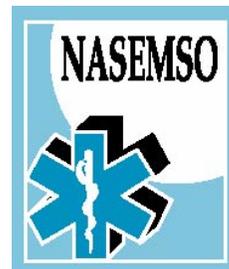


Joint Statement on Ambulance Reform

Policymakers Should Examine Short- and Intermediate-Term Policies to Promote Innovation in the Delivery of Emergency and Non-Emergency Care Provided by Ambulance Services



**Joint Statement of the
American Ambulance Association;
National Association of EMS Physicians;
National Association of EMTs; and
National Association of State EMS Officials**

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**Policymakers Should Examine Short- and Intermediate-
Term Policies to Promote Innovation in the Delivery of
Emergency and Non-Emergency Care Provided by
Ambulance Services**

As the federal government, state policymakers, and commercial payers look to find innovative ways to provide high quality health care in the most efficient setting, it is critically important that the role of ambulance services – both emergency and non-emergency – are recognized and taken into account. Since their initial inclusion in the Medicare program, ambulance services have evolved and today provide health care services that were only available in a hospital emergency room or physician's office twenty years ago. In addition, the unique training and skills of ambulance service personnel allow other health care providers to confidently transfer patients too ill to travel by conventional means to the most appropriate, cost effective health care settings, even when there is no specific emergency. Ambulance services provide a critical link in the health care system, but current law limits their ability to use their unique skills in innovative ways that can improve patient outcomes and reduce overall health care expenditures.

The American Ambulance Association (AAA), National Association of EMS Physicians (NAEMSP), National Association of EMTs (NAEMT), and National Association of State EMS Officials (NASEMSO) support the following policies that are necessary to stabilize the current Medicare ambulance benefit and set the stage for innovation. In brief, short-term reform includes:

- Building current add-ons into the base rate (through the conversion factor);
- Establishing the cost surveys; and
- Shifting ambulance services from “suppliers” to “provider” status.

These policies are the top priorities to address through legislation in 2016.

Intermediate-term reform policies would allow Medicare to leverage the unique aspects of ambulance services, reduce unnecessary emergency room visits, and

eliminate fraud and abuse in the area of non-emergency services. Once the ambulance benefit is stabilized, the AAA, NAEMSP, NAEMT, and NASEMSO ask the Administration and the Congress to implement policies that would:

- Provide coverage and payment for alternative destinations transport;
- Establish coverage and payment for response, assessment, and referral at the scene without transport; and
- Define more specifically non-emergency services.

As these intermediate-policies are implemented, the [insert organizations] will continue efforts to build consensus and support for longer-term reform efforts that will allow for even greater innovation. These policies include:

- Seeking coverage and reimbursement for triage services;
- Seeking coverage and reimbursement for community paramedicine; and
- Seeking more comprehensive payment reform related to the ambulance fee schedule, including refining payment categories, addressing high-cost items, and considering patient characteristic and/or ambulance provider adjusters.

I. Short-Term Reform to Stabilize the Medicare Ambulance Benefit

Building current add-ons into the base rate

The current ambulance payment add-ons of: (1) 2 percent for urban transports; (2) 3 percent for rural transports; and (3) 22.6 percent for super rural transports should be made permanent by incorporating them into the conversion factors of the base rate before they expire on December 31, 2017.

Establish the cost surveys

Medicare should be required to collect demographic and cost data from all ambulance services enrolled in Medicare by using a cost survey methodology that would collect cost and revenue data similar to that collected for other Medicare providers, but that is tailored to address the unique aspects of ambulance services. While all ambulance services would be required to report cost data during a full cycle, the survey approach would require that only a statistically significant sample of ambulance services in each of the different categories of ambulance services report the data during a given year. Before a service were required to report the cost data a second time, all the services in its category would have to have reported cost data or been penalized for not doing so. Specifically, the cost survey methodology would:

- Require all ambulance services to report to CMS demographic information, such as organizational type (governmental agency, public safety, private, all volunteer, etc.), average duration of transports, number of emergency and nonemergency transports. CMS would use this data to establish organization categories so that the data collected align with the type of organization providing it.
- Require all ambulance services to report cost data, such as labor costs, administrative costs, local jurisdiction costs, through a survey process. During any survey period, CMS would identify a statistically valid sample of ambulance services in each category to be surveyed. These services would have to provide the data or be subject to a five percent penalty. Those ambulance services that provide data will not be asked to do so again until every service in its organization category has submitted the data.

Shift ambulance services from “suppliers” to “provider” status

Under current law, ambulance services are defined as suppliers, rather than as providers. The reimbursement structure reflects this distinction by focusing on the transport rather than the services being provided. Given the evolution of ambulance services and the importance of allowing for innovative solutions to help bend the overall health care cost curve, designating ambulance services as providers will allow the Medicare program not only to more directly recognize and reimburse the actual health care services being provided, but also hold ambulance services accountable as the program does with other providers.

II. Intermediate-Term Reform to Reduce Overall Medicare Spending and Reduce Fraud and Abuse

Alternative Destination Transport

Current law limits Medicare reimbursement to those instances when the beneficiary is transported to/from specified origins and destinations.¹ Medicare currently distinguishes among the following providers by having unique payment systems for each one:

- Ambulatory Surgical Centers;
- Hospital Outpatient Centers;
- Inpatient Psychiatric Facilities;

¹ *Medicare Claims Processing Manual*, Pub. 100-04, Ch. 15, § 20.1.1; *Id.* at §410.40(e).

- Inpatient Rehabilitation Facilities; and
- Long Term Care Hospitals.

The language below is one way of modifying the current legal restrictions.

- (1) From any point of origin to the nearest hospital (including freestanding emergency centers and hospitals specializing in the provision of emergency services), CAH, SNF, ambulatory surgical center, inpatient psychiatric hospital, hospital outpatient department, inpatient rehabilitation facility, long-term care hospital, urgent medical care facility, or physician offices, that is capable of furnishing the required level and type of care for the beneficiary's illness or injury;
- (2) From a hospital, CAH, or SNF to the beneficiary's home;
- (3) From a SNF, inpatient rehabilitation facility, long-term care hospital to the nearest supplier of medically necessary services not available at the SNF, inpatient rehabilitation facility, or long-term care hospital where the beneficiary is a resident, including the return trip; and
- (4) From a beneficiary's home to the nearest ESRD facility if the beneficiary is receiving dialysis treatments for ESRD, including the return trip.

Unknown
Deleted: or

Unknown
Deleted:

In addition to modifying the current regulatory text, it will be necessary to strengthen medical necessity requirements to protect against fraud and abuse. We suggest a three-part approach. The first part would require ambulance services to meet conditions of participation for the Medicare program, which would be possible with the shift to ambulance services being designated as providers. The second part would provide more specific statutory language related to medical necessity for alternative destinations. One option could be to adopt a restriction on any follow-up transports. If an ambulance services transports a beneficiary to any destination (including an alternative destination), Medicare will deny any subsequent claim on the same day if it is related to the same injury or illness. Third, a new definition for alternative destination should be added to the current Medicare manual:

Definition: Alternative Destination Transport (ADT) is the transportation of an injured or ill beneficiary by a ground ambulance vehicle when medically necessary to an independent freestanding emergency center, hospital specializing in the provision of emergency services, ambulatory surgical center, inpatient psychiatric hospital, hospital outpatient department, inpatient rehabilitation facility, long-term care hospital, urgent medical care facility, or physician office in the context of an emergency response. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. An immediate response is one in which the

ambulance provider or supplier begins as quickly as possible to take the steps necessary to respond to the call.

Application: The determination to provide ADT must be in accord with the local 911 or equivalent service ADT protocol **as approved by the provider's or supplier's medical director**. This protocol must meet, at a minimum, the standards of the ADT protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of an ADT protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other ADT protocol within the State. Where the ADT was inconsistent with this standard of protocol, including where no protocol was used, the transport will not be reimbursed.

Experts in the field of emergency medicine would develop the appropriate protocols to govern alternative destination transports, as they do today for other service levels.

Response, Assessment, and Referral at the Scene without Transport

To establish payment for response, assessment, and referral at scene without transportation, the Medicare coverage criteria for ambulance services will need to be altered significantly. Medicare requires the provision of transport, as well as medical services for payment. Response, assessment, and referral at the scene without transport would be implemented by establishing coverage through expanded statutory authority or initially as a pilot program. For example, statutory language could be written as follows:

(16) Payment adjustment for response, assessment, and referral at the scene without transport by ambulance services

- (a) The Secretary shall pay for ambulance services when no transport is provided by an eligible provider or supplier. In consultation with interested stakeholders, the Secretary shall determine in regulation the amounts of payments to be made for ambulance services when transport is not provided on a cost-related basis or other economical and equitable basis (we might want to include a reference to the cost survey here).
- (b) For purposes of this paragraph, an eligible provider or supplier means an ambulance provider or supplier that the governmental entity contracting for ambulance services permits to provide emergency transports for the designated geographic area in which the response, assessment, and referral at scene without transport services are provided.

Through regulation, a definition for response, assessment, and referral at the scene without transport, which would be similar to those for ALS and SCT in the current Medicare manual, would need to be added.

Definition: Response, assessment, and referral at the scene is the provision of health care services that does not include the transportation of an injured or ill beneficiary by a ground ambulance vehicle in the context of an emergency response. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. An immediate response is one in which the ambulance provider or supplier begins as quickly as possible to take the steps necessary to respond to the call.

Application: The determination to provide response, assessment, and referral without transport at the scene must be in accord with the local 911 or equivalent service response, assessment, and referral at the scene without transport protocol as approved by the provider's or supplier's medical director. This protocol must meet, at a minimum, the standards of the response, assessment, and referral at the scene without transport protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a treatment at scene without transport protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other treatment at scene without transport protocol within the State. Where the treatment at scene without transport was inconsistent with this standard of protocol, including where no protocol was used, the transport will not be reimbursed.

Appropriate protocols would be developed by experts in emergency medicine, as they are today for other service levels.

For response, assessment, and referral at the scene without transport, there are two options for payment. First, until appropriate data are collected about the costs associated with response, assessment, and referral at scene without transport become available, the rate could be set using a modified current ambulance fee schedule methodology. To be more precise in the rate, the mileage rate could be reduced since one part of the services (transport to an ER or alternative destination) is not provided. Second, this model could be used as a pilot during which time cost data could be collected to establish an alternative payment rate based upon the cost of the care provided. For example, there could be a basic rate for the most fundamental treatment. This rate could be increased using case-mix adjustors linked to the type of services provided and potentially patient characteristics. A pilot question might also pursue alternative payment models, such as rewarding ambulance services that successfully reduce emergency room visits over a defined period of time.

Specifically Define Non-Emergency Services

We understand the concerns about bad actors taking advantage of beneficiaries and the Medicare program by providing non-emergency transports when they are not medically necessary, but it is important to maintain these services for those beneficiaries who do require them. While the Medicare program should remain deferential to state law, the Medicare program could follow the lead of several states and specifically define these services by linking the transport to specific patient needs. Specifically, non-emergency services (both transportation and health care services) would be appropriate based upon the following patient characteristics or medical needs:

- Morbidly Obese
- Mental/Behavioral Health
- Oxygen Administration
- Special Handling/Positioning
- Ventilation/Advanced Airway Management
- Suctioning
- Isolation Precautions
- Intravenous Fluid Administration
- Specialized Monitoring

In addition, there are situations when ambulance services may be necessary because of the extreme distances being traveled or duration of the trip. For example, a patient might be able to be transported using non-ambulance vehicles and without medical personnel if he/she is being moved to a health care facility near his/her current location. However, that same patient may require an ambulance and medical personnel if the transfer between health care facilities requires a drive of multiple hours. This geographic situation should be recognized, as well as the patient characteristics already described, as an appropriate trigger for determining the medical need for ambulance services. To qualify as medically necessary in these circumstances, the ambulance service would be required to meet the following criteria. Ideally, CMS would approve a template to standardize the reporting of this information that could be used to review, assess, and modify the system over time.

- An order for the ambulance services made by a physician, physician's assistant, registered nurse, advanced practice nurse, or clinical nurse specialist;
- An indication that the distance transported is 100 miles or greater or the time of the expected transport is 90 minutes or greater;
- A description of the specific health care services or reason medical personnel are required to assist the patient in the transport; and
- The name of the health care facilities involved in the transport, including the distance between the originating facility and the destination facility.

The originating site for such transports would be a hospital, while the destination could be any type of health care facility.

III. Longer-Term Reform to Allow for Greater Innovation

Triage Services

Ambulance services are in the unique position of being able to direct patients to the most appropriate setting, especially when it comes to emergency services. Patients call 911 or other emergency response systems often not knowing whether they need an ambulance transport or not, but most jurisdictions require some type of a response. Implementing a triage process involving health care professionals and overseen by a medical director could help to ensure that ambulances are not inappropriately dispatched.

Expanding ambulance services to include triage would require changing protocols, practices, and personnel for ambulance services and increase the cost of providing services. However, the savings associated with reduced transports would offset any increase the Medicare program might experience in providing reimbursement for triaging patients.

To prevent potential fraud and abuse, triage services would have to meet new definitions and requirements set forth in the Claims Processing Manual, which could be as follows:

Definition: Triage is the early assessment of patients calling 911 (or similar emergency service) by a trained health care professional, to ensure that they receive appropriate attention, in a suitable location, with the requisite degree of urgency.

Application: The use of triage must be in accord with the local 911 or equivalent service triage protocol as approved by the provider's or supplier's medical director. This protocol must meet, at a minimum, the standards of the triage protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a triage protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other triage protocol within the State. Where the triage was inconsistent with this standard of protocol, including where no protocol was used, the transport will not be reimbursed.

For triage, it may be difficult to link the rate for these services to the current fee schedule methodology because it is currently related to general service levels and transportation. New rates would have to be developed. There are many options for setting a rate, but one option would be to pilot the program by establishing a rate based upon the labor costs associated with the service. Another alternative would be to pursue a time-and-motion study.

Community Paramedicine

Ambulance services also have the potential for reducing overall Medicare spending by extending the services of physicians and other prescribers to include a patient's home. Specifically, ambulance services could assist hospitals and other providers with transitional care management services, as well as individual care services pursuant to a valid prescription. They could also provide community public health services in cooperation with local, state, or federal public health agencies. Any services provided would be consistent with the local and/or state scope of practice laws for ambulance personnel. Additional regulatory and/or legislative authority would be needed to allow ambulance services to participate in alternative care models or to establish Medicare coverage and reimbursement for services provided through the fee-for-service program. The additional cost of these services would likely be offset by the reduction in more expensive services that the patient would otherwise incur.

Transitional Care Management Services. Transitional care management services would leverage the expertise and skill set of ambulance personnel, including EMTs, to help patients after an acute hospitalization episode or other release from a facility. They could also be used to address the needs of patients who frequently call 911 or an equivalent emergency system and require care management rather than emergency services. The specific services provided would include:

- Assessment
 - Assure patient follows plan of care
 - 12-lead EKG with interpretation
 - point of care lab tests – results to care team
 - Interval history
 - Physical exam including vital signs
 - Medication reconciliation
- Treatment
 - Administering physician-ordered medications, IVs, diuretics, etc.
 - Providing reminders and follow-ups
 - Monitoring O₂
 - Assisting with home therapy devices
 - Following unique protocols for COPD and MI patients
- Disposition
 - Documentation

- Providing patient education
- Referral to a physician or other provider
- Assisting with social service needs

Patients could be identified in two ways. First, they could be referred from another health care provider, such as a hospital, who would like to work with the ambulance service to manage the patient's care. Second, ambulance services could identify patients commonly referred to as "frequent fliers." These are individuals who seek emergency assistance on a regular basis. By identifying these patients and working with them in their homes, ambulance services could address their health care and social service needs in an effort to reduce their use of the emergency medical system.

Payment for these services could be linked either to an alternative delivery model, such as partnering with an accountable care organization, or to assist fee-for-service provider, such as a hospital, trying to manage patients to improve quality outcomes measures or as a way to cover the cost of providing services to reduce the unnecessary use of the emergency medical system. First, ambulance services should be allowed to participate in alternative delivery models and not expressly excluded. In addition, multiple pilots could be conducted to determine the costs involved in providing the treatment through time-and-motion studies, savings related to reductions in readmissions or other quality outcome measures, or other ways of valuing the services. If part of alternative delivery models, the costs could be included as part of a global capitation payment rate. For fee-for-service providers or to address "frequent fliers", it would be useful to develop a rate that could be linked to quality improvement as well as the cost of providing the services.

Individual Care Services. In addition to transitioning care management, ambulance services could provide community-based support to physicians and other prescribing health care providers to help patients manage their chronic diseases. These services would be provided pursuant to a valid prescription. The services provided would include assessment, care coordination, episodic clinical interventions, counseling, and triage.

Individual care services could be reimbursed through fee-for-service or as part of larger bundled arrangements. If the latter, it is important for ambulance services to be permitted to participate in the organizational entities overseeing the bundle and not excluded outright. For reimbursement under a fee-for-service model, the services listed above could be cross-walked with relevant CPT/HCPCS codes and linked to current reimbursement rates under the fee schedule (e.g., similar to payments for physician extenders).

Public health services. Ambulance services could also extend the reach of local, state, and federal public health services by providing immunizations, conducting health screening activities, participating in stockpiling programs, providing community education and awareness programs, and monitoring quarantined

patients. These services should not be reimbursed through a patient's insurance plan, but rather subject to a contract relationship with a federal, state, or local public health agency.