# Act 493: Ambulance Transfer Alternatives Task Force

*Initial Report*

**Louisiana Department of Health**

*Bureau of Health Services Financing*

April 2018

LOUISIANA DEPARTMENT OF HEALTH

# Contents

# Preface

In 2015, the state of Louisiana had the sixth highest rate of hospital visits per 1,000 persons out of the fifty states and the District of Columbia.[1] As emergency departments face increasing numbers of visits and longer wait times across the board, many seek creative solutions to a growing problem. Act 493 of the 2016 Regular Legislative Session created the Ambulance Transfer Alternatives Task Force which was charged with studying the potential for an ambulance diversion pilot program in East Baton Rouge parish and providing corresponding recommendations to the Louisiana Department of Health (LDH) and the legislature. It further directed that the task force provide technical assistance to LDH in applying to the Centers for Medicare and Medicaid Services (CMS) for an innovation grant, waiver, or other federal funding opportunity to support the pilot.

Statewide implementation of an ambulance diversion program would depend on data collection during the pilot facilitated by the task force. For a detailed listing of the task force membership, please refer to Attachment 4.

Act 493 further directs the task force to consider the following in making its recommendations:

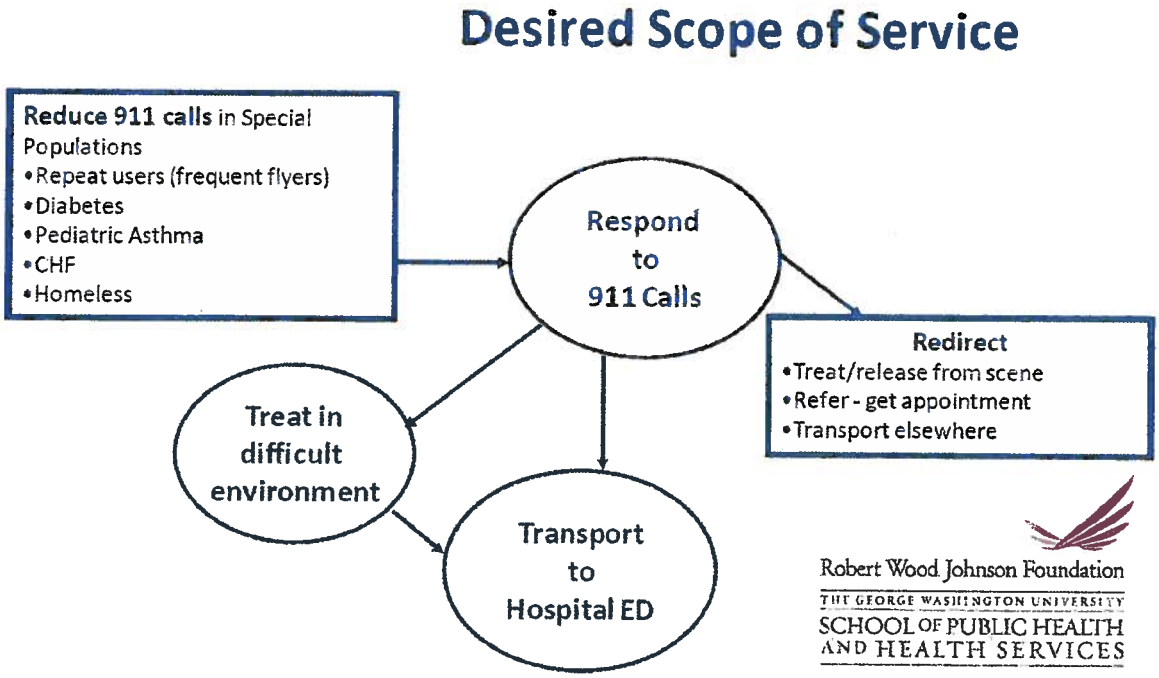
1. Alternative transportation options for non-emergent 9-1-1 calls. ;
2. Appropriate medical director oversight and training for paramedics, emergency medical technicians, or others on protocols for non-emergency patients including data collection;
3. Methods for early destination evaluation and advanced assessment if a 9-1-1 patient can be safely treated at an alternate medical facility other than a hospital emergency department (ED);
4. Methods for advanced assessment to confirm that no priority symptoms exist requiring treatment in the ED; and
5. Process for explaining and educating patients about alternative care locations when applicable.

The below report captures the current state and city infrastructure relative to ambulance transportation and reimbursement, review diversion or community paramedicine programs in other states, and makes recommendations on ongoing actions for the task force.

[1] http://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%22,%22sort%22:%22desc%22%7D

## Section 1: Alternative destination and community paramedicine models in other states

Many areas of the country are focusing on alternative destination or community paramedicien programs as a means to limit the number of patients transported to the emergency department. The goal of these programs is based on the following model of desired scope of service for emergency responders:




The foundation of both programs involves increased training of paramedics to enable them to fulfill two key functions:

1. Assess patients on emergency calls and route them to the appropriate medical facility – not necessarily an emergency department visit.
2. Provide prevention and public health visits.

These strategies work to reduce the flow of patients to the emergency room, leading to improved emergency department performance while maintaining optimal health outcomes for the patients who receive the necessary care to either stave off an emergency room visit or receive care at a more appropriate facility.

## Reno Emergency Services Community Health Programs

In 2012, the Regional Emergency Medical Services Authority (REMSA) in Reno, Nevada received a three-year, $9.9 million dollar CMS Healthcare Innovation Award. The grant was extended for a fourth year, but concluded after the fourth year. Renown Health is now partnering with REMSA to continue the programs started under the CMS award including[2]:

- Ambulance Transport Alternatives
- Nurse Health Line
- Community Paramedicine

### *Ambulance Transport Alternatives*

Under this program, field personnel provides advanced assessment of 9-1-1 patients to facilitate alternative patheways of care including transport to: Urgent care centers

- Clinics/medical groups
- Community Triage Center
- Mental health hospitals

The program features locally-developed protocols for low acuity, intoxicated and psychiatric patients and includes a rigorous clinical quality assurance program with medical director oversight and special training for all field medics. The core element is an early destination evaluation — an advanced assessment performed in the field to determine if a 9-1-1 patient is clinically eligible to be treated at an alternative medical facility. The medic first confirms that no priority symptoms exist that require treatments that can only be performed in an emergency department. The medic then explains to the patient that the medical condition may be appropriately treated at an alternative care location. The selection of a location will depend upon: insurance accepted, facility hours, facility capability, facility capacity, and nearest appropriate location. Within clinical triage and destination guidelines, patient choice and consent will always be the final determinant.[3]

Partners that were identified as critical to the success of this program primarily centered around healthcare providers (medical centers, pharmacy, FQHC, Community Triage Center, urgent care and clinics), the State EMS Office, the State Health Officer, the local health district, Fire Department/District, senior and community groups, and data informatics assistance (university resources, statistic analysts, and independent evaluator).

### *Nurse Health Line*

REMSA's Nurse Health Line is staffed with specially-trained registered nurses (called nurse navigators) available 24 hours-per-day, 7 days-per-week to provide assessment, care recommendations and/or referral to the appropriate health care or community service. Nurses are co-located and fully integrated with the 9-1-1 emergency medical dispatch system, which assures warm hand-off of callers transferred to 9-1-1.

REMSA's registered nurses provide care using the Emergency Communications Nurse System (ECNS), which is comprised of more than 200 protocol-based algorithms. The ECNS symptom-based protocols guide the nurse through a series of medical questions. After confirming there are no

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[2] http://www.emsworld.com/news/12256096/renown-health-remsa-partner-to-sustain-community-health-programs

[3] https://www.remsahealth.com/community-health/%e2%80%8balternative-destination-transport/

priority symptoms requiring emergent care and gathering additional information about the caller , a recommended level of care is selected based on the caller's answers, including options such as: send ambulance now, seek immediate care at an emergency department, seek care at urgent care center/clinic, schedule appointment with primary care doctor or stay home with self-care instructions provided. The nurse identifies a recommended location of care and assists the patient in gaining access to the closest available medical and community services. Services include: urgent care centers, primary care doctors, medical clinics, mental health services, community service agencies, public assistance programs, and alternative means of transportation.[4]

***Community Paramedicine***

REMSA has paramedics complete additional training to qualify as community paramedics, able to determine the best place of treatment for people who have called 9-1-1. Prior to receipt of the CMS award, paramedics were only able to transport patients to one of five emergency departments in the region. Due to the receipt of the award and additional training of the community paramedics, they are now able to transport patients to one of many partnering community care facilities, including urgent care centers, clinics/medical groups, community triage centers, and mental health hospitals.

## FUNDING

The program was initially funded by a CMS Healthcare Innovation Award, but is now funded at the local level by a collaboration between REMSA and Renown Health. Reimbursements for transport are currently covered under a fee-for-service model with community tax support.[5]

## OUTCOMES[6]

As of June 2016, the program had produced the following results:

- 63,866 calls to Nurse Health Line (9/13 – 6/16)
- 1,524 enrolled Community Paramedic patients (6/13 – 6/16)
- 1,438 Transports to Alternative Destinations (1/13 – 6/16)
- Total est. program savings from the three initiatives: $9.66 million over the course of two to three years resulting from:
    - 6,202 ED Visits Avoided
    - 1,024 Ambulance Transports Avoided
    - 104 Hospital Readmissions Avoided

## POTENTIAL ISSUES

- Sustainable funding source including local taxation supports
- Reimbursements for services provided
- Pushback from others doing similar work (American Nurses Association raised concerns about whether paramedics are receiving enough extra instruction)[7]

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[4] https://www.remsahealth.com/community-health/nurse-health-line/
[5] http://www.leg.state.nv.us/Interim/77th2013/Exhibits/HealthCare/E050714T.pdf
[6] http://www.naemsp.org/Documents/2016%20Annual%20Meeting%20Handouts/MIH-CommParamed/MIH%20-%20REMSA.pdf
[7] http://khn.org/news/paramedics-steer-non-emergency-patients-away-from-ers-2/

## Wake County, North Carolina Advance Practice Paramedic Program

Wake County, North Carolina has a population of 1.05 million people. Wake County Emergency Medical Services (WCEMS) consists of 249 full-time employees. In a given year, they receive 90,000 requests for service, 67,000 of which result in transports.[8]

In 2009, WCEMS implemented their advanced practice paramedics (APP) program which is based on three main objectives:

- Reduce the occurrence of emergent medical situations for those with specific medical conditions.
- Redirect patients with mental health or substance use crises to facilities that provide services specifically for those particular medical conditions.
- Respond to high-acuity calls which require an added level of expertise.[9]

There are currently 17 APPs operating five APP response units, housed in Dodge Chargers. Training of APPs consists of an in-house program developed by WCEMS. Those who undergo the training and serve as APPs receive a 10% pay increase compared with non-APP medics with similar years of experience.[10]

Wake County has established criteria for EMS referral to approved alternative to emergency departments in order to facilitate the most appropriate triage and care for persons with acute mental health or substance use concerns. Patients with a primary mental health or substance use complaint are eligible for consideration for alternative destination if certain criteria and medical clearances are met. Blood alcohol concentration (BAC) is a determinant of which alternative destinations are an option for the patient. The higher the BAC limits the availability of providers. For example, patients with a BAC greater than 0.4 are not eligible for alternative destination and must be referred to the Emergency Department. In any circumstance, transport crews must communicate directly with the APP either on-scene, on the phone, or by radio to ensure that proper notification of the alternate destination can be made by the APP. The APP must approve the patient for potential alternate destination in all cases.[11]

### FUNDING

The WCEMS is funded by a combination of user fees (65%) and a tax subsidy from the general fund (35%).[12] Bills for transport are not itemized, rather they use a Medicare flat rate structure:

| *Service Type* | *Fee* | *Loaded Miles* |
|---|---|---|
| *Basic Life Ssaving* | $515.97 | $10.91/mile |
| *Advance Life Saving I* | $612.71 | $10.91/mile |
| *Advance Life Saving II* | $886.82 | $10.91/mile |
| *Basic Life Saving (no transport)* | $150 | |
| *Advance Life Saving (no transport)* | $200 | |

[8] http://www.mckesson.com/about-mckesson/newsroom/press-releases/2017/wake-county-ems-selects-mckesson/

[9] http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx

[10] https://smhs.gwu.edu/urgentmatters/sites/urgentmatters/files/QandAfromAug2012APPWebinar.pdf

[11] Wake County EMS System Standards and Practice: Policies, Procedures, Protocols & associated References

[12] http://www.wakegov.com/ems/patient/Pages/servicefeebudget.aspx

A portion of the user funding is made up by the Wake County Rescue Squad EMS Fund (Fund), through which each household can pay $60 per year, and all members of the household can receive emergency 9-1-1 ambulance service to anywhere in Wake County as often as needed, without having to pay any direct costs not covered by their insurance. Any funds leftover from the Fund are added to WCEMS operating funds.[13]

## Outcomes

In 2013, the WCEMS APPs successfully referred 346 patients directly for mental health evaluation rather than sending them to the emergency department. There was also a 50% reduction in transports to the emergency department for patients living in assisted living who experienced a fall. Finally, the department was able to create care plans for 13 high frequency patients, who generally cost the system more and have chronic conditions that do not necessarily require emergency care.[14]

## Potential Issues

- This program is focused on providing access to rural areas, outcomes may not be replicable in suburban or urban areas.
- It may be difficult to get people in low resource areas to sign up for a subscription service like the Fund.

[13] http://www.wakegov.com/ems/patient/Pages/servicefeebudget.aspx
[14]http://www.wakegov.com/budget/past/fy16/Documents/Wake%20County%20-%20Adopted%209.30.15%2010AM%20FINAL.pdf

## California Community Paramedicine Pilot Programs

California has thirteen pilot programs currently underway in nine areas of the state which focus on the following aspects of Community Paramedicine:

- Post discharge
- Alternate destination
- Frequent 9-1-1
- Hospice
- Tuberculosis
- Behavioral health

Under California law, paramedics must transport all 9-1-1 patients to the emergency department of an acute care hospital.[15] However, under the Health Workforce Pilot Project (HWPP) program (California Health and Safety Code §§ 128125-128195) which is administered by the California Office of Statewide Planning and Development (OSHPD), scope of practice laws are waived to test new models of care. [16]

Training for all community paramedics in the state of California is coordinated through the UCLA Center for Prehospital Care. The training can be completed in-person or in a part-time hybrid which combines online and in-person instruction. Community paramedics receive at least 1230 hours of advanced training.

### FUNDING

Thus far, the pilot programs have received funding through the California Health Care Foundation and the HWPP. The program budget was $446,185 for a twenty-four month grant cycle.[17]

### OUTCOMES[18]

| Pilot Category | Region of Implementation | Outcomes |
|---|---|---|
| **Post-Discharge Follow-Up** | Alameda County, Los Angeles County, San Bernadino County, Sierra Sacramento Valley, Solano County | • Decrease in readmissions in all but one site<br>• Significant cost savings for payers at all but one site(not large enough to offset costs of project)<br>• Avoided adverse health effects due to misunderstanding medical instructions |
| **Frequent EMS Users** | Alameda County and San Diego | • Number of 9-1-1 calls, ambulance transports, and ED visits was significantly reduced among enrolled patients<br>• Cost savings due to a decrease in amount of uncompensated care |

[15] http://www.emsa.ca.gov/Community_Paramedicine
[16] https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Evaluation%20of%20California%C2%B9s%20CP%20Pilot%20Program_final2%5B1%5D.pdf
[17] ibid
[18] https://healthforce.ucsf.edu/publications/evaluation-california-s-community-paramedicine-pilot-program

| | | |
|---|---|---|
| **Directly Observed Therapy for Tuberculosis** | Ventura | • Patients more likely to receive all doses of TB medication |
| **9-1-1 Hospice Calls** | Ventura | • Reduced rates of ambulance transports to an ED from 80% to 36% |
| **Alternate Destination: Behavioral Health** | Stanislaus County | • 98% of patients were evaluated at behavioral health crisis center without ED delay<br>• Less than 3% of patients required subsequent transfer to ED – no adverse outcomes<br>• Savings for payers<br>• Decrease in amount of uncompensated care |
| **Alternate Destination: Medical Care** | Los Angeles County, Orange Count, San Diego | • Numbers too low to draw firm conclusions |

## POTENTIAL ISSUES

- Louisiana does not have a program with funding like the HWPP program
- This initiative is operating under a two year grant cycle which is not much time to assess outcomes
- Dependent on foundation funding

# Section 2: Louisiana Current Initiatives

## East Baton Rouge Community Paramedicine

East Baton Rouge EMS started a community paramedicine program January 2, 2017, but has not yet expanded into behavioral health. The program tracks patients as high utilizers with eight or more 9-1-1 calls within 6 months. Once a person is identified as a high utilizer a Community Paramedicine Medic makes contact with the individual to explain the program and do an initial assessment of their situation. They are given the option to enroll in the program and a plan is developed.

Data from the Community Paramedic program for dates of service between January, 2017 – December, 2017 is included below.

- Total number of patients enrolled: 36
- Reduction in total number of 911 calls: 63%
- Reduction in total number of transports: 67%
- Approximately $9,500.00 per month saved from avoided transports

## Capital Area Human Services (CAHS) Crisis Intervention Team Training (CIT)

The 40-hour training teaches law enforcement officers about behavioral health issues, de-escalation skills, and crisis communication needed to get citizens the help they need safely and quickly.

CAHS developed the training in 2008 as part of a 10-part comprehensive plan to respond to the increased behavioral health crises for persons with mental illness, addictive disorders, and developmental disabilities. The officers learn about the signs, symptoms, and treatment of mental illnesses, as well as suicide prevention, homelessness, and dementia.

Since 2008, more than 500 members of law enforcement have completed the CAHS program. In the most recent class, thirty law enforcement officers from four area agencies completed the CAHS Crisis Intervention Team Training held in October of 2017.

# Section 3: East Baton Rouge Pilot Strategy

## Alternate Destinations: Behavioral Health Focus

There is ample data and precedence from other states to support the decision to focus an ambulance diversion pilot focused on behavioral health. As indicated in the tables below for East Baton Rouge (EBR), 16% of Medicaid trips and 19% of Medicaid payments are behavioral health related based on primary diagnosis alone.[19] **This does not account for Medicare, commercial or other insurance carriers, which make up the significant majority of EMS trips.** National EMS data indicates Medicaid is only 14% of ambulance trips.[20]

According to EBR EMS, psychiatric patients account for 8.8% of its total transports and 7.2% of total call volume. This amounts to approximately 11 patients per day with a psychiatric impression and EBR EMS transports 82% of them to the hospital. Managing behavioral health transports using alternative destinations could potentially result in a significant reduction to unnecessary hospital

[19] NOTE: Data using any diagnosis with over ten trips only.
[20] EMS Innovations White Paper (HHS), 2013. Retrieved from: https://www.ems.gov/pdf/2013/EMS_Innovation_White_Paper-draft.pdf

transports, especially considering that 97% of the psychiatric 9-1-1 calls are classified as non-emergent.

Comparison of rates between the average Medicaid inpatient per diem ($864.86) and the average substance use residential rate of $152.42 shows the potential to produce savings in the Medicaid program if patients are diverted from unnecessary inpatient admissions into alternate treatment. Though the Task Force initiated contact with three of the local behavioral health residential providers, engaging with the five hospitals with emergency departments in East Baton Rouge and the other local behavioral health providers will be key to ongoing development.

*Table 1: EBR Medicaid Emergency Ambulance Trips by Primary Diagnosis (Over 10 trips)*

| Diagnosis Code Description | Trips | MCO Payment | FFS Payment | Total Payment |
|---|---|---|---|---|
| OTHER ACUTE PAIN | 953 | $ 233,500 | $ 9,077 | $ 242,576 |
| ABDOMINAL PAIN UNSPECIFIED SI | 763 | $ 215,862 | $ 12,174 | $ 228,036 |
| CHEST PAIN UNSPECIFIED | 577 | $ 208,725 | $ 13,386 | $ 222,111 |
| ALTERED MENTAL STATUS | 504 | $ 151,636 | $ 5,821 | $ 157,457 |
| SHORTNESS OF BREATH | 479 | $ 169,042 | $ 23,068 | $ 192,111 |
| CONVULSIONS NEC | 389 | $ 112,214 | $ 17,541 | $ 129,755 |
| OTHER GENERAL SYMPTOMS | 316 | $ 81,456 | $ 4,302 | $ 85,759 |
| OTHER SIGNS & SYMPTOMS INVOLVING EMOTIONAL STATE | 212 | $ 43,325 | $ 3,294 | $ 46,619 |
| BACKACHE UNSPECIFIED | 191 | $ 50,192 | $ 987 | $ 51,179 |
| RESPIRATORY ABNORM NEC | 176 | $ 58,068 | $ 4,208 | $ 62,276 |
| SUICIDAL IDEATION | 175 | $ 161,609 | $ 7,368 | $ 168,977 |
| SYNCOPE AND COLLAPSE | 155 | $ 52,932 | $ 2,088 | $ 55,020 |
| OTHER ABNORMAL GLUCOSE | 139 | $ 44,581 | $ 6,143 | $ 50,725 |
| PREG COMPL-UNSPEC | 135 | $ 42,894 | $ - | $ 42,894 |
| TRANSIENT ALTERATION OF AWAREN | 133 | $ 19,431 | $ 37,264 | $ 56,696 |
| POISON-MEDICINAL AGT UNSPECIFIED | 133 | $ 48,253 | $ 1,568 | $ 49,820 |
| FEVER UNSPECIFIED | 124 | $ 43,188 | $ 6,992 | $ 50,180 |
| OTH SIGNS SYMPTOMS INVOLV COGN | 116 | $ 33,371 | $ 1,225 | $ 34,596 |
| ORTH MALAISE & FATIGUE | 94 | $ 28,305 | $ 2,963 | $ 31,268 |
| HEMORRHAGE UNSPECIFIED | 91 | $ 23,028 | $ 583 | $ 23,611 |
| INJURY-SITE UNSPECIFIED | 91 | $ 45,108 | $ 1,194 | $ 46,302 |
| ABDOMINAL PAIN GENERALIZED | 86 | $ 25,543 | $ 4,413 | $ 29,956 |
| HEADACHE | 81 | $ 23,771 | $ 646 | $ 24,417 |
| ABRASION NEC | 81 | $ 29,712 | $ 995 | $ 30,707 |
| HEAD INJURY | 78 | $ 28,602 | $ 6,219 | $ 34,821 |
| OTH DISEASES LUNG-OTH PULMONA | 67 | $ 24,975 | $ 1,148 | $ 26,123 |
| INJURY OF FACE AND NECK | 59 | $ 18,022 | $ 3,179 | $ 21,201 |
| UNS PERSIST MENTL D/O COND CLS | 59 | $ 16,259 | $ 986 | $ 17,245 |
| OTHER SPECIFIED HEADACHE SYNDR | 57 | $ 16,695 | $ 499 | $ 16,194 |
| PSYCHOSIS UNSPECIFIED | 52 | $ 41,599 | $ 3,960 | $ 45,558 |
| SECOND HYPERTENSION NEC | 45 | $ 17,307 | $ 3,030 | $ 20,337 |
| PAIN IN LIMB | 45 | $ 11,702 | $ 381 | $ 12,083 |
| ACUTE MYOCARDIAL INFARCTION-SU | 43 | $ 24,946 | $ 676 | $ 25,622 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ABDOMINAL PAIN OTHER SPECIFIE | 40 | $ | 11,100 | $ | 1,196 | $ | 12,296 |
| NAUSEA WITH VOMITING | 39 | $ | 11,754 | $ | 1,704 | $ | 13,458 |
| HYPOTENSION UNSPECIFIED | 38 | $ | 12,375 | $ | 1,632 | $ | 14,007 |
| UNSPEC NONPSYCHOTIC MENTAL DIS | 38 | $ | 19,492 | $ | 2,138 | $ | 21,630 |
| ALLERGY UNSPECIFIED | 38 | $ | 11,348 | $ | - | $ | 11,348 |
| PATHOLOGIC ALCOHOL INTOX | 37 | $ | 8,736 | $ | 919 | $ | 9,656 |
| LOWER LEG INJURY UNSPECIFIED | 36 | $ | 11,368 | $ | 622 | $ | 11,990 |
| ANXIETY STATE UNSPECIFIED | 35 | $ | 10,872 | $ | - | $ | 10,872 |
| CHEST PAIN NEC | 34 | $ | 9,823 | $ | 893 | $ | 10,716 |
| CARDIAC ARREST | 33 | $ | 14,010 | $ | 2,031 | $ | 16,041 |
| CARDIAC DYSRHYTHMIA UNSPECIFIED | 30 | $ | 10,297 | $ | 1,254 | $ | 11,551 |
| TACHYCARDIA UNSPECIFIED | 29 | $ | 7,908 | $ | 2,404 | $ | 10,312 |
| CONDUCT DISTURBANCE UNSPECIFIED | 27 | $ | 6,989 | $ | 5,576 | $ | 12,565 |
| OTHER INJURY OF OTHER SITES TR | 27 | $ | 9,753 | $ | 234 | $ | 9,987 |
| DIZZINESS AND GIDDINESS | 26 | $ | 7,960 | $ | 1,249 | $ | 9,209 |
| LUMBAGO | 26 | $ | 13,920 | $ | 470 | $ | 14,390 |
| HYPERTENSION UNSPECIFIED | 26 | $ | 7,488 | $ | 623 | $ | 8,111 |
| PALPITATIONS | 25 | $ | 8,852 | $ | - | $ | 8,852 |
| HYPOGLYCEMIA UNSPECIFIED | 25 | $ | 8,139 | $ | 1,487 | $ | 9,627 |
| HALLUCINATIONS | 23 | $ | 9,902 | $ | 604 | $ | 10,506 |
| ELB/FOREARM/WRST INJ UNSPECIFIED | 23 | $ | 6,333 | $ | 841 | $ | 7,173 |
| ALCOHOL ABUSE-UNSPEC | 22 | $ | 6,682 | $ | 653 | $ | 7,335 |
| ACUTE PAIN DUE TO TRAUMA | 21 | $ | 5,165 | $ | - | $ | 5,165 |
| DEPRESSIVE DISORDER NEC | 20 | $ | 10,391 | $ | 968 | $ | 11,360 |
| ELEV BL PRES W/O HYPERTN | 20 | $ | 6,876 | $ | - | $ | 6,876 |
| HIP & THIGH INJURY UNSPECIFIED | 18 | $ | 5,525 | $ | 885 | $ | 6,410 |
| CEREBR ARTERY OCC UNSPECIFIED | 17 | $ | 6,246 | $ | 802 | $ | 7,048 |
| SHLDR/UPPER ARM INJ UNSPECIFIED | 17 | $ | 5,436 | $ | 910 | $ | 6,346 |
| UNKN CAUSE MORB/MORT NEC | 15 | $ | 3,657 | $ | 223 | $ | 3,880 |
| JOINT PAIN-L/LEG | 14 | $ | 3,374 | $ | 443 | $ | 3,817 |
| GASTROSTOMY-MECH COMPLI | 14 | $ | - | $ | 4,360 | $ | 4,360 |
| JOINT PAIN-PELVIS | 14 | $ | 4,047 | $ | 429 | $ | 4,476 |
| ALTERATION OF CONSCIOUSNESS OT | 14 | $ | 7,608 | $ | 1,033 | $ | 8,641 |
| MULTIPLE CONTUSIONS NEC | 14 | $ | 4,634 | $ | - | $ | 4,634 |
| CARDIAC DYSRHYTHMIAS NEC | 13 | $ | 2,998 | $ | 2,425 | $ | 5,422 |
| ABDOMINAL PAIN LEFT LOWER QUA | 13 | $ | 3,808 | $ | 1,129 | $ | 4,937 |
| OTHER INJURY OF ABDOMEN | 13 | $ | 4,948 | $ | 415 | $ | 5,363 |
| THREAT PREM LABOR-UNSPEC | 13 | $ | 6,106 | $ | - | $ | 6,106 |
| AC CEREBROVASC INSUF NOS | 12 | $ | 3,490 | $ | 1,909 | $ | 5,399 |
| CERVICALGIA | 12 | $ | 2,710 | $ | 834 | $ | 3,544 |
| HYPOXEMIA | 12 | $ | 9,054 | $ | 2,343 | $ | 11,397 |
| PSYCHOGEN PARANOID PSYCH | 12 | $ | 5,131 | $ | 200 | $ | 5,332 |
| JOINT PAIN-SHLDER | 12 | $ | 3,305 | $ | 369 | $ | 3,675 |
| OTHER SPEC COMPLIC OF PROC NOT | 12 | $ | 2,983 | $ | 700 | $ | 3,682 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| OTH DISEASES OF LUNG-RESPIRATO | 11 | $ | 10,253 | $ | 356 | $ | 10,609 |
| OTHER INJURY OF CHEST WALL | 11 | $ | 8,669 | $ | 402 | $ | 4,071 |
| NAUSEA ALONE | 11 | $ | 3,144 | $ | 240 | $ | 3,384 |
| GENERALIZED ANXIETY DIS | 11 | $ | 2,576 | $ | - | $ | 2,576 |
| DRUG WITHDRAWAL SYNDROME | 11 | $ | 2,560 | $ | - | $ | 2,560 |
| VOMITING ALONE | 10 | $ | 2,273 | $ | 1,185 | $ | 3,458 |

*Table 3: EBR Emergency Ambulance Trips by Top Ten Medicaid Super-utilizers*

| RECIP_ID | Trips | MCO Payment | FFS Payment | Total Payment |
|---|---|---|---|---|
| 1 | 36 | $ 10,784.42 | $ - | $ 10,784.42 |
| 2 | 34 | $ 14,275.50 | $ - | $ 14,275.50 |
| 3 | 29 | $ 8,759.51 | $ - | $ 8,759.51 |
| 4 | 26 | $ 7,169.32 | $ - | $ 7,169.32 |
| 5 | 25 | $ 8,022.44 | $ - | $ 8,022.44 |
| 6 | 24 | $ 4,622.02 | $ - | $ 4,622.02 |
| 7 | 22 | $ 8,139.41 | $ - | $ 8,139.41 |
| 8 | 22 | $ 4,609.13 | $ - | $ 4,609.13 |
| 9 | 22 | $ 5,088.28 | $ 587.65 | $ 5,675.93 |
| 10 | 21 | $ 7,288.72 | $ - | $ 7,288.72 |

In order to facilitate a pilot program that will allow for alternate destination transport, a Nurse Help Line with use of symptom-based protocols/algorithms will need to be established and funded within the 9-1-1 call center in order to triage the calls appropriately and help EMS identify available locations for transport if an ambulance is still deployed. The Task Force discussed a potential process flow for the pilot inclusive of the Nurse Help Line which is outlined in Attachment 2. In addition to the Nurse Help Line, a community paramedicine program will help facilitate additional diversions, especially if transportation to an alternate destination for treatment is not necessary and the paramedic can resolve the issue on-site. The Task Force created the Behavioral Health Screening Assessment for EMS to potentially use as part of a paramedicine program, which can be reviewed in Attachment 3. This tool can help identify if transport to a hospital ED is still needed or if other treatment options are available. Extensive additional training will need to be built out with the state's educational institutions for healthcare and EMS personnel to perform duties as community paramedics, and arrangements with insurance providers including the MCOs, Medicare, and commercial payors will be necessary to ensure sustainable funding.

# Section 4: Funding Resources and Challenges

## Medicaid (State)

Louisiana Medicaid currently reimburses for ambulance transportation for its members for both emergency and nonemergency trips. Medicaid reimbursement is not restricted by the destination, and as such, no changes in rule or State Plan are needed to effectuate this pilot initiative for Medicaid.

Medicaid currently pays EMS claims for trips meeting the definition of "emergency response" as defined by CMS. CMS defines the emergent nature and level of need (BLS vs ALS) of a response *at the time EMS is called* and *based on the patient's reported condition at the time of dispatch*. So, under our

current payment structure, the level of services billable to Medicaid is determined at the point of dispatch, not the actual level of need displayed at the point of transport.

  - This will result in an EMT level of payment for patients whose reported symptoms appear to require ED care but whose actual symptoms once EMS arrives only support a lower level of services (NEAT or NEMT).
  - Non-medically-necessary trips (note: <u>not</u> medically necessary trips at a lower-than-dispatched level of need), on the other hand, are not reimbursable at all and are chargeable to the patient.
  - If Medicaid were to add a point-of-transport-based rate for EMS diversion, this could reduce the overall program cost for trips that are already occurring.
- The only potential cost would be if the protocol resulted in *new* trips that would not have otherwise occurred (rather than diverting existing trips that would currently go to the ED). To avoid this issue, LDH could look to pay these trips at an NEMT rate.
  - NEAT is inappropriate in this case, because that rate is only available when the patient cannot be transported by NEMT.
  - The main difficulty would be to distinguish between current trips being diverted and new trips that would have otherwise been transported via NEMT. This would likely take some collaboration between LDH and the ambulances.

Though it is too early to make any estimation on savings, reducing ED utilization through 9-1-1 nurse triage, diversion, or a community paramedicine program could potentially reduce Medicaid spending depending on the offsetting level of utilization and relative costs of alternative services. Strong data collection from EMS, hospital providers, and behavioral health providers involved in any pilot would be necessary to understand the associated cost avoidance. The managed care organizations (MCOs) should be engaged in order to develop the behavioral health network as needed for the Medicaid population that could potentially be diverted from the ED.

## Medicare (Federal)

According to a 2013 projection by the Office of Emergency Medical Services (EMS), Medicare alone could annually save close to $600 million nationwide by preventing unnecessary transports to the emergency department. This is in large part because a significant percentage of ambulance trips are for Medicare recipients and thereby reimbursed through Medicare as opposed to Medicaid. Acadian Ambulance reports that 40% of its transports are Medicare. This corresponds with national data which shows that National estimates for EMS payer-mix are: 44% Medicare, 14% Medicaid, 14% Private Pay, 21% Commercial Insurance, and 7% other.[21] Most of the funding challenges preventing a diversion pilot from succeeding currently are due to Federal Medicare regulations which prevent reimbursement of ambulance trips to locations other than a hospital. In response to this challenge, the national associations are appealing to policymakers to examine short and intermediate reforms in definitions and reimbursement regulations over the course of the next three to five years that would support innovations such as diversion and paramedicine programs. Please see Attachment 1: Joint Statement on Ambulance Reform drafted by the American Ambulance Association, National Association of EMS Physicians, National Association of EMTs, and national Association of State EMS Officials for additional details.

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[21] EMS Innovations White Paper (HHS), 2013. Retrieved from: https://www.ems.gov/pdf/2013/EMS_Innovation_White_Paper-draft.pdf

### Commercial Insurance

**Medical clearance**: Some behavioral health facilities are having EMS bring patients to the ED for medical clearance at the hospital before admitting them when this can be done at urgent care or by EMS onsite. This defeats the purpose of originally diverting the patient to the behavioral health facility.

**Insurance**: Not just medical clearance is needed but also insurance clearance. This means that medical necessity will need to be determined with the insurance carrier prior to the alternative provider accepting the patient. Absent the requirement to screen and treat that exists for emergency departments under federal EMTALA legislation, there is the potential issue of patients without adequate insurance coverage being turned away from service at non-emergency department facilities.

### City/Parish

Local funding sources will need to be identified to pay for the Nurse Help Line to assist with behavioral health triage in the 9-1-1 call center similar to the REMSA model. Exploration of CMS Innovation Awards may also assist with funding identification. In keeping with this model, strong outreach into the community including key marketing strategies to patients will be needed to encourage ongoing cooperation and understanding of diversion sites.

## Section 5: Legal & Operational Impediments

The first change to facilitate a pilot requires changes to local EBR ordinances relative to ambulance destination at Sec. 10:401.1. Currently local law restricts ambulance destinations to hospital emergency departments when a 9-1-1 call is received.

There are significant Federal changes needed to Medicare definitions and regulations in order facilitate consistent transport of non-emergent behavioral health patients to alternative destinations or to initiate a community paramedicine program. Attachment 1 outlines these recommendations for Congressional consideration.

Additionally, there are operational issues to consider. If the intent of EMS is to transport patients to a behavioral health clinic and they are not stable:

1. A clinic is not a 24 hour facility and therefore cannot accept people in crisis since it is not possible to know they can be stabilized within its hours of operation.
2. A clinic cannot restrain a patient who is out of control, cannot lock someone in a room, and cannot provide involuntary treatment. When a patient of becomes out of control, or in a crisis, clinic physicians must complete an emergency certificate and they are then transported via ambulance or law enforcement to the closest emergency room.

## Section 6: Conclusion & Recommendations

1. Any diversion pilot needs to be implemented through a three-pronged approach including a Nurse Help Line and a community paramedicine program in addition to alternate destinations.
2. An EMS community health program should be instigated at the city/parish level through changes in local ordinances and identification of local, state, or federal funding sources to pay for appropriate 9-1-1 triage personnel. LDH can support local efforts by assisting with research and application for federal funding through a CMS Innovation Award.

3. No changes are needed in rule or the Medicaid State Plan by LDH as Medicaid currently covers ambulance transport as both an emergency and non-emergency service regardless of destination site.
4. In order to make the pilot successful, changes in Federal Medicare regulations will be required to ensure appropriate reimbursement for the large majority of transports. Resources should be strategically focused on working with Congress to effectuate these changes.
5. As demand increases, access to behavioral health providers needs to simultaneously expand. Medicare coverage of behavioral health is limited and so providers are forced to rely primarily on commercial insurers and Medicaid as payors. With limited state funding resources, Medicaid reimburses at well below both the Medicare and commercial rates. To encourage expansion of the substance use residential and psychiatric inpatient provider network, increasing state Medicaid appropriations for a dedicated provider rate increase may be necessary.
6. The Task Force should engage with a separate group of East Baton Rouge stakeholders inclusive of hospitals with emergency departments, behavioral health residential/inpatient providers, the MCOs, the Office of Behavioral Health, and other specialty providers in primary care or opioid treatment to explore partnerships necessary to make the pilot succeed.

## Attachments

Attachment 1: Joint Statement on Ambulance Reform

Attachment 2: Ambulance Diversion Options Flow Diagram

Attachment 3: Behavioral Health Medical Screening Assessment

Attachment 4: Ambulance Transfer Alternatives Task Force Members

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# 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**

## Table of Contents

# Joint Statement of the American Ambulance Association, National Association of EMS Physicians, National Association of EMTs, and National Association of State EMS Officials:

## 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;

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[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 $O_2$
  - 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.

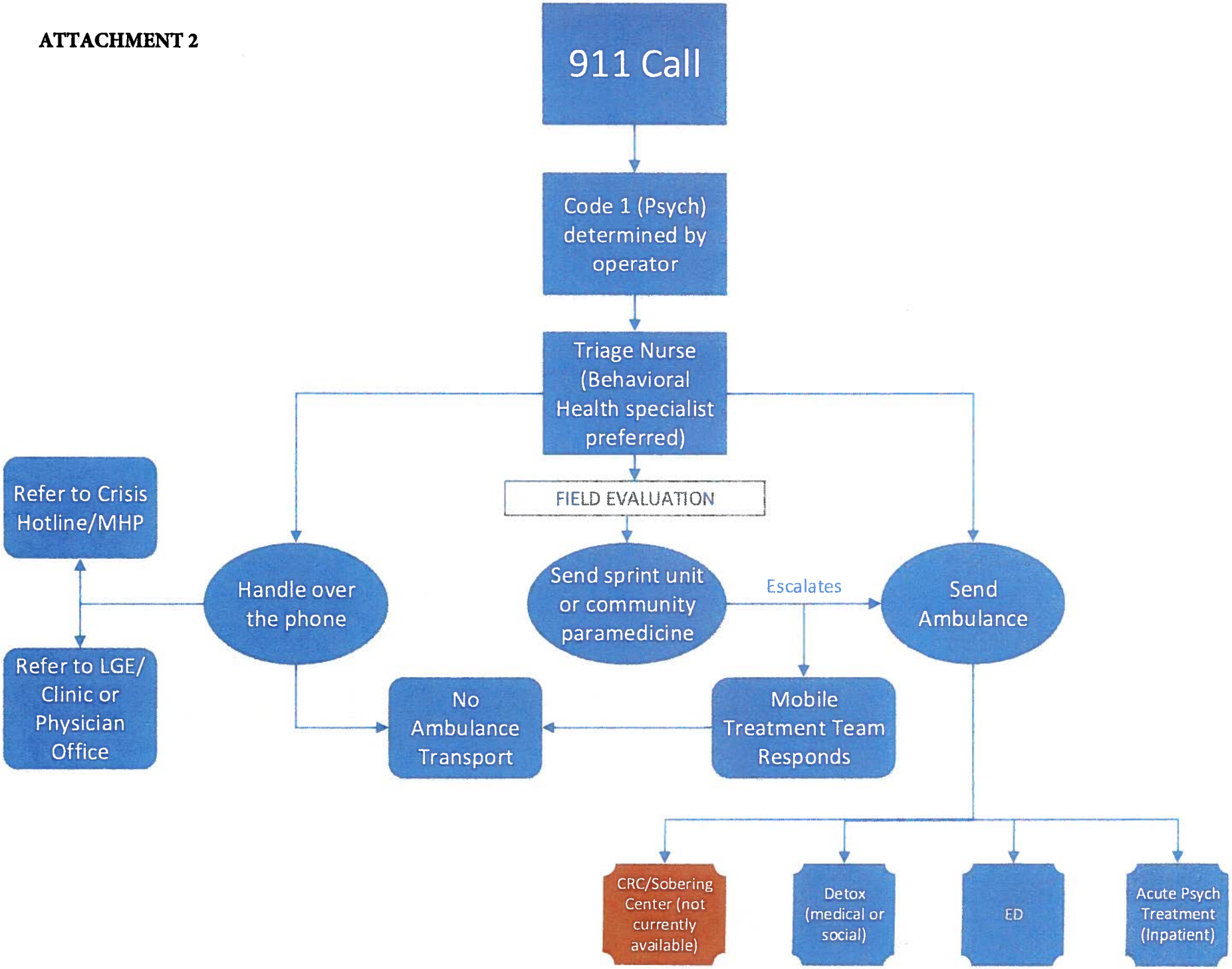
***Individual Care Services.*** In addition to transitioning care management, ambulance services could provide community-based support to physicians and other prescribing health care providers to help patients manage their chronic diseases. These services would be provided pursuant to a valid prescription. 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.

**ATTACHMENT 2**



**ATTACHMENT 3**

Behavioral Health Medical Screening Assessment

Time: Date:

| Location of Assessment: | | | | |
|---|---|---|---|---|
| Patient Name: Last | First | Middle | DOB/Age | Gender |
| Street Address: | City | State | Zip Code | Phone # |
| Insurance: | Company: | | | |

**Exclusionary Criteria**

| | | | |
|---|---|---|---|
| Age < 18 | yes | no | |
| Persistently Combative (restraint needed) | yes | no | |
| Current Chest Pain | yes | no | |
| Disoriented to person, place, time | yes | no | |
| Signs of Delirium/Confusion (chemical sedation needed) | yes | no | |
| New psychiatric symptoms | yes | no | |
| Head Trauma | yes | no | Describe: _____ |
| Pupils Equal, Round, Reactive to Light (PERRL) | yes | no | Pupils: _____ |
| Blood pressure SBP>200, DBP>120 | yes | no | Blood Pressure: _____/_____ |
| Blood pressure SBP<100 | yes | no | Blood Pressure: _____/_____ |
| Pulse >120bpm or <50bpm | yes | no | Pulse Rate: _____ |
| Respiratory rate >24bpm | yes | no | Respiratory Rate: _____ |
| Blood oxygen saturation level (SpO2) <94% | yes | no | SpO2 level:_____ |
| Blood Sugar >300 or <60 | yes | no | BGL: _____ |
| Temperature >100.4 F or <96.0 F | yes | no | Temperature: _____ |
| Abnormal Lung Sounds | yes | no | Lung Sounds: _____ |
| Cardiac Disrythmia | yes | no | EKG rhythm: _____ |

A YES to any of the above questions results in a **FAILED** field ED diversion.

**Discretionary Criteria**

| | | | |
|---|---|---|---|
| Acute substance intoxication | yes | no | What is the substance? _____ |
| Alcohol sensor test completed? | yes | no | Reults: _____ |
| Oral swab test performed | yes | no | If no, why? _____ |
| Active infection/communicable disease? | yes | no | _____ |
| Any home medical equipment? | yes | no | Type: _____ |
| Needs assistance with ADL's? | yes | no | _____ |

**Oral Swab Test Results (enter + or -)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Amphetamine | | Cocaine | | Marijuana | | Oxycodone | |
| Methamphetamine | | Opiates | | Phencyclidine | | | |

**Medications**

| Medication | Dose | Medication | Dose | Medication | Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Pharmacy Name:**

**Allergies**

| Allergy | Reaction | Allergy | Reaction | Allergy | Reaction |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Destination**

| | | | |
|---|---|---|---|
| ☐ Detox | ☐ Emergency Room | ☐ Acute Psych Hospital | ☐ CRC/Sobering Center |

**Additional Notes**

EMT Signature:_____

Print Name:_____

Date: / /

**ATTACHMENT 4**

| **Ambulance Transport Alternatives Task Force** | | | |
|---|---|---|---|
| **Member** | **Organization** | **Email** | **Representing** |
| Mark Majors | Med Express Ambulance Service | mmajors@medexpress.net | Ambulance provider |
| Allyson Pharr | Acadian Ambulance Service | apharr@acadian.com | Ambulance provider |
| Jen Katzman | Medicaid | jennifer.katzman@la.gov | Secretary of LDH |
| Randy Davidson** | Medicaid | randy.davidson@la.gov | Secretary of LDH |
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| **Chairman* | | | |
| ***Vice-Chairman - recently left Medicaid and is replaced by Frank Opelka* | | | |
| | | | |
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