

**National EMS Advisory Council  
Committee Reporting Template**  
**Final (pending format and grammatical changes)**  
**September 29, 2009**

**Committee: Finance**

**Report Number: 002-FIN-07-FINAL**

**Title: Finance Committee Report to NEMSAC, 29 September 2009**

**Issue Synopsis:**

- A. **Problem statement;** It is generally recognized that financing EMS has many challenges and that the way the system is funded is fragmented, conflicted and often underfunded. For example, in 2007, the GAO found that Medicare paid 6% below average cost of providing ambulance services. Over the last decade there have been recommendations to move financing to more of a readiness based model rather than principally based on transports. This readiness must include the funding of the capacity to surge to some predetermined level in the event of a disaster. Additionally, NEMSAC wants to explore the potential impact on EMS system financing by prevention programs, treat and release, and transportation to other health care settings besides ED's.

A significant portion of the costs associated with EMS is readiness, that is costs incurred in order to be ready to respond in a timely and effective manner. Those costs range from 24x7 staffing levels based on call demand experience algorithms to the costs of equipment and supplies that will be replaced due to age before being used. These costs are inherent in the delivery of service and must be adequately accounted for in the revenue models. Qualitative studies of the costs associated with assuring the availability of EMS are needed as a baseline against which modified service options can be measured.

EMS produces downstream savings in healthcare costs because of actions taken in the field. These savings have not been scientifically quantified. If they were, the argument could be made that these savings could be used to better fund readiness costs for EMS. Examples of this that could be researched are use of 12 lead ECG, CPAP, termination of codes in the field, and treat refer and release to name just a few categories of activities.

Specific qualitative studies clearly point to actions that can be taken to address improved patient outcome through adjustments to reimbursement schedules. Actions should be taken to implement these changes independent of additional review of the potential for other EMS funding transformations.

**B. Resources/references related to the issue:**

- 2006 GAO report on ambulance cost
- 2006 IOM Report on Emergency Medical Services
- Configurations of EMS Systems: A Pilot Study
- Bibliography with 46 citations in Finance Committee White Paper "EMS Makes a Difference"

**C. Crosswalk with other standards and documents**

1. EMS Agenda for the Future
  - a. Base reimbursement on preparedness model (readiness)
  - b. Dedicate funding streams for EMS infrastructure
  - c. Coordinate care with public health and family practice (primary care)
2. EMS Agenda for the Future Implementation Guide
  - a. Stakeholders address conflicts in financing incentives
  - b. Fund pilot projects for EMS response and treatment
  - c. Develop relative value unit (RVU) for reimbursement not based on patient transport
3. Model State EMS Plan:
  - a. State systems are to assess payment adequacy to maintain EMS safety net
  - b. State systems are to assess and promote integration of EMS with primary and specialty care and align financial incentives to promote the integration
4. EMS Research Agenda:
  - a. Key factors driving EMS research (Recommendation 5)
    - system effectiveness
    - system impact on public health
    - level of funding
    - level of care
    - equipment utilized
    - system performance standards

**D. Analysis:**

1. The committee has conducted a review of the literature regarding the issue of the effectiveness of EMS interventions and the impact on downstream health care savings. (attached white paper "EMS Makes a Difference").
2. The committee has discussed the issue of readiness costs and have reviewed on several occasions a conceptual model for the components of readiness costs and two different ways to fund the system that incorporate the current array of revenue inputs with some significant restructuring. We have also agreed with the Systems committee that we should incorporate the 16 Guiding Principles of science base system design in computing the costs of readiness and have incorporated this into a definition of readiness costs.

## **E. Committee conclusions**

1. The Finance committee has attempted to involve CMS in the discussion on EMS system financing based on the cost of readiness. In October of 2008, NEMSAC supported our recommendation that: "FICEMS make of highest priority implementing the IOM recommendation calling for CMS to assemble an ad hoc working group with expertise in emergency care, trauma, and EMS systems to evaluate the reimbursement of EMS and make recommendations with regard to including readiness costs and permitting payment without transport." Subsequently, when FICEMS put this issue on the agenda for FICEMS, CMS issued a position statement indicating they would not support the formation of such a working group as they believe the emergency RVU in the AFS adequately addresses the issue of cost of readiness and the issue of reimbursing non-transport related services is a matter for Congress to consider. Therefore the Finance committee must find another approach to convening the needed expertise to address how to incorporate the cost of readiness into the EMS financing system.

2. While the number of studies is not large, we have concluded that with cardiac arrest, STEMI, respiratory emergencies, stroke, pediatrics and trauma, EMS does make a clinical difference and as a result produce downstream health care savings. A common element to these categories of patients, is that the evidence indicates that comprehensive systems of care that includes EMS protocols, transportation protocols and specialty emergency care centers results in the best outcomes of patients. The severity of the patients medical condition requires intensive efforts and critical decision making at every step of the system. This level of intensity also is expensive to reliably deliver and there is inconsistency across the nation as a result. We have also concluded that certain EMS interventions such as glucometry and oxymetry at the BLS level, treat and release, and termination of resuscitation can contribute to system efficiency and cost savings.

We believe there is enough evidence to support changes in the reimbursement for these interventions to assure the rapid and complete and on-going adoption of these interventions. We also believe that systems and cost-effectiveness research must accompany the implementation of changes in the reimbursement structure to measure the impact on patient care and EMS systems.

## **Recommended Actions/Strategies:**

### **National Highway Traffic Safety Administration:**

1. Support efforts to raise the baseline national ambulance fee schedule to end the discrepancy between cost and reimbursement as identified in the GAO report.
  
2. The research supports that regionalized, coordinated and accountable systems of care in which EMS plays a critical part results in the best possible clinical outcomes for our patients. We found that these systems of care for STEMI, Cardiac Arrest, Trauma, Stroke and Pediatrics make a clinical difference. NEMSAC advises NHTSA to utilize whatever governmental entity is best including but not limited to FICEMS, Council on Emergency Medical Care (CEMC) and the Office of Health Care Reform to advance the following system finance recommendations
  - A. Ambulance services that provide ALS care for patients whose severity in the field qualifies them to be transported to a specialty emergency care center, for example a Level1 trauma center, STEMI Center or Stroke Center, should get reimbursed at the ALS 2 rate for those patients to adequately compensate for the resource intensity of the services required and full participation in the system of care.
  - B. BLS level providers that transport patients to specialty emergency care centers based on the severity of the patient in the field should be reimbursed at a higher rate to adequately compensate for the resource intensity and participation in the system of care.
  - C. Methods should be developed in advance that will minimize the opportunity to fraudulently up-triage patients in order to enjoy these higher reimbursement rates.
  - D. Evidenced based practice leads to innovations and changes in pre-hospital care often requiring expensive new medical devices or medications that are not part of the existing cost and reimbursement schema in place. CPAP is an example of such an advance that has shown to have very positive clinical outcomes and prevents and reduces hospital stays for patients with pulmonary edema. CMS must institute a process that adjusts payment methodology in a timely fashion once the evidence is in.
  
3. The issue of treating and referring patients rather than transport and transporting certain sub-acute patients to alternative destinations has been researched and trialed numerous times in many locations and countries. There are several potential advantages from health care cost savings, EMS system efficiencies, reduction of ED overcrowding and building surge capacity of EMS systems during public health emergencies that these capabilities promote. In the current context of health care reform, NEMSAC advises NHTSA to utilize whatever governmental entity is best

including but not limited to FICEMS, CEMC and the Office of Health Care Reform to advance the following recommendations as identified in the "EMS Makes a Difference" white paper:

A. Develop National Guidelines: Using the Evidence Based Practice Guideline Model, NHTSA convene an expert panel to develop national guidelines for treat and refer and transport to alternative destinations.

B. Treat, Release and Refer; CMS convene a negotiated rule making committee of stakeholder organizations to develop the relative value units (RVU) for EMS assessment, treatment and referral without transport of certain patients under medically approved protocols and oversight which would include but not be limited to diabetic patients in hypoglycemia and non-transport of non-viable cardiac arrest patients and a host of sub-acute medical conditions.

C. Transport to Alternative Receiving Facilities: The prehospital triage and treatment of patients that activate EMS through the 911 system and classified as emergency calls but are transported to alternative care facilities (i.e. urgent care centers) after evaluation by EMS can be billed at the appropriate level of service (BLS or ALS1).

4. As with any change in a system, changes in clinical practice and reimbursement policy have system impacts. NEMSAC recommends that NHTSA utilize whatever governmental entity is best including but not limited to FICEMS, CEMC and the Office of Health Care Reform to support systems and cost effectiveness research so as to evaluate the efficacy and the economic effect of these recommendations. Such research could develop "Utstein-like" research and reporting criterion for each of the disease states identified as being effectively treated by EMS.

5. NEMSAC advises NHTSA to utilize whatever governmental entity is best including but not limited to FICEMS, CEMC and the Office of Health Care Reform to advance the investigation into models and methods reimbursing EMS systems based on the readiness costs built on an evidence and performance based system design. CMS should be invited to participate meaningfully in this process.