

Report to NEMSAC, June 2009
Finance Committee
Report No.: 001-FIN-06-FINAL

**NATIONAL EMS ADVISORY COUNCIL
COMMITTEE REPORTING TEMPLATE
FINAL
June 3, 2009**

Committee: EMS Finance
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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. 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.

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.

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 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. 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. 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.
2. 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 (Federal Interagency Committee on Emergency Medical Services) 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.

Recommended Actions/Strategies:

National EMS Advisory Council:

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 the best governmental entity, including but not limited to FICEMS, CEMC (Council on Emergency Medical Care) and the Office of Health Care Reform, to advance the following system finance recommendations as identified in the "EMS Makes a Difference" white paper:

A. STEMI care: STEMI patient care should be considered an ALS 2 level service for purposes of reimbursement, when a 12 lead ECG is acquired in a symptomatic cardiac patient, and the results of the 12 lead ECG are transmitted or communicated and the patient is transported to a STEMI Center for treatment; or transported to the closest, most clinically appropriate emergency department for stabilization and care with a STEMI referral program as appropriate per an established EMS STEMI protocol.

B. Stroke care: The field impression of acute CVA with neurological deficits should be considered an ALS 2 level of service for purposes of reimbursement when a Stroke Center is activated and the patient is transported to a stroke center for treatment; or transported to the closest, most clinically appropriate emergency department for stabilization and care with a stroke referral program as appropriate, per an established EMS stroke protocol.

C. Trauma Care: The pre-hospital triage of a trauma patient and transport to a Level 1 trauma center, or the highest, most appropriate trauma center in the system, as according to the 2009 CDC trauma triage category should be considered an ALS 2 level of service

D. Respiratory Care: While there do not exist systems of respiratory care, the evidence regarding CPAP suggests that CPAP should be included in the list of interventions that is reimbursed at the ALS 2 level of service

3. The issue of treating and referring patients rather than transport them, 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 including: health care cost savings, EMS system efficiencies, reduction of ED overcrowding and building EMS System surge capacity during public health emergencies. In the current context of health care reform, NEMSAC advises NHTSA to utilize the best governmental entity, 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 who are seen by EMS through 911 system activation and who are classified as emergency calls by 911, but are transported to alternative care facilities (i.e. urgent care centers) after EMS evaluation and treatment can be billed at the appropriate level of service (BLS or ALS1).

4. As with any system modifications, changes in clinical practice and reimbursement policy have system-wide impacts. NEMSAC recommends that NHTSA utilize the best governmental entity including but not limited to FICEMS, CEMC and the Office of Health Care Reform to support EMS systems and cost effectiveness research to evaluate the efficacy and the economic effect of these recommendations. Such research could develop "Utstein-like" reporting criterion for each of these disease states (STEMI, CVA. Trauma and others) that may be effectively treated by EMS.