Ambulance Payment Reform

MOVING AMBULANCE FROM A SUPPLIER TO A PROVIDER
Overview

1. Ambulance Payment Reform Update
2. Cost Data Collection
3. Supplier to Provider
4. Recap
Industry Partnership

National Association of State EMS Officials
The Evolution of Ambulance Payments

1997: BBA created fee-for-service for all types of services

2000: Negotiated rulemaking established current payment categories

2003: MMA created the add-ons

2003-2014: Living with the add-ons
2013: Rate cut to address fraud

2014: Intermediate reform – SFC extension of add-ons, cost survey

Our Future: Long-term reform
Ambulance Medicare Payment System
Core Components of Other Medicare Payment Systems

- **Base rate**
  - Single rate
  - Multiple rates tied to services

- **Adjustors**
  - Geographic
  - Service complexity
  - Patient characteristics
  - Low Volume

- **Address high costs**
  - Pass-through payments
  - Outlier policy

- **Update mechanism**
  - Market basket

- **Quality**
  - Bonus
  - Reduction
Key Payment Reform Principles

- **Permanent Relief**: Build Medicare add-ons into the base

- **Cost Data Collection**: Base long-term reimbursement upon cost data that allow for modifications over time

- **Scalable Reform**: Take into account operational issues for all types, sizes of services

- **Prior Authorization**: Address fraud and abuse provisions

- **Quality**: Be patient-centric and incentivize high quality care
Payment Reform at a Glance

Short-Term
- Extender Stabilization
- Cost Reporting
- Supplier to Provider*

Intermediate
- **Alternative Destination Transports**
- Treat and Refer
- Non-Emergency Transportation

Long-Term
- Triage Services
- Community Paramedicine
2017 Expectations

- **S.967**: Introduced April, 2017
- **H.R. 3236**: Introduced July, 2017
- **H.R. 3729**: Introduced September, 2017
- **Non-ER Ambulance Advocacy**
- **Medicaid Reform**

Meetings with the Centers for Medicare and Medicaid Services (CMS)

Repeal & Replace may impact CPE/UPL Programs

**Co-sponsors & Advocacy Needed!**
Safety Net Providers

1. Mirror Disproportionate Share Hospital (DSH) eligibility criteria
2. EMS DS = 15% or greater un- and underinsured and provide emergency response services through a 9-1-1 system or equivalent
3. Give ability to the states to request a State Plan Amendment or waiver under Section 1115(a)(2) to allow for additional payment.
Cost Data Collection System
Data Collection Differences

S. 967

• Statistically appropriate sample of suppliers & providers based on organizational type
• Cost data collected is specific in legislation
• Every supplier & provider has to provide data before sampled again
• 5% payment penalty for not reporting
• Data collection occurs at least one every 3 years

H.R. 3236 & 3729

• Effective 1/1/2020
• All ambulance suppliers & providers cost report
• Secretary authority to modify cost reporting and requirements after MedPAC report or after 1/1/2023
• Suspension of payment penalty for not reporting
• Secretary has broad authority to implement cost reporting requirements and data collection but requires stakeholder input
Demographic Data

- Organizational designation (e.g., a government authority, independent company, public safety or fire-based, hospital-based, other)
- Percentage of volunteer EMT labor
- Volume of ambulance services delivered per year
- Percentage of Medicare emergency and non-emergency services provided per year
- Average duration of transports
- If have sole source contract and the percent of the activity provided under that contract
- If required to pay fees to the local jurisdiction
- Other services that are a requirement of doing business
- Percentage of transports that are urban, rural, or super rural
Cost Data

• Total revenue data, including but not limited to
  • Medicare revenues
  • Subscription programs
  • Medicaid revenues
  • Other health care plans and self-pay
  • Public funding
  • Fundraising and donations
  • Uncompensated care
  • Write-offs
Cost Data (con’t)

- Total cost data, including but not limited to
  - Labor costs (paid and volunteer)
  - Operating costs
  - Vehicle and fleet costs
  - Communications costs
  - Equipment and supplies (including drugs)
  - Maintenance
  - Building and facility costs
  - Administrative costs
  - Local jurisdiction costs
  - Cost of readiness
  - Central office administration costs
How To Move Forward

• Payment Reform Steering Committee leadership

• Data collection **must** produce accurate and reliable data

• American Ambulance Association will provide and be a resource to assist all ambulance providers to provide accurate and reliable data
Immediate Step: Standardization

- Virtually no standardization of definitions or metrics
- Without standardization, cost surveys (including GAO reports) subject to ambiguities
- AAA developed standardized reporting
- Industry must implement recommendations to succeed
Supplier to Provider: Why?

Healthcare Practitioners
Suppliers

• Do not provide healthcare services

• Commodity-driven
  • Equipment
  • Supplies
  • Transportation

• Costs are set based upon commodity
  • DMEPOS subject to competitive bidding
  • Ambulance focuses on the transportation aspect only
EMS Evolution

Past

Present

Future
“The committee’s vision expands the concept of an inclusive trauma system to include all illnesses and injuries, as well as the entire continuum of emergency care—including 9-1-1 dispatch, prehospital EMS, and clinics and urgent care providers that may play a role in emergency care.”
IOM: Crisis Standards of Care (2012)

EMS personnel utilizing disaster triage systems (sort, assess, life-saving interventions, treatment/transport; simple triage and rapid treatment [START]; and JumpSTART triage methods) so they can assess patients within 60 seconds and categorize them for immediate or delayed care.
Examples of Health Care Services

- Induced Hypothermia
- Impedance Threshold Device (RESQPOD)
- Capnography
- Interosseous (IO) Infusion
- 12 Lead ECG Transmission and Interpretation
- Continuous Positive Airway Pressure (CPAP)
- Non-Invasive Positive Pressure Ventilation (NIPPV) (Portable Vent)
- Supraglottic Airway Devices
- Quick Trach
- Met Hemoglobin
- Meconium Aspirator
- Cook’s Catheter

Advances require more training and carrying expensive drugs or equipment on vehicles.
Non Emergency: Medical Services

Focusing on Patients’ Medical Needs

• Morbidly Obese
• Mental/Behavioral Health
• Oxygen Administration
• Special Handling/Positioning

Health Care Services Provided

• Ventilation/Advanced Airway Management
• Suctioning
• Isolation Precautions
• Intravenous Fluid Administration
Recognizing Ambulances as Providers

Ambulance services’ core mission is to provide mobile health care services to patients

- Inappropriate to consider for competitive bidding – providing more than lowest bid on transportation
- Payment rates need to recognize the costs of the health care services provided, as well as the transportation
- Important to raise the bar to reduce fraud and abuse
What Will It Mean To My Agency?

1. Survey or Accreditation Process Required*
2. CMS Participation Agreement
3. Electronic Claims Submission, except for low volume providers
4. Cost Reporting or Cost Data Collection
5. Quality Data Reporting
Allows for Conditional of Participation

Conditions of Coverage/Conditions of Participation

• Set a federal standard for how providers operate and interact with beneficiaries

Sample provisions

• Organizational/Administration
• Administrative and Medical Records
• Compliance with Other Laws
• Personnel
• Safety
• Patient Rights

State and local requirements will remain primary
Allows for Provider Payment Review Board

• Independent Panel as established under Section 1878 of the SSA
• Avenue for certified Medicare providers to dispute CMS final approval regarding reasonable cost reimbursement
• Covers all providers who cost report
• Also covers HMOs and competitive medical plans that participate in the Medicare program
• There are a few nonprovider entities that file periodic cost reports that are excluded from the protections under PPRB (*$1000 or >)
Accreditation or Survey Process

• Accreditation Organization or State-sponsored
• Site review
• Certify minimum operational and administrative procedures
• Similar to CAAS but not as extensive
Provider Status Change **WILL NOT**....

1. Impact any Third Party or Medicaid Reimbursements
2. Require you to participate in CP programs or the equivalent
3. Allow for Paramedics or EMTs to bill for services to Medicare Part B
4. Change the current billing requirements and reimbursement for ambulance agencies under Medicare Part B
Initiate.

The easiest thing is to REACT. The second easiest thing is to RESPOND. But the hardest thing is to INITIATE.

-Seth Godin
Next Steps

1. Co-sponsors for S.967
2. Advocate that offset is specifically targeted
3. Educate House and Senate delegation regarding the “WHY” first responders and ambulance services are safety net providers.
4. Engage and educate House and Senate delegation on the importance of the provisions in S.967 regarding supplier to provider.
5. Get involved! Grassroots matters and is VERY effective!
Q&A

You have Questions
We have Answers
Contact

Asbel Montes  
Vice President, Revenue Cycle & Government Relations  
Chair, Payment Reform, American Ambulance Association  
Asbel.Montes@acadian.com  
337.291.4086