

Emergency Medical Services: Decreasing Revenue and the Regulated Healthcare Environment

Will Ambulance Transport Providers Survive?

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Introduction

Defining the Problem

Healthcare systems and EMS ambulance transport providers are struggling to find alternative funding sources because of the decreasing reimbursement dollars from private and public insurance.¹ Pre-hospital Emergency Medical Services systems are currently struggling to find a balance between the increased federal government involvement, steadily increasing business costs of providing emergency medical care, and the declining reimbursement funds from Medicare and Medicaid.² CMS reimbursement has decreased their reimbursement but unlike the hospital systems that have been under the regulatory spotlight for reimbursement standards, EMS has recently found themselves held accountable to the same standards as hospital health systems.³ The hospital health systems had to change and remodel their business practices to embrace the government oversight by developing robust internal compliance departments with personnel who had the necessary background and experience to implement effective programs and policies.⁴

EMS needs to accept government oversight in their daily practices, just as their hospital system counterparts did years ago, if EMS transport providers want to remain viable in the ever-changing healthcare climate.⁵ Leadership of EMS providers is failing to adopt the regulatory standards and recommendations.⁶ This is apparent when management neglects to implement effective compliance programs within their current business practices.⁷ The leadership is unwilling to place key personnel in positions with the ability to implement necessary compliance standards.⁸ Fire based EMS systems have a difficult time in hiring essential staff who have the credentials and expertise necessary to operate an effective compliance program due to their traditional business structure. This traditional structure of the fire service

¹ Medicare Payment Advisory Commission. *Mandated Report: Medicare Payment for Ambulance Services*. Report to Congress: Medicare and the Health Care delivery System. xi-xviii (June 2013), http://www.medpac.gov/documents/reports/jun13_entirereport.pdf

² CENTERS FOR MEDICARE AND MEDICAID SERVICES. *Ambulance Fee Schedule*. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service> (last visited April 2015)

³ Medicare Payment Advisory Commission. *Mandated Report: Medicare Payment for Ambulance Services*. Report to Congress: Medicare and the Health Care delivery System. 167-168 (June 2013), http://www.medpac.gov/documents/reports/jun13_entirereport.pdf

⁴ Frank Sheeder, et al., *Health Care Industry Compliance in a Shifting World: Putting it all Together*, DLA Piper Insights <https://www.dlapiper.com/en/us/insights/publications/2014/10/healthcare-industry.htm> (last visited July 15, 2015)

⁵ Jonathan Washko, *Understanding Why EMS is Failing*, JEMS (Jan 26 2015), <http://www.jems.com/articles/print/volume-40/issue-2/administration-and-leadership/understanding-why-ems-systems-fail.html>

⁶ *Id.*

⁷ Christopher Kelly. *OIG Reports: Ambulance Industry Overpaid \$402 Million*, EMS World (Jan 10, 2007), <http://www.emsworld.com/article/10322148/oig-report-ambulance>

⁸ *Id.*

relies on internal promotion resulting in fitting the position to the person and not the qualified person to the position. This practice places Fire Service EMS providers at a disadvantage and leaves them unprepared for the increased scrutiny being placed on their business practices by the Office of the Inspector General (OIG).⁹ Until EMS transport providers whether public, private, or fire-based systems embrace recommended compliance practices, they will continue to be subject to fines and fees as a covered entity.¹⁰

Exposing the Problem: Whistle Blowers and Fraud

Today's EMS providers, public and private, are being plagued with whistle-blowers, fraud, and request for penalty reliefs.¹¹ As an example, in Texas a headline read, "Whistle-blower's suit alleges fraud by Dallas Fire official's ambulance billing service."¹² The Dallas Fire Department was implicated in billing fraud due to illegal billing practices by their contract billing company.¹³ The lawsuit alleged violation of the False Claims Act by illegally billing for a higher level of service.¹⁴ The news article claimed the emergency transports were billed at a higher advanced life support (ALS) rate instead of the lower basic life support (BLS) rate.¹⁵ According to the Dallas Fire Department officials, they felt entitled to bill at the ALS rate because the personnel responding met the ALS credential requirements and did not take into account the level of treatment rendered to the patient.¹⁶ The suit was settled out of court, and the City of Dallas has agreed to refund 2.47 million dollars in overpayments received during the questionable billing period from 2006 through 2009.¹⁷ In addition, the Fire Department's Emergency Ambulance Service will be required to comply with compliance requirements set forth by Health and Human Services.¹⁸ The department agreed to implement a compliance program with

⁹ Paul Barr. *Trauma in EMS: Emergency Medical Services System faces Myriad Challenges-including overhaul of reimbursement structure*, Modern Healthcare (May 12, 2012), <http://www.modernhealthcare.com/article/20120512/MAGAZINE/305129910/>

¹⁰ Pat West. *FAQs for HIPAA Compliance*, EMS World (April 24, 2003)

<http://www.emsworld.com/news/10341944/faqs-for-hipaa-compliance>

¹¹ Kelly, Christopher. *OIG Reports: Ambulance Industry Overpaid \$402 Million*, EMS World (Jan 10, 2007), <http://www.emsworld.com/article/10322148/oig-report-ambulance>

¹² Selwyn Crawford, *Whistle-blower's suit alleges fraud by Dallas fire officials, ambulance-billing service*, Dallas Morning News (July 2010) <http://dallasnews.com/news/crime/headlines/201007>

¹³ *Id.*

¹⁴ DALLAS OBSERVER BLOG, *United States and State of Texas ex rel and Douglas Moore v City of Dallas*, 3:09 http://blogs.dallasobserver.com/unfairpark/2011/06/city_agrees_to_pay_feds_25_mil.php (last visited Jan. 5, 2015)

¹⁵ Selwyn Crawford, *Whistle-blower's suit alleges fraud by Dallas fire officials, ambulance-billing service*, Dallas, Morning News (July 2010), <http://dallasnews.com/news/crime/headlines/201007>

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ THE FEDERAL BUREAU OF INVESTIGATION. *City of Dallas to Pay 2.47 million to Resolve Allegations that it caused improper Medicare and Medicaid ambulance claims*. FBI: Dallas Division (June 2, 2011) <http://www.fbi.gov/dallas/press-releases/2011/city-of-dallas-to-pay-2.47-million-to-resolve-allegations-that-it-caused-improper-medicare-and-medicaid-ambulance-claims>

necessary policies and procedures adhering to OIG recommendations for ambulance transport compliance standards.¹⁹

Another example of an ineffective compliance program occurred in 2012, when the Los Angeles Fire Department was subject to possible fines for a breach in patient's medical records.²⁰ The Los Angeles Times reported that the Los Angeles Fire Department (LAFD) was subject to a violation of the privacy act when their contracted billing service leaked thousands of personal information.²¹ The Los Angeles Times reported, "the information was leaked deliberately and maliciously by a past employee of the billing contractor that delivers ambulance service billing for the LAFD²²." The breach occurred when a previous employee of the contracted service had stolen over nine hundred records of patients that were transported by the LAFD.²³ According to the notification, their stolen information was used to file fraudulent tax returns to the Internal Revenue Service (IRS).²⁴ By refusing to be accountable for implementing robust compliance programs with effective personnel, EMS business practices will continue to be audited, and the leadership will continue to pay fines and penalties.

In addition to Federal and State regulatory compliance standards, EMS transport providers are being held accountable by local governments for emergency response performance standards.²⁵ In 2015, Rural Metro Ambulance, in California, requested a 7 million dollar relief from contractual response breach fines, and penalties for not meeting the required response times from the Santa Clara County EMS Agency.²⁶ During the same time, the company experienced a decrease in revenue collection caused from the shift in the county's payer mix.²⁷ The company could not pay the amount of fees and penalties due to decreasing revenue, causing the request the reprieve.²⁸ Rural Metro is not the only transport provider being held to compliance standards, public and private systems are being required to maintain performance measures resulting in monetary and economic sanctions being ordered.²⁹

¹⁹ *Id*

²⁰ David Zahnsier, *LAFD billing firm's leak of personal data under investigation*, Los Angeles Times (Nov. 29, 2012), <http://articles.latimes.com/print/2012.nov/29/local/la>

²¹ *Id.*

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ Eric Kurhi, *Santa Clara County: Ambulance Contract Amended;rebid proposal coming back in Summer*, San Jose Mercury News (May 5, 2015), http://www.mercurynews.com/bay-area-news/ci_28054181/santa-clara-county-ambulance-contract-amended-rebid-proposal

²⁶ *Id.*

²⁷ Correspondence between Rural Metro Reporting Public financial Operating Report to the City of Santa Clara. (May 2013), <http://ruralmetrosantaclara.com/public-financials/0313.pdf>

²⁸ Eric Kurhi, *Santa Clara County: Ambulance Contract Amended;rebid proposal coming back in Summer*, San Jose Mercury News (May 5, 2015), http://www.mercurynews.com/bay-area-news/ci_28054181/santa-clara-county-ambulance-contract-amended-rebid-proposal

²⁹ Paul Barr. *Trauma in EMS: Emergency Medical Services System faces Myriad Challenges-including overhaul of reimbursement structure*, Modern Healthcare (May 12, 2012), <http://www.modernhealthcare.com/article/20120512/MAGAZINE/305129910/>

It is evident that over the past decade, EMS transport providers are more heavily regulated by all levels of government and are being held accountable to the same standards as other healthcare organizations through increased enforcement actions of the OIG.³⁰ In order for EMS transport providers to continue to survive in this environment of increased government oversight while reimbursement dollars are decreasing, EMS transport providers will have to implement effective compliance programs within their current business practices while discovering a practicable delivery of service model without decreasing quality of service.

THE OFFICE OF INSPECTOR GENERAL

Enforcement Actions

The OIG released its report to the Center for Medicare and Medicaid (CMS) regarding ambulance transports that occurred during 2006.³¹ The OIG reports that over 3 billion dollars were spent on emergency and non-emergency ambulance transports.³² The audit separated the type of transport into three distinct categories of transports: Advanced Life Support (ALS) Emergency, Basic Life Support (BLS) emergency, and BLS non-emergency.³³ A medical emergency is defined by CMS as:

The sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy, result in serious impairment of bodily functions, or result in serious dysfunction of any bodily organ. Any symptoms or conditions that may warrant an emergency ambulance transport include, but are not limited to; severe pain or hemorrhage, Unconsciousness or shock, Injuries requiring immobilization of the patient, patient needs to be restrained to keep from hurting himself or others, patient requires oxygen or other skilled medical treatment during transportation, and suspicion that the patient is experiencing a stroke or myocardial infarction.³⁴

Of those transports audited that met ALS or BLS emergency transport criteria, seven percent were found to have a coverage payment error.³⁵ This error of coverage amounted in 71 million dollars being paid for emergency ambulance transports that did not meet the requirements under the Medicare guidelines.³⁶ Furthermore, 9 percent of all transports audited did not meet the criteria for the level of service

³⁰ DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Medicare Payments for Ambulance transports*. OIG. (Jan 2006), <https://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf>

³¹ OFFICE OF THE INSPECTOR GENERAL. *Medicare Payments for Ambulance Transport*, (January 2006), <http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf>

³² *Id.* at 1-2

³³ *Id.* at 1-2

³⁴ *Id.* at 2

³⁵ *Id.* at 14-17

³⁶ *Id.* at 14-17

billed, accounting for 21 million paid for EMS transports billed at the higher level of service.³⁷ In addition, EMS emergency, ALS or BLS transports, are paid at a higher rate per transport than non-emergent BLS transports.³⁸

The audit helped to discovered several errors within the billing pre-payment process and post-payment review process.³⁹ In most cases, EMS transport providers lacked an effective pre-billing and post-payment review system; almost half of all EMS transport providers surveyed did not perform a post-payment claim review.⁴⁰ The OIG report also highlighted that the majority of EMS transport providers do not have a mechanism in place to request additional documentation in order to determine the appropriateness of the transport.⁴¹ It continued by pointing out that, “of the 73 contract jurisdictions audited, 13 of the contractors reported using a third party medical records business to determine whether the transport met coverage and level of service guidelines.”⁴² The level of service required for the ambulance transport is dictated by the patient’s medical acuity at the time of the request and whether there was a medical necessity.⁴³

Medical necessity for emergency medical transport, just as in the medical necessity for treatment in hospitals, has very broad criterion from CMS.⁴⁴ Medical necessity is defined as the treatment necessary for the illness or injury.⁴⁵ There is no list of medical conditions that will meet the criteria of medical necessity for emergency transports; however, in order for an ambulance transport to be eligible for Medicare Part B coverage, the transport has to meet conditions.⁴⁶ The requirements include, “the vehicle and personnel providing the service meet certain quality and crew size...and the ambulance trip, as a general rule, stay within certain distance and destination limitations.”⁴⁷ Following the evaluation as to whether these specific requirements have been met, medical necessity can be assessed.⁴⁸ OIG identified payments that were made to a Medicare beneficiary that were submitted as advanced life support transport claims where the patient’s medical problem did

³⁷ *Id.* at 14-21

³⁸ *Id.* at 14-21

³⁹ *Id.* at 14-21

⁴⁰ *Id.* at 19-20

⁴¹ “There are no uniform requirements regarding the kind of documentation contractors review to determine the appropriateness of ambulance transports. We were informed by contractors that contractor medical reviewers are allowed to and often do determine the appropriateness of the transport without obtaining additional documentation from the ambulance supplier or third-party providers, which include dialysis facilities, hospitals, and nursing homes.” OFFICE OF THE INSPECTOR GENERAL, *Medicare Payments for Ambulance Transport*, at 4 (January 2006), <http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf>

⁴² *Id.* at 20

⁴³ *Id.* at 17-18

⁴⁴ OFFICE OF THE INSPECTOR GENERAL. *Medical Necessity of Medicare Ambulance Services*, at 5(Dec 1998), <https://oig.hhs.gov/oei/reports/oei-09-95-00412.pdf>

⁴⁵ OFFICE OF THE INSPECTOR GENERAL, *Medicare Payments for Ambulance Transport*, at 44 (January 2006), <http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf>

⁴⁶ *Id.* at 14-15

⁴⁷ *Id.* at 14-15

⁴⁸ *Id.* at 14-21

not meet the need for that level of service.⁴⁹ Consequently, CMS has placed medical necessity and appropriate level of service as the priority during OIG audits in determining appropriateness of the ambulance transport.⁵⁰

Office of the Inspector General: Work Plans: 2014 & 2015

The work plan for 2014 included auditing for medical necessity and level of service required compared to the acuity of the patient at the time of the transport. A new audit area was introduced for ambulance service in the 2014 work plan; it was to audit ambulance services who receive payments under Medicare Part B, the presence of policies, procedures, and the effectiveness of organizations transport compliance programs.⁵¹ While in the work plan for 2015, OIG continues their focus for medical necessity and level of service transport enforcement actions.⁵² The plan included parameters to hone in on claims that listed the appropriate level of transport for the patient's at the time of the emergency.⁵³ It continues from the previous year with a focus on claims submission for EMS transports, the medical necessity of the transport with focus on auditing the effectiveness of the EMS provider's compliance programs.⁵⁴

INCREASED ENFORCEMENT ACTIONS AND DECREASING REVENUE

Why an Increase in Enforcement Actions?

Enforcement actions are moving rapidly into the EMS world. Audits are not only focusing on ambulance transport providers, but also state regulatory agencies. In 2010, Oklahoma State EMS Medical Services Authority (EMSA) was audited by the OIG.⁵⁵ The audit was conducted due to the fact that the state of Oklahoma was one of the states receiving the highest reimbursement through their emergency medical transport service.⁵⁶ The audit discovered EMSA billed for ALS emergency services when the beneficiary did not meet the medical necessity requirements for ALS service.⁵⁷ Medicare requires that the "beneficiary must be transported, the transport must be medically necessary, and the condition of the beneficiary would not allow

⁴⁹ AdvantEdge. Emergency Medicine/Ambulance Services- 2015 OIG Work Plan. Newsletter. [http://advantedgenewsletter.ahsrcm.com/2014/12/17/emergencymedicineaambualnce service](http://advantedgenewsletter.ahsrcm.com/2014/12/17/emergencymedicineaambualnce%20service). (last visited July 25, 2015)

⁵⁰ *Id.*

⁵¹ OFFICE OF THE INSPECTOR GENERAL, *Work Plan for Fiscal Year 2014*, at 15 (December 2013), <http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf>

⁵² AdvantEdge. Emergency Medicine/Ambulance Services- 2015 OIG Work Plan. Newsletter. [http://advantedgenewsletter.ahsrcm.com/2014/12/17/emergencymedicineaambualnce service](http://advantedgenewsletter.ahsrcm.com/2014/12/17/emergencymedicineaambualnce%20service). (Last visited July 25,2015)

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ DEPARTMENT OF HEALTH AND HUMAN SERVICES. *The Emergency Medical Services Authority of Oklahoma City billed and was paid for advanced life support transports that were not medically necessary*. OIG reports, (Nov, 12 2012) <https://oig.hhs.gov/oas/reports/region6/61100050.pdf>

⁵⁶ *Id.* at i

⁵⁷ *Id.* at ii

transportation by any other means.”⁵⁸ The medical necessity is measured on the beneficiary’s severity and acuteness of symptoms at the time of ambulance transport.⁵⁹ According to the audit, 10 percent of ALS emergency transports performed were incorrectly billed and EMSA failed to submit the required modifier for those transports, which did not meet the medical necessity guidelines causing the government to overpay the EMSA transport service 365,899 dollars.⁶⁰

The OIG’s audit resulted in the recommendation that EMSA of Oklahoma put a more effective compliance program into their business practices.⁶¹ They further recommended the compliance program implement more efficient billing policies in order to submit claims appropriately under the applicable service standards.⁶² EMS providers have to be responsible with their billing practices, “In the rush to meet budget deficits by billing Medicare and other third-party payers for ambulance service, many public officials are overlooking Medicare rules and regulations and the steep penalties (civil and criminal) they could face for violating these rules.”⁶³

Government EMS authorities are not the only emergency medical providers under the scrutiny of increased government oversight. In 2002, American Medical Response (AMR) a for-profit privately owned EMS transport service was audited by the OIG in regards to their billing practices.⁶⁴ During the audit, OIG found ambulance transports that were neither medically necessary nor failed to meet Medicare reimbursement guidelines and resulted in the “improper payment” of over 1,900,000 million dollars.⁶⁵ The audit concluded with the recommendation of AMR implementing a compliance program with effective policies for billing and coding.⁶⁶ In addition, AMR was required to enter into a three-year corporate integrity

⁵⁸ *Id.* at 1

⁵⁹ “Section 1861(s)(7) of the Social Security Act states that when other means of transport can be utilized without endangering the individual’s health (whether or not such other transportation is actually available), no payment may be made for ambulance service. Regulations (42 CFR § 410.40(d)) state that Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary’s condition must require both the ambulance transportation itself and the level of service provided for the billed service to be considered medically necessary. Failure to meet coverage requirements means that the beneficiary’s condition did not warrant transportation by ambulance; rather, the beneficiary could have safely been transported by other means, such as taxi, private car, wheelchair van, or other type of vehicle.” DEPARTMENT OF HEALTH AND HUMAN SERVICES, *The Emergency Medical Services Authority of Oklahoma City billed and was paid for advanced life support transports that were not medically necessary*, OIG reports at 3 (Nov 2012), <https://oig.hhs.gov/oas/reports/region6/61100050.pdf>

⁶⁰ DEPARTMENT OF HEALTH AND HUMAN SERVICES, *The Emergency Medical Services Authority of Oklahoma City billed and was paid for advanced life support transports that were not medically necessary*, OIG reports, at 3-4 (Nov 2012) <https://oig.hhs.gov/oas/reports/region6/61100050.pdf>

⁶¹ *Id.* at 3-4

⁶² *Id.* at 4

⁶³ Tim Timothy Simpson, *Development of an EMS billing/HIPAA Compliance and Operations Policy manual for the Clearcreek Fire District.* at 7 (April 2003)

<http://www.usfa.fema.gov/pdf/efop/efo35559.pdf> www.usfa.fema.gov/pdf/efop/efo35559.pdf

⁶⁴ DEPARTMENT OF HEALTH AND HUMAN SERVICES. *Review of ambulance services provided by American Medical Response of Massachusetts, Inc.* OIG Reports (April 2006), <https://oig.hhs.gov>

⁶⁵ *Id.* at i

⁶⁶ *Id.* at i

agreement with the OIG requiring an annual review of AMR's compliance programs and billing standards.⁶⁷

A major economic factor causing EMS to struggle in the current regulatory environment is the amount of reimbursement per ambulance transport, which makes sustainability questionable with the current business structure, and practices of EMS services.⁶⁸ CMS pays a base rate for BLS and ALS ambulance transport services.⁶⁹ According to a report published report by the Government Accountability Office in 2010, EMS transport providers found that reimbursement distribution was widely based on the volume of Medicare beneficiary transports, the level of acuity of the beneficiary at the time of transport, and the level of government subsidies received by the ambulance provider.⁷⁰ This wide reimbursement distribution causes a significant economic strain on the EMS transport provider.⁷¹

Widening the Gap

The Medicare Prescription Drug, Improvement, and Modernization Act allowed for a 1 to 3 percent increase for services provided.⁷² The billing add-ons for ambulance services allowed for an overall increase of payment made to EMS transport providers.⁷³ The add-ons were subject to expire on April 1, 2015, but saw an extension granted by the Senate extending the program through December 31, 2017.⁷⁴ Despite these measures, and in an attempt to provide some financial relief to EMS transport providers, the Medicaid expansion only widened the gap between private to public insurance and the increase of demand sought by all the newly insured Americans.⁷⁵

In California, legislation was passed to decrease Medi-Cal reimbursement for ambulance services up to 10 percent.⁷⁶ This change, coupled with the shift from private insurance to a government subsidized insurance plan, results in EMS

⁶⁷ *Id.* at ii

⁶⁸ Michael Hall, *Senate Passes 33-month Medicare Ambulance Relief Extension*, AAA Member Alert Bulletin (April 15, 2015), <http://enhancedms.com/enhance/news-from-enhanced/senate-passes-33-month-medicare-ambulance-relief-extension> (last visited May 15, 2015)

⁶⁹ Medicare allows for seven different levels of ambulance transports to be billed: BLS non-emergency transports and emergency transports, ALS Level 1 non-emergency transports and emergency transports, ALS Level 2 non-emergency transports, specialty care transports to include CCT, and paramedic non-transports with care. GOVERNMENT OF ACCOUNTABILITY, *Costs and Medicare Margins varied Widely; Transports of Beneficiaries Have Increased*, GOA Reports, at 7-8 (Oct 1, 2012), <http://www.gao.gov/products/GAO-13-6>

⁷⁰ GOVERNMENT OF ACCOUNTABILITY, *Costs and Medicare Margins varied Widely; Transports of Beneficiaries Have Increased*, GOA Reports (Oct 1, 2012) <http://www.gao.gov/products/GAO-13-6>

⁷¹ *Id.* 8-10

⁷² *Id.* at 9-10

⁷³ *Id.* at 9

⁷⁴ Michael Hall, *Senate Passes 33-month Medicare Ambulance Relief Extension*, AAA Member Alert Bulletin (April 15, 2015), <http://enhancedms.com/enhance/news-from-enhanced/senate-passes-33-month-medicare-ambulance-relief-extension> (last visited May 15, 2015)

⁷⁵ Teresa McAllion, *Ambulance Billing and Reimbursement Update*, Jems (June 2011) <http://www.jems.com/articles/2011/06/ambulance-billing-reimbursement-update> (last visited Feb 1, 2015)

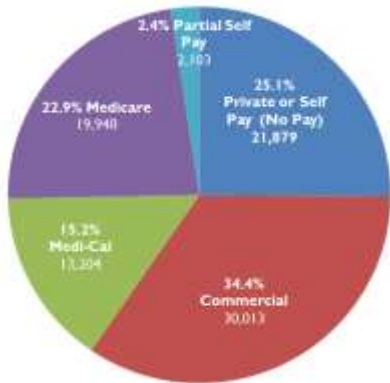
⁷⁶ *Id.*

transport providers struggling to find a solution that will enable them to continue to provide services.⁷⁷

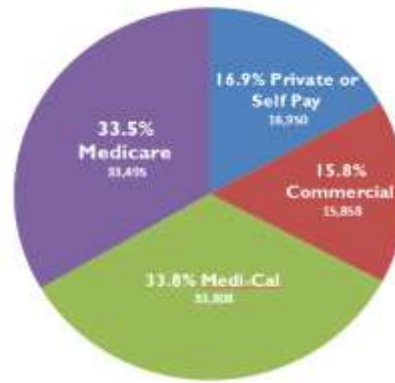
Why is the Revenue Decreasing?

In the San Francisco Bay Area, the shift from those covered by private insurance to those covered by a state Medi-Cal based program during the period from 2010 to 2014 changed dramatically.⁷⁸ The chart below compares 2008 with 2014 with the adjustment of the insurance coverage payer mix. The most significant shift is seen in the number of privately insured moving to the state funded program, Medi-Cal.

SF Bay Area Payer Mix: 2008 and 2014



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The average amount collected for Medicare transports equates to 412 dollars per transport in the San Francisco Bay Area with the average Medicaid transport collecting 146 dollars per transport.⁸¹ The shift equates to a decrease in the reimbursement rate, which also affects the overall profit margin for EMS transport providers.⁸²

Increased Cost of Business

Most EMS transport providers reported that the cost of doing business far exceeded the reimbursement standard received from CMS.⁸³ According to the GOA report, most providers surveyed report that over 60 percent of their business cost is invested in the licensed personnel providing the medical services. The chart below demonstrates the overall cost of providing ambulance transport services to the community.

⁷⁷ *Id.*

⁷⁸ Alex Briscoe, ALCO Public Health Director, Lecture Address at the EMSAAC, *Conference: EMS Financial Challenges- Do You Think You're Immune?* (May 26, 2015)

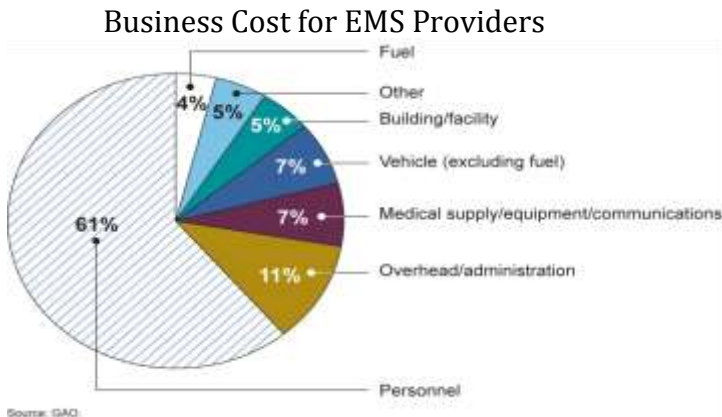
⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ GOVERNMENT OF ACCOUNTABILITY, *Costs and Medicare Margins varied Widely; Transports of Beneficiaries Have Increased*, GOA Reports at 15-16 (Oct 1, 2012), <https://gao.gov>



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Alternative Revenue for Ambulance Transport

Community based EMS programs

The increased regulation and federal oversight of EMS transport providers coupled with the increased demand resulted in a reexamination of the current reimbursement standards by CMS.⁸⁵ CMS has had tremendous success with increasing quality when they held hospitals accountable for illnesses acquired while Medicare beneficiaries were hospitalized.⁸⁶ The philosophy that better health outcomes result from better care and not more expensive care was derived from the “latest legislation passed with the ACA, the Institute for Healthcare Improvement’s Triple Aim Initiative, which suggests that it is possible to simultaneously improve the patient experience, reduce healthcare costs, and improve the population’s health.”⁸⁷

Under Triple Aim, healthcare will shift from a reactionary response to prevention and education.⁸⁸ By “reducing inefficiencies, coordinating services, and providing evidence-based, patient-centered care, costs can be reduced by eliminating redundancies and avoiding unnecessary tests, procedures, and other health care spending.”⁸⁹ In 2013, CMS announced a “1 billion dollar initiative to launch Health

⁸⁴ *Id.* at 16

⁸⁵ Jay Fitch, Steve Knight, *EMS in the Era of Health Care Reform*, PM Magazine (June 2015), http://icma.org/en/press/pm_magazine/article/105817

⁸⁶ Medicare Payment Advisory Commission. *Mandated Report: The Next Steps in Measuring Quality*. Report to Congress: Medicare and the Health Care delivery System, at xiv (June 2015), http://www.medpac.gov/documents/reports/jun13_entirereport.pdf

⁸⁷ Jay Fitch, Steve Knight, *EMS in the Era of Health Care Reform*, PM Magazine (June 2015), http://icma.org/en/press/pm_magazine/article/105817

⁸⁸ Joseph Fitch, et al., *The New EMS Imperative: Demonstrating Value*, 47 *In Focus*. 1, 5-6 (2015) discussing healthcare reform, <http://www.fitchassoc.com/wp-content/uploads/2012/12/ICMA-InFocus-Report-The-New-EMS-Imperative.pdf>

⁸⁹ *Id.* at 6

Care Innovation Awards to provide better health care and lower costs.”⁹⁰ The goal for the innovation awards is to “drive down health care costs while providing high quality of care.”⁹¹

One of the highest costs for Medicare is hospital re-admission, according to the Center for Healthcare Quality and Payment Reform Report of 2012. The center reported that nearly 25 percent of all hospital discharges would be readmitted within 30 days of the discharge date.⁹² CMS announced the implementation of “Section 3025 of the ACA, Section 3025 added section 1886(q) to the Social Security Act, which requires CMS to reduce payments to hospitals with excess readmissions.”⁹³ Furthermore, the Medicare Payment Advisory Committee recommended that Home Health Care Agencies become subject to re-admission penalties just as their hospital counterparts.⁹⁴ The increased oversight and penalty structure is causing many hospitals and Home Health care entities to look at different options, including partnering with EMS systems to change the type of service provided.⁹⁵ This partnership will move EMS from emergency service into home health, and will require a change in business practices to include compliance.⁹⁶ CMS is recognizing the need for an alternative direction, moving away from traditional methods of healthcare delivery.⁹⁷

In 2012, CMS awarded a 911-provider, Reno Emergency Medical Services Agency (REMSA) with a 9.9 million dollar grant under their Innovation Award program.⁹⁸ The program placed registered nurses in the dispatch center allowing for them to ascertain true medical emergencies from emergencies that do not require an emergency room visit.⁹⁹ The program allows paramedics to transport to alternative destinations other than emergency departments.¹⁰⁰ The program decreases overall healthcare costs by reducing the total number of emergency department visits by

⁹⁰ DEPARTMENT OF HEALTH AND HUMAN SERVICES, News for Immediate Release, (May 2013), <http://www.hhs.gov/news/press/2013pres/05/20130515a>

⁹¹ *Id.*

⁹² CENTER FOR HEALTHCARE QUALITY & QUALITY PAYMENT REFORM, Reducing Hospital Readmissions, <http://www.chqpr.org/readmissions.html> (last visited July 26, 2015)

⁹³ CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Readmission Reduction Program*, <http://www.cms.gov/medicare/medicaid/medicare-fee-for-service-payment-reduction>. (last visited on May 15, 2015)

⁹⁴ Meredith Anastasio, *Mobile Integrated Healthcare Part 4: Integrating Home Care, Hospice and EMS*, EMS World (Mar 29, 2015), <http://www.emsworld.com>

⁹⁵ *Id.*

⁹⁶ Patricia Barret, *Mobile Integrated Healthcare Part 5: Why should you Accredite your MIH-CP Program*, EMS World (May 1, 2015), <http://www.emsworld.com>

⁹⁷ CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Readmission reduction program*, <http://www.cms.gov/medicare/medicaid/medicare-fee-for-service-payment-reduction>. (last visited on May 15, 2015)

⁹⁸ Theresa McCallion, *MIH Summit Ponders Payer and Policy Issues*, EMS World (Apr 25, 2014), <http://www.EMSWorld.com/article/11423395>

⁹⁹ Joseph Fitch, et al., *The New EMS Imperative: Demonstrating Value*, 47 In Focus. 1, 9-10 (2015) discussing healthcare reform, <http://www.fitchassoc.com/wp-content/uploads/2012/12/ICMA-InFocus-Report-The-New-EMS-Imperative.pdf>

¹⁰⁰ *Id.* at 10-13

non-emergency patients.¹⁰¹ Another such program utilizes specially trained paramedics under the Mobile Integrated Health Care Program, EMS partnered with Home Health Care and Hospice in an attempt to cut emergency room visits for those patients whose illness can be controlled outside of the hospitals.¹⁰² The overall goal was to decrease the hospitals re-admission rates in an attempt to find an alternative revenue source for the EMS providers.¹⁰³

Currently, there is no payment structure for health care provided by paramedics outside of the ambulance transport.¹⁰⁴ The next reasonable step for the mobile integrated health care programs is to obtain accreditation. This will allow them to expand their revenue source and not be solely reliant upon grants and local government funding.¹⁰⁵ However, by obtaining accreditation it moves EMS systems into the Home Health Care realm and they will find themselves subject to the same standards under the guidelines of participation and payment as any other home health care entity for CMS reimbursement.¹⁰⁶ EMS leadership have yet to change their business practices to embrace compliance programs specific to the ambulance transport guidelines, by EMS moving into home health, the leadership needs to seriously change current business practices or they will find themselves subject to additional fines and enforcement actions.

Are the Emergency Medical Services Prepared for the Future?

In addition to looking at expanding the role of EMS systems, other solutions proposed is to change the current reimbursement standards.¹⁰⁷ Currently, EMS transport providers are subject to the fee-for-service model where the patient's acuity or medical necessity dictates the level of reimbursement provided by CMS.¹⁰⁸ However, this model can change to the model most hospital systems are now accountable to which is the fee-for-quality model.¹⁰⁹ This change in focus will affect EMS transport providers from measuring volume performance standards to quality of care performance standards.¹¹⁰ This movement will move the reimbursement from payment for transport to payment for quality service.¹¹¹ EMS transport providers continue to struggle to find solutions to the decreasing revenue all during a period in healthcare where request for services have sky-rocketed. Other solutions

¹⁰¹ *Id.* at 10-13

¹⁰² Meredith Anastasio, *Mobile Integrated Healthcare Part 4: Integrating Home Care, Hospice and EMS*, EMS World (Mar 29, 2015), <http://www.emsworld.com>

¹⁰³ *Id.*

¹⁰⁴ Kenneth kizer, et al, *Community Paramedicine: A promising Model for Integrating Emergency and Primary Care*, Institute for population health and improvement, UC Davis. July 2013.

¹⁰⁵ Patricia Barret, *Mobile Integrated Healthcare Part 5: Why should you Accredite your MIH-CP Program*, EMS World (May 1, 2015), <http://www.emsworld.com>

¹⁰⁶ *Id.*

¹⁰⁷ Jay Fitch, Steve Knight, *EMS in the Era of Health Care Reform*, PM Magazine (June 2015), http://icma.org/en/press/pm_magazine/article/105817

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ GOVERNMENT OF ACCOUNTABILITY, *Costs and Medicare Margins varied Widely; Transports of Beneficiaries Have Increased*, GOA Reports (Oct 1, 2012), <https://gao.gov>

are being directed by one of the biggest private EMS transport provider, AMR, recently the company doubled their overall footprint in order to guarantee their survival by their purchasing of Rural Metro Inc.

Ambulance Providers: Is there Power in Numbers?

As of June 2015, AMR entered into an acquisition agreement to buy Rural Metro Corporation.¹¹² Rural Metro was one of the largest emergency and non-emergency ambulance transports in the United States. Their operations are located in 21 states and are responsible for almost 700 communities and EOA areas for local state governments.¹¹³ This purchase is subject to review from the U.S. Securities and Exchange Commission, and “is expected to close in the fourth quarter of 2015.”¹¹⁴ This transaction is a product of the current economic environment that allows AMR to have a larger footprint resulting in less competition and a bigger piece of the market share. Rural Metro is estimated to generate over 600 million dollars in revenue, according to the president and chief executive officer of AMR, “This acquisition will broaden our ability to partner with the fire departments and local government leadership to build increasingly better community health models.”¹¹⁵

Private-Public Partnership: An Alternative Revenue Stream

The private-public partnership could be the next chapter for EMS transport providers. The public-private partnership allows for the private ambulance transport providers to partner with public entities in order for the privately owned companies to become qualified for a federal and state funding mechanism known as the Ground Emergency Medical Transport (GEMT) Supplemental Reimbursement.¹¹⁶ The GEMT allows for ambulance transport providers to receive additional funds from the Medicaid program to balance the cost of providing emergency transport services to Medicaid recipients.¹¹⁷ This type of partnership, just as in any EMS transport business model, requires the implementation of a successful compliance program to assure adherence to the additional regulatory guidelines for participation in the GEMT program.¹¹⁸

The Solution: Accountable and Effective Compliance Programs

A Transformation is Necessary

EMS transport providers will need to modify current business practices while finding a more efficient way to deliver service without decreasing quality of service. The change in business practices needs to start with accountability of EMS business

¹¹² Business Wire, *Envision Healthcare Enters Definitive Agreement to Acquire Rural/Metro*, (July 2015), <http://www.evhc.com>

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, *Medi-Cal Ground Emergency Medical Transport Supplemental Reimbursement*, <http://www.dhcs.ca.gov/provgovpart/Pages/GEMT.aspx>

¹¹⁷ *Id.*

¹¹⁸ *Id.*

to CMS reimbursement guidelines.¹¹⁹ The first step is for ambulance providers to establish an effective compliance program by placing key personnel in positions that have a direct relationship with the leadership of their agencies.¹²⁰

Initial Step: An Effective Compliance Program

The OIG recommends seven components to an effective compliance program for the EMS transport providers.¹²¹ These seven components include:

- Policies and procedures
- A designation of a compliance officer who has knowledge of laws and regulations and who can report to the business leadership
- Education programs
- Internal auditing and monitoring programs
- Procedures in place for enforcement of breaches or violation of policy
- A communication program to allow for self disclosures or reports of possible fraud or violations
- Mechanism for investigating and evaluating.¹²²

The presence of a compliance program substantiates the EMS provider took appropriate measures to detect, prevent, and correct any improper or ethical fraudulent billing practices.¹²³

These recommendations are merely voluntary for providers to put compliance programs in place.¹²⁴ “This voluntary compliance program guidance should assist ambulance suppliers and other health care providers in developing their own strategies for complying with federal health care program requirements,”¹²⁵ and the presence of an effective compliance program provides “relief for any criminal conviction.”¹²⁶ The Sentencing Commission utilizes the presence of an effective compliance program to estimate the “culpability score by calculating aggravating and mitigating factors.”¹²⁷ Culpability scores can be lowered as much as 60 percent, however, not having any compliance measures in effect adds

¹¹⁹ DEPARTMENT OF HEALTH AND HUMAN SERVICES. *OIG Compliance Program Guidance for Ambulance Providers*. <http://oig.hhs.gov/>

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ John Outlaw, *The Case for Compliance: Why you need an effective compliance program*. Management of Pathology Practices, (Feb 2007)

<http://www.pathologyoutlines.com/management/psa200702.html>

¹²⁴ DEPARTMENT OF HEALTH AND HUMAN SERVICES, *OIG Compliance Program Guidance for Ambulance Providers*, <http://oig.hhs.gov/> (last visited May 30, 2015)

¹²⁵ *Id.*

¹²⁶ United States Sentencing Commission. Part B - Remediating harm from criminal conduct, and effective compliance and ethics program. Chapter 8: Sentencing of Organizations <http://www.ussc.gov/guidelines-manual/2011/2011-8b21>

¹²⁷ John Outlaw, *The Case for Compliance: Why you need an effective compliance program*. Management of Pathology Practices, (Feb 2007)

<http://www.pathologyoutlines.com/management/psa200702.html>

to the culpability score for the leaders and the organization.¹²⁸

Final Step: Accountability in Leadership

Therefore, the leadership of EMS providers need to realize that by implementing an effective compliance program to their daily business practices with hiring qualified personnel from outside the department rather than from promoting within, they will be more liable to discover improper billing practices and less likely to pay large fines and penalties.¹²⁹

Additionally, EMS transport providers will be more prepared for future changes in CMS reimbursement standards and move from a fee-for-service model to a quality-for-fee model. EMS transport providers will be more equipped for an efficient transition to the world of home health care by implementing an effective compliance program encompassing all business practices; including, their movement into community based health programs.

¹²⁸ *Id.*

¹²⁹ *Id.*