment manufacturers also maintain lists of places to apply for grants for specialized equipment and/or vehicles. You may be able to find assistance specific to your state from your state EMS office. Local United Way offices also try to maintain lists of resources.