

The Effect of the Affordable Care Act on EMS

The Effect of the Patient Protection and Affordable Care Act

On Emergency Medical Services Reimbursement

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**Certification Statement**

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Signed: \_\_\_\_\_

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## **Abstract**

The problem is the impact of the Affordable Care Act (ACA) has not been identified for the emergency medical services (EMS). It is uncertain how the ACA will affect reimbursement practices for EMS agencies and the services they provide. Many EMS agencies will have to adapt to these changes by developing new ways of delivering service. The purpose of this ARP is to identify the potential impact of the Affordable Care Act on Emergency Medical Services. A descriptive research method will be used to answer four research questions. The questions answered (a) were what are the potential revenue losses to hospitals for readmissions under the Affordable Care Act, (b) what are the potential revenue losses to EMS for hospital readmission, (c) how can the hospitals help fund a Mobile Integrated Healthcare Program and (d) what revenue sources could be available to help offset the impact of the Affordable Care Act? The literature review revealed information about penalties hospitals will experience that could affect EMS agencies due to readmission rules in the Affordable Care Act. The literature review and meetings attended also revealed new programs and funding sources EMS agencies can use to offset losses due to changes in Medicare, Medicaid and private insurance funding. The results of the ARP showed that the information on how the ACA is going to affect EMS is speculative. The final outcome of this applied research project is to begin the process of developing a partnership between local hospitals and EMS agencies. This partnership will focus mainly on developing a workable Mobile Integrated Healthcare program that will save both the hospital and EMS agency from losing revenue due to 30 day readmissions of high risk medical patients. Mobile Integrated Healthcare Program will also allow EMS agencies to develop new revenue streams to fund their services.

## **Introduction**

On January 5<sup>th</sup>, 2010 the United States Congress passed the Patient Protection and Affordable Care Act (ACA). This sweeping legislation was intended to bring sweeping changes and help overhaul the healthcare system in America to make healthcare more affordable and available to all Americans. Even though the changes may potentially benefit patients through increased access to health insurance coverage, better primary care coverage and accountability in healthcare there are unanswered questions concerning other provisions within the Affordable Care Act. One of the concerns is the role of emergency medical services (EMS) within the American healthcare system. One role that EMS could fill is to help reduce 30 day readmission rates in hospitals through the use of mobile Integrated Healthcare Programs.

The problem is the financial impact of the Affordable Care Act has not been identified for EMS. The Affordable Care Act and insurance reimbursement practices to hospitals and EMS agencies will have to be researched to ascertain the exact role EMS will potentially have in the future of healthcare. Trends in ambulance reimbursements will also have to be watched in order see how EMS agencies are affected by the changes made to insurance under the ACA.

The purpose of the study is to identify the potential impact of the Affordable Care Act on Emergency Medical Services particularly in the State of Wisconsin. This applied research project will look in to how the ACA is defining the role of EMS in healthcare as well as revenue gains, losses and alternative programs that could be developed to help EMS thrive in the changed healthcare system.

This applied research project will utilize a descriptive research method that will be used to answer four research questions: What are the potential revenue losses to hospitals for readmissions under the Affordable Care Act? What are the potential revenue losses to EMS for hospital readmission? How can the hospitals help fund a Mobile Integrated Healthcare Program? What revenue sources could be available to help offset the impact of the Affordable Care Act?

### **Background and Significance**

In 2010 the United States Congress passed the Patient Protection and Affordable Care Act (PPACA) which was intended to bring sweeping changes to the United States' healthcare system (Congress, 2010). Of the changes that the PPACA made to healthcare laws in the United States, changes to reimbursement for readmissions of patients within thirty days of discharge are of concern to EMS agencies. Most of the questions from EMS are whether ambulance services will be penalized under the thirty day readmission rule and will payments to ambulance services decrease due to changes in reimbursement. Emergency medical services may have to change the way services are provided in order to adapt to the changes under the ACA.

According to the ACA, grant funding has been made available to EMS services that show a regionalized approach in providing emergency care services (p.401). In section 1204 of the ACA it states that there will be no fewer than four of the grants available to emergency medical services (p.400). Few grants have actually been awarded to emergency medical services since 2010 which is concerning to EMS providers (Munjal & Carr, 2013). The current Medicare reimbursement practices are solely a fee-for-service model which states that ambulance services

will not be reimbursed unless the patient is transported to an emergency room for further evaluation (Munjaj & Carr, 2013).

The City of Beloit Fire Department serves a population of 40,000 people in an urban and rural area. Four ambulances provide service to the community with two of the ambulances being reserve status. In 2013 the EMS division responded to 3726 calls for service (BFD, 2013). A total of 2986 patients were transported to area hospitals or transferred to regional facilities through the department's interfacility transfer program (BFD, 2013). In 2013 there were over 600 no-transportations with 50 of those being requiring treatment and release. The City of Beloit itself has a larger than average lower income population.

The problem is that emergency medical services have very limited information on how they will be affected by the changes made in the Affordable Care Act. The changes brought about may or may not affect revenue sources of EMS agencies because of the possibility of reduced reimbursement. These reductions in reimbursements could force EMS services to partner with their area healthcare providers under an Accountable Care Organization or require EMS agencies to bill healthcare providers under a Bundled Payment System (Zavadsky & Hooten, 2014). If an EMS agency is required to become a member of an ACO in order to receive full reimbursement they would be subject to showing value in the service they provide to the people of their community (Zavadsky & Hooten, 2014). These changes may or may not affect the care that is provided by EMS agencies to the citizens they serve.

This applied research project will address one of the objectives listed in the Executive Analysis of Community Risk student manual which is "Identify potential challenges to reducing community risk" (DHS, 2013). The risk that will be identified is the potential impact of the ACA

on emergency medical services and how it may affect or benefit the individual EMS agencies. This ARP will utilize a descriptive research method that will be used to describe what is known, perceived and unknown about the Affordable Care Act. This information will then be used to determine if a Mobile Integrated Healthcare/Community Health Paramedic Program would be beneficial to the author's department.

This ARP relates to one of the United States Fire Administration Operational Objectives, which is, "improve the fire and emergency services' professional status" (DHS, 2013). This ARP will improve the professional status of the fire service by describing how fire based EMS services can counteract the potential losses of the ACA by developing alternative programs aimed at reducing multiple transports for the same patient. These transports are the source of possible revenue reduction for hospitals as well as EMS services.

Research for this ARP will include a literature review of the Patient Protection and Affordable Care Act as well as associated articles and journals with information on how the ACA may affect EMS. A meeting with Pat Mannix from Andres Medical Billing will also be attended to discuss possible trends in EMS billing services. The discussion will also include what EMS agencies are seeing related to the ACA and ambulance service reimbursement. The author is also planning to meet with a regional Accountable Care Organization (ACO) representative to gain more information on how an ACO would benefit the development of a Mobile Integrated Healthcare program. A search of CMS rules and regulations that pertain to ambulance transport will be conducted. Alternative means of revenue sources will be researched as part of this ARP which could be used to help develop and permanently fund a Mobile Integrated Healthcare program.

The end result of this ARP is to begin the process of developing a partnership between local hospitals and EMS agencies. This partnership will focus mainly on developing a workable Mobile Integrated Healthcare system that will save both the hospital and EMS agency from losing revenue due to 30 day readmissions of high risk medical patients.

### **Literature Review**

#### **Question 1 – What are the possible revenue losses to hospitals for readmissions under the Affordable Care Act?**

In an attempt to provide better healthcare to the citizens of the United States and reduce the cost of healthcare the Patient Protection and Affordable Care Act was created. The healthcare funding reforms are focused primarily on reducing payments to hospitals that have higher than average readmission rates. Hospital readmissions have become a focus because of increased healthcare costs which may or may not be directly linked to the quality of care from a hospital (MedPAC, 2007). The 2007 Medicare Payment Advisory Commission (MEDPac) report to congress can be seen as the driving force behind the Affordable Care Act. Many of the recommendations from the report were placed in the ACA including penalties for excessive hospital readmissions (MedPAC, 2007).

Hospitals will be penalized a percentage of their Medicare and Medicaid reimbursements if they are deemed to be a facility that has excessive readmissions of a defined class of patients (Congress, 2010). The reduction in payment is based on the specific medical condition a patient is being treated for as well as the time frame of when a patient is readmitted to the hospital for treatment of the same condition (Congress, 2010). The ACA (2010), section 3025, defines a readmission as;

*Readmission means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.*

The ACA uses a readmission time definition of 30 days as the time period in which hospitals will be penalized for what is perceived as sub-standard health care (Congress, 2010). The readmission penalty is not applicable to all medical conditions but just those that are deemed to be in the high-risk category (JCREC, 2010).

Under the Hospital Readmission Reduction Program in section 3025 of the ACA (p.290) the federal government will reduce payments to hospitals starting in October of 2012 for patients who have high rates of readmissions for applicable conditions. The applicable conditions were defined in 2012 as AMI (Acute Myocardial Infarction), Heart Failure and Pneumonia (AAMC, 2014). In 2015 this list has been expanded to COPD, CABG, PTCA and other vascular conditions as defined by the June 2007 MedPac report (MedPAC, 2007). These listed conditions are considered to be high-risk conditions and are the primary cause of frequent hospital readmissions.

What hospitals will lose in revenues under section 3025 in the ACA is significant. The revenue lost would include Diagnosis Related Group Payment (DRG) payments, the adjustment factor for the hospital fiscal year and the floor adjustment factor (Congress 2010 p.291-293).

These revenue losses could be a portion or the entire cost of the patient's stay in the hospital during their readmission. Most hospitals operate on a 2-3% profit margin according to Zavadsky and Hooten (2014). Currently the excessive readmission penalty is set at 3% (Zavadsky & Hooten, 2014). A hospital could be penalized anywhere from 0-3% depending on the number of readmissions they have.

The ACA is vague when describing the exact quantity of readmissions that would constitute being excessive and only states that many of these decisions are left to the Secretary (Congress, 2010). Further research of available literature shows that CMS considers excessive readmissions to be the current national average which is 20% of patients discharged (CMS, Readmissions Reduction Program, 2014). The ACA does not describe how section 3025 (4)(C)(ii) (p.292) covers some conditions which are excluded from the excessive readmission rule. Under this section the ACA states that "excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary)"... there is no specific number that constitutes how many readmissions are excessive in the "other" medical condition category (Congress, 2010 p. 292).

A review of the author's local hospital's 2013 discharge rate revealed that 3995 patients were discharged from the hospital (BMH, 2014). This number included patients who died in the hospital. The Wisconsin Department of Health Services states that the average death rate in the state is 8.7% (DHS, Wisconsin Death Rates 2012). This left approximately 3647 patients who were discharged alive from Beloit Memorial Hospital in 2012. Research of the excessive readmission rate revealed that the current national 30 day inpatient readmission rate was 20% in 2012 (CMS, Readmissions Reduction Program, 2014). The average admission cost of a patient who falls under the high-risk medical condition category would be approximately \$20,000

(Zavadsky & Hooten, 2014). In 2013 the Medicare and Medicaid payer mix in the author's community was 48% combined (BFD, 2013).

Additional revenue loss that hospitals and healthcare providers could suffer is a loss of revenue from poor patient satisfaction ratings. The ACA provides for a 30% bonus or penalties based on these ratings (Zavadsky & Hooten, 2014). Hospitals could see similar penalties due to long ER wait times which in turn will directly affect their reimbursement (Zavadsky & Hooten, 2014). Hospitals and healthcare providers must also demonstrate quality care according to standards set forth by CMS (Zavadsky & Hooten, 2014). Any hospitals and healthcare providers that fall below these standards will be penalized and lose reimbursement.

## **Question 2- What are the potential revenue losses to EMS for a hospital readmission?**

Even though hospitals will suffer the largest losses due to changes in the ACA, EMS agencies may see losses due to changes in Medicare, Medicaid and private insurance reimbursements. During a 2013 presentation at the Congressional Fire Institute meeting one speaker stated that federal officials "don't see EMS and part of the healthcare system" (Nicol, 2013). This perception holds true in the Affordable Care Act with very little mention of emergency medical services. The literature research was unclear if EMS will be affected by readmissions or in changes to healthcare systems in general. In section 1204(b)(3) emergency medical services is mentioned under a grant program to provide "regionalized, comprehensive, and accountable emergency care and trauma systems" (p.400). This is a matching grant where services will have to fund \$1 for every \$3 they are given through the federal government (Congress, 2010 p.410).

The current practice for EMS billing is a fee-for-service model which incorporates EMS agencies not being able to collect payment from insurance companies unless the patient is transported to the ER (Patterson & Skillman, 2012). This fee-for-service model requires EMS services transport patients who may not need to be transported to the ER in order to receive payment. The downstream effect of the transport means that the patient or the insurance company is billed and additional ER fee (Zavadsky & Hooten, 2014). In 2012 the Government Accountability Office listed the average cost for ambulance transport in urban areas was between \$374 and \$410 (GAO, 2012). The average cost was based on the level of service provided (GAO, 2012). During a meeting with Pat Mannix from Andres Medical billing he stated that the Beloit Fire Department's average reimbursement from Medicare was \$382 and Medicaid paid an average of \$198 (Mannix, 2014). There was also discussion during the interview that if EMS is penalized under the Readmissions Reduction Program he believed that agencies could see a possible 10% reduction in revenue (Mannix, 2014). If this amount of revenue is lost EMS agencies would have to cut staffing or close down.

An area of concern for EMS providers could be insurance deductibles and co-pays which would be required under the health insurance exchanges. A search of health insurance plans in the author's local area revealed plans with premiums starting at about \$550/month for Bronze level plans and over \$1600 a month for the Platinum level plans (getinsured.com, 2014). The criterion for family coverage used was a family of three (two adults and one child) which is the average family size for the author's city according to the 2012 census statistics (Bureau, 2012). Deductibles ranged from no-deductible to a \$12,000 deductible (getinsured.com, 2014). A further search of how ambulance transport is covered under some of the plans shows that all are subject to the deductible as well as up to a 50% coinsurance payment for the ambulance transport

(getinsured.com, 2014). High deductibles and coinsurance payments could possibly cause a reduction in revenues for EMS due to lack of affordability and adding to high rates of patients being moved to a collections status.

Accountable Care Organizations (ACO) could force EMS agencies to join. Joining an ACO may be a benefit or detriment to revenue. The loss or gains would depend on the contracts that EMS agencies negotiate with other healthcare partners. The ACA defines the Accountable Care Organization (ACO) as a “group of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization” (Congress, 2010). The ACO is made up of groups of doctors, hospitals and other healthcare providers whose intent is to provide high-quality care to its patients (Ambulance Billing Services, 2013). These groups would be tied to evaluating reimbursements to healthcare providers based on quality of care to its patients (Ambulance Billing Services, 2013). They will be able to reduce or deny reimbursement based on the quality of care provided (Ludwig, 2013). The ACO’s could contract with Medicare as the monitoring group for cost, quality, care and management of large groups of Medicare beneficiaries under the Medicare Shared Savings Program (Ambulance Billing Services, 2013).

During a meeting on December 4, 2014 the author conducted with Andres Medical Billing CEO Pat Mannix, the issue of bundled payment systems was addressed and how EMS could possibly lose revenue. Under the ACA a bundled payment system is defined as a system where healthcare systems will receive a lump sum payment for the care of a patient (Congress, 2010). Other providers who are directly involved in patient care would then have to bill the primary healthcare system for payment (Zavadsky & Hooten, 2014). The healthcare system in charge of distributing payments to all of the providers would then determine if the care met

established standards and could either give the providers either a bonus or assess a penalty (Zavadsky & Hooten, 2014). Mr. Mannix felt this was a very subjective way of paying providers because the healthcare systems could establish their own patient outcome standards that were not in line with current EMS practices (Mannix, 2014). He also stated that he believed that this was the eventual route healthcare reimbursement was going to go (Mannix, 2014).

EMS providers may see a loss in revenue as people are switched from Medicare to the Healthcare Exchange Insurance Programs or Medicaid depending on their current insurance status. Patients who have no insurance or are underinsured will be placed on Medicaid which may give them a new perception on how to access healthcare through the inappropriate use of EMS providers and the local emergency room (Ambulance Billing Services, 2013). EMS providers will then be reimbursed at the lower Medicaid rate but will have a higher demand placed on their services which will not cover their operational costs (Ambulance Billing Services, 2013). The lower Medicaid reimbursement will force a loss of revenue on EMS providers who operate in areas with a higher than average entitlement program population.

### **Question 3 – How can the hospitals help fund a Mobile Integrated Healthcare Program?**

Healthcare systems stand to lose millions of dollars in reimbursements due to the Hospital Readmission Reduction Program mentioned in the ACA. Hospitals have the opportunity to partner with local EMS to provide care to high-risk patients once they have been discharged from the hospital. These patients would be cared for under the EMS agencies Mobile Integrated Healthcare (MIH) program. The MIH program will require EMS agencies to alter the way

service is provided to the population they serve and transition to the new MIH system (Goodwin, 2013). Goodwin (2013) goes on to further suggest that by preventing readmissions hospitals could save millions of dollars in losses for healthcare providers and provide a new funding stream for EMS agencies.

The funding for the MIH programs would come from the money that EMS agencies save hospitals through prevention services by keeping high-risk patients from being readmitted within the 30 day penalty time period (Ambulance Billing Services, 2013). Services provided by EMS agencies would include post-discharge follow-up, medication reconciliation, ensuring that the patient is following all discharge orders, and fall prevention programs are services EMS is capable of providing (Ambulance Billing Services, 2013). If the hospital is part of an Accountable Care Organization that hospital would be reimbursed by the ACO for providing quality care to a patient, preventing a readmission within 30 days of patient discharge (Ambulance Billing Services, 2013). A portion of the savings would be used to reimburse the EMS agency for their services. This funding mechanism would allow EMS agencies to continue to provide alternative means of care to patients who are considered to be at high-risk for readmission as well as save healthcare systems from being penalized for excessive patient readmission.

A Cost Avoidance Program would be utilized to address concerns with “super users” or patients who use the emergency room as a means of primary care (Zavadsky & Hooten, 2014). These patients are normally low acuity patients who are covered under Medicaid, Medicare or have no insurance (Zavadsky & Hooten, 2014). EMS agencies would be paid to intercept these patients and address their medical concerns as well as treat underlying issues or re-direct the patient to a more appropriate care facility (Zavadsky & Hooten, 2014). The down side to this

form of funding is that in order for a savings to be realized cuts to ambulance staffing may be needed due to a reduction in call volume (Zavadsky & Hooten, 2014).

Zavadsky and Hooten (2014) discuss that EMS could also assist hospitals in avoiding loss of revenue by increasing patient satisfaction. They state that EMS agencies could play a pivotal role with increasing patient satisfaction by ensuring that the experience patients have with EMS personnel is a positive one (Zavadsky & Hooten, 2014). The positive contact provided by EMS personnel will set the tone for positive contact in the receiving hospital therefore giving them a higher satisfaction score.

Patients who are determined to be low-acuity could be seen and treated in the home by an EMS crew instead of having to wait in the ER for hours (Zavadsky & Hooten, 2014). Not having to wait hours for care could then translate to a more positive experience for the patient (Zavadsky & Hooten, 2014). Hospitals would receive bonuses from Medicare because of higher patient satisfactions scores. A percentage of the bonuses could be distributed to the EMS agency to help fund a MIH program (Zavadsky & Hooten, 2014). Many of these funding mechanisms would depend on the hospital or healthcare provider's willingness to pay EMS agencies to do this type of work rather than hire their own personnel.

**Question 4 - What revenue sources could be available to help offset the impact of the Affordable Care Act on EMS agencies?**

EMS agencies will have to find alternative and sustainable sources of funding for services provided in order to offset potential losses due to the changes in healthcare funding. Current reimbursement practices for EMS agencies are based on a fee-for-service model (Munjaj

& Carr, 2013). This means that EMS agencies are incentivized to transport patients to the local ED in order to be reimbursed by Medicare and Medicaid (Munjal & Carr, 2013). The most sustainable form of funding for EMS would be changes in Medicare and Medicaid reimbursement rules to allow for Mobile integrated Healthcare billing as well as treatment and non-conveyance reimbursement (Munjal & Carr, 2013).

On December 18, 2014 the author conducted a meeting with the Deej Lundgren who is the senior legislative liaison for Governor Scott Walker. The meeting was conducted at the Wisconsin state Capitol in the Governor's office. During the meeting information was presented to Mr. Lundgren about how a state funded MIH program could save the Medicaid System of Wisconsin money by altering the way patients are assessed, treated and released or navigated to a clinic or physician office (Appendix B). A letter was also left with Mr. Lundgren to give to Governor Walker that described the MIH program (Appendix C).

A review of non-conveyance calls in the City of Beloit revealed that there were 585 no-transport calls in 2013 (BFD, 2013). These calls are not considered to be reimbursable under Medicare and Medicaid rules unless the patient signs a waiver stating that they are willing to pay the no-transport fee. The patient is billed \$310 only if the criteria are met that the ambulance is on scene longer than 20 minutes and care is provided to the patient (BFD, 2013). Fifty-two additional patients were treated and released by EMS crews in the City of Beloit. Current Medicare and Medicaid rules state that this is a service that cannot be billed for (Mannix, 2014). The only treatment and no-transport service that is currently billable to Medicare and Medicaid is a cardiac arrest where the patient is treated and pronounced in the field (Wisconsin Physicians Service Insurance, 2014). Medicare and Medicaid do have a billing code (AO998) which is not currently funded but does not allow for EMS services to bill for treatment and no-transport

(Wisconsin Physicians Service Insurance, 2014). This was confirmed in the interview with Pat Mannix. EMS services could use this information to their advantage to show CMS and hospitals that millions of dollars could be saved if patients can be treated at home and billed appropriately.

The ACA recommends EMS agencies look in to value-based patient care options as well as partnerships with other healthcare providers in order to help Medicare and Medicaid save money (Congress, 2010). EMS agencies need to look at alternative means of funding and providing care they could show a value based service that meets the Institute for Healthcare Improvement's Triple Aim of;

- Improve patient experience
- Improve the health of the population
- Reduce per capita cost of healthcare

As previously mentioned, billing local healthcare providers for Mobile Integrated Healthcare services is one funding source to help offset potential impacts of the ACA. Sponsorship Funding would include Patient Contact Fees that would be billed directly to the referring partner (Zavadsky & Hooten, 2014). A fee for services charged to a hospital under the ACA's Readmission Reduction Program would be one example of a Sponsorship Fee (Zavadsky & Hooten, 2014). The EMS agency's MIH program would conduct home health visits in an attempt to limit patient readmissions.

A second example of a Sponsorship Fee would include a percentage of bonuses hospitals receive based on increased patient satisfaction rates (Zavadsky & Hooten, 2014). An EMS agency could use its MIH program to help the hospital improve patient satisfaction by helping low-acuity patients navigate through the healthcare system (Zavadsky & Hooten, 2014). Helping

navigate these low-acuity patients would improve their overall experience and improve patient satisfaction. The fee would be a percentage of the bonus that the hospital received for improved patient satisfaction under the IHI Triple Aim (Zavadsky & Hooten, 2014).

Referral fees would be paid to EMS agencies for care provided to patients who are listed in the high-risk medical condition category mentioned in the ACA. EMS agencies would be paid to not only prevent patient readmission to the hospital but also to improve the patients overall health (Zavadsky & Hooten, 2014). Program objectives would be agreed upon by the agencies involved and if they are met the EMS agency would receive a bonus payment for keeping the patients healthy and out of the hospital (Zavadsky & Hooten, 2014). This form of reimbursement to EMS agencies could also work for patients who need to be observed for a longer period of time but do not meet criteria for being admitted to the hospital (Zavadsky & Hooten, 2014).

A final sustainable funding source that EMS agencies could implement is a subscription service. Patients with newborn children would pay an annual fee for a predetermined number of visits by the EMS agency (Zavadsky & Hooten, 2014). This would be for low-acuity assessment visits and access to an on-call nurse. Limits would have to be set as to the maximum number of visits each year (Zavadsky & Hooten, 2014). This service could also be implemented for the elderly population in the community who do not have relatives close by.

In order for services to offset the possible losses from the ACA they will have to become creative in the way that their agencies bill for services. Being able to charge for user fees as well as allowing EMS agencies to provide an expanded service model will allow for better care of the general population allowing Medicare and Medicaid programs to save money.

## **Procedures**

A descriptive research method was used to determine the impact of the Patient Protection and Affordable Care Act to EMS operations. The findings of this project will be archived as a reference for the later development of a Mobile Integrated Healthcare Program for the City of Beloit Fire Department. Information from the research project will be used to present to lawmakers in the State of Wisconsin and local Accountable Care Organizations to show how a MIH program would save the state and local hospitals money. The information from this ARP will describe how the ACO's or State of Wisconsin can help fund a MIH program.

To answer the first question of what revenue losses hospitals will see from excessive readmissions a literature review was conducted of materials related to the ACA and readmission penalties. A search for information from the Center for Medicare and Medicaid Studies was also conducted to see if any additional information could be obtained on readmission penalties. An internet search was conducted for articles that pertained to the first research question. All of the sites and articles used were from professional organizations that are considered stakeholders in the healthcare system. All periodicals were examined for appropriateness to the subject matter as well as to make sure that they were written and published no more than 5 years ago.

Sections from the PPACA were reviewed to see what may or may not pertain to the first research question in the ARP. Sections that were included in the review included sections 3022, 3024 and 3025. All three of these sections addressed the issue of hospital readmissions and reduction in payment to healthcare providers for what were deemed to be "excessive readmissions" (Congress, 2010). These sections were also reviewed for information that pertained to how hospitals and other healthcare providers may be affected by penalties and

bonuses as related to patient satisfaction scores and alternative care programs. A book about Mobile Integrated Healthcare was reviewed for appropriateness to the first research question. Much of the information contained in the book related to how hospitals are losing money by funding changes brought about by the ACA (Zavadsky & Hooten, 2014).

A review of the Association of American Medical Colleges website showed what the PPACA defines high-risk conditions as. The importance of this information is hospitals lose money because of excessive readmissions then EMS may be directly affected through a reduction of support in educational programs, medical control costs, equipment donation, increases in cooperative purchases of medical equipment and possibly loss of revenue reimbursement to EMS agencies if they have to become part of an ACO with the local healthcare facility.

In order to obtain more information on how a healthcare system ACO works a meeting was conducted with the ACO manager, of Mercy Health System. The meeting did not yield any new information as it pertained to the first research question. A search of patient discharges was conducted with Beloit Memorial Hospital to obtain the number of discharges described in the literature review for the first research question. Beloit Memorial does not have an ACO at the time this ARP was written so there was no meeting scheduled with them.

When answering the second research question concerning the loss of revenue to EMS services under the PPACA the law was reviewed for sections that pertained to EMS system reimbursement. Much less information was found with only two sections of the ACA pertaining directly to EMS. Internet sources were queried for on-line articles, and papers that pertained to the second research topic. All internet sources were reviewed for accuracy and that they

pertained to the subject of the second research question. The sources were also reviewed to ensure that they were no older than five years. A couple of sources did contain information that was older than 5 years but was still used due no other current information related to that subject. A book on Mobile Integrated Healthcare was purchased and reviewed because of information pertinent to the research second research question.

There was a limitation in the information on how the ACA will affect EMS reimbursement. Most of the articles found had speculative information and were based only on what the author's think may happen with EMS reimbursement. The belief amongst many of the authors was that there was no real concrete proof on EMS reimbursement reductions due to the ACA. The articles and papers found stated that the true effects of the ACA would not be seen for at least two years by EMS agencies.

To find out more information on how EMS agencies will be affected financially by the ACA a meeting with Pat Mannix from Andres Medical Billing was conducted. The objective of the meeting was to discuss the current billing practices of the BFD and how they may be affected by the ACA. The meeting with Pat Mannix from Andres Medical Billing was on December 4, 2014 at Beloit Fire Department Headquarters (Appendix A). Pat was chosen because of his knowledge on how the ACA will potentially affect the EMS division of the Beloit Fire Department. Andres Medical Billing is the billing service that the BFD uses to collect user fees from all patients who are transported by ambulance within the City of Beloit. The interview provided information on how the author's department may be directly affected by reduction in payments because of higher insurance deductibles from insurance exchanges. Information was confirmed with a search on health insurance policies through a State of Wisconsin insurance exchange ([getinsured.com](http://getinsured.com), 2014).

The search of Wisconsin health insurance plans showed that there was a wide variety of plans for people to choose from. Most all of the plans examined showed they had deductibles ranging from \$1500 to \$12,000 (getinsured.com, 2014). All plans listed that ambulance transports were subject to deductibles and co-pays before the insurance plan begins to pay for services (getinsured.com, 2014).

When answering the third research question concerning how hospitals can help fund a MIH system a literature search was conducted on the internet to find articles from professional journals regarding funding of MIH programs. This information was speculative and varied widely based on the region of the MIH program being funded. Funding sources also varied widely and were inconsistent with any common practices across the country. The best source of information that could be found on different funding sources was the book on Mobile Integrated Healthcare (Zavadsky & Hooten, 2014). A total of ten programs were listed in the appendix of the book on Mobile Integrated Healthcare (Zavadsky & Hooten, 2014). Of the ten programs listed only three received any form of funding from a hospital or healthcare provider (Zavadsky & Hooten, 2014).

The meeting the Mercy Health System's ACO manager did yield positive results regarding funding by hospitals and healthcare providers. After a discussion about how a MIH program could help prevent readmissions and save the ACO money Ladd Udy stated that Mercy Health System's ACO may be willing to fund a pilot program by allowing the EMS agencies who are conducting the services, to bill the Mercy ACO a pre-determined amount for each patient visit. Talking points for the meeting can be seen in Appendix B.

Hospital funding of MIH programs is new territory for EMS and healthcare providers. There is limited information currently available on how programs are being funded by hospitals and healthcare systems. This lack of information was one of the limitations for this ARP question.

To answer the fourth and final ARP question on what revenue sources were available to offset the impact of the ACA on EMS agencies an internet search was conducted as well as professional journals searched for articles that pertained to the ARP question.

A review of a book on Mobile Integrated Healthcare yielded ideas on funding sources for EMS agencies (Zavadsky & Hooten, 2014). These funding sources involved user fees that could be billed to Medicaid, Medicare and private insurance companies. Additional forms of funding were discussed in this book which included agreements between healthcare providers and EMS agencies. These agreements would allow EMS agencies to receive a percentage of the bonus payments from an ACO type agreement if the EMS agency can prove that they provide a value based service (Zavadsky & Hooten, 2014).

Medicare billing rules were researched and did not yield any other new funding information other than that which is already known. This information was obtained through the Centers for Medicare & Medicaid Services website as well as through a Wisconsin based insurance company that sets the rules on how ambulance services are reimbursed as well as how much (Wisconsin Physicians Service Insurance, 2014). The conference proceedings from the National Conference on Community Paramedicine were also reviewed. These notes did not provide any additional information other than ideas that had been presented by other articles and journals.

Research was conducted on current billing practices by the Beloit Fire Department to see where potential revenue losses may affect operations and how the EMS service could be changed to benefit the department. The information did not yield any concrete information. Only speculative information on how insurance reimbursements may change due to changes in health insurance coverage and plan coverage. There were also no new revenue sources available that could help offset losses.

The meeting with Pat Mannix from Andres Medical Billing did not provide any new sources of funding other than ones discovered during research. When asked about how these losses could be offset Mr. Mannix had no specific answers other than the possibility of partnering with local healthcare providers and hospitals to develop a MIH program to help reduce patient readmissions (Mannix, 2014).

The author met with senior legislative liaisons from Governor Walker's office and presented information on how EMS agencies could bill for these services as well as save Medicaid money in the state budget. Talking points for this meeting can be reviewed in Appendix C and the letter left for Governor Walker can be seen in Appendix D.

Billing for services provided beyond the normal scope of practice in EMS is also new territory for EMS providers. The information was limited on this topic and like some of the questions was speculative at best. In the book on Mobile Integrated Healthcare there are seven services that have MIH programs which are self-funded. Of these programs one is known to be in jeopardy of failure and a second program in Green Bay WI did fail after the book was published.

## Results

This section answered the four research questions used for this applied research project. The research questions were: (a) what are the possible revenue losses to hospitals for readmissions under the Affordable Care Act? (b) What are the potential revenue losses to EMS for a hospital readmission? (c) How can the hospitals help fund a Mobile Integrated Healthcare Program? (d) What revenue sources could be available to help offset the impact of the Affordable Care Act on EMS agencies?

The first research question answered was what are possible revenue losses to hospitals for readmissions under the Affordable Care Act? A 2007 congressional report from the Medicare Payment Advisory Commission states the reasons for looking at readmissions are twofold. The first reason is that once a patient is discharged from the hospital the time that follows is critical because the patient has to depend on themselves or family members for their care and not professionals. (MedPAC, 2007). This is a time for confusion for patients who have seen multiple care providers and will not know which provider to call should problems arise. The report states the reason behind the confusion is that care providers will act independently of one another and not coordinate care for the patient (MedPAC, 2007). The lack of coordination results in the patient being readmitted to the hospital due to exacerbation of condition (MedPAC, 2007).

A search of the ACA was conducted to determine what would cause a hospital to lose reimbursement money for excessive readmissions. A total of twenty sections from the ACA were reviewed for this question. Of those twenty sections only sections 3022, 3024 and 3025 mentioned penalties for excessive hospital readmissions (Congress, 2010). Section 3022 addresses the Medicare Shared Savings program. Under this section hospitals would be

incentivized to form Accountable Care Organizations that would be responsible for determining the quality of care provided to a patient (Congress, 2010). The quality of care would determine how the ACO is reimbursed for a patient who is readmitted within 30 days of discharge. The penalty suffered by the ACO would be spread amongst all participants in the ACO who are directly responsible for the patient's care (Congress, 2010).

Section 3024 establishes the Independence at Home Demonstration Program assists hospitals in funding physician and nurse practitioner care teams (Congress, 2010). These teams would be responsible providing care along with other healthcare professionals to a patient 24 hours a day 7 days a week (Congress, 2010). The primary purpose of these care teams is to reduce preventable hospitalization, prevent emergency room visit and prevent hospital readmissions (Congress, 2010). Non-participation in the program may cost hospitals incentive payments which could help cover costs for such a program.

Section 3025 of the ACA covers the Hospital Readmission Reduction Program (Congress, 2010). According to this section hospitals that are deemed to have excessive readmissions for "applicable" conditions will lose part or all reimbursement for a patient's care (Congress 2010 p.292). The applicable conditions mentioned in section 3025 are defined as high volume or high expenditure medical conditions (Congress 2010 p.292). High-risk medical conditions mentioned in the ACA are considered to be the most costly and include COPD, MI, CHF, Pneumonia, PTCA, CABG and other vascular conditions (AAMC, 2014). Section 3025 goes on to define that hospitals will be penalized only if these patients are readmitted within 30 days of their discharge from the hospital (Congress, 2010 p. 293).

The ACA does not directly mention what number would constitute excessive readmissions for a hospital so further research was conducted. A publication on Mobile Integrated Healthcare stated that their research findings showed that the national hospital readmission rate of 20% (Zavadsky & Hooten, 2014). This number was considered to be excessive but hospitals would be assigned their own excessive readmission rate (CMS, Readmissions Reduction Program, 2014). A hospital's exact percentage would be calculated by using three years of readmission data (CMS, Readmissions Reduction Program, 2014). The data would include a minimum of twenty-five cases for each applicable condition to determine a hospital's exact readmission excess ratio (CMS, Readmissions Reduction Program, 2014). According to this CMS rule hospitals that have readmission rates lower than the national average would still be penalized. The following example of the author's local hospital illustrates the losses a hospital can face due to excessive readmissions.

In 2013 Beloit Memorial Hospital discharged 3900 patients which also included patients who were deceased (BMH, 2014). The average death rate in Wisconsin is 8.7% which would leave 3561 patients discharged from the hospital alive (DHS, Wisconsin Death Rates 2012, 2014). The 2013 payor mix for Medicare and Medicaid patients in Beloit is 48% leaving 1710 patients that fall under this form of coverage (BFD, 2013). The current national average for 30 day readmissions is 20% (CMS, Readmissions Reduction Program, 2014). Therefore it can be concluded that approximately 341 patients who are covered under Medicare and Medicaid would be readmitted to the hospital, within 30 days, in 2013. The average cost to Medicare and Medicaid for the hospital admission is approximately \$15,000 (AAMC, 2014). Beloit Memorial Hospital would lose approximately five million dollars due to penalties under the Readmission Reduction Program.

Section 3023 of the ACA allows for funding of a National Pilot Program on Payment Bundling. This program is meant to test a bundled payment system as a means to reimburse hospitals and other healthcare providers (Congress, 2010). Hospitals will receive a lump sum payment for the care of a patient and will distribute this payment to other healthcare providers involved in the care (Congress, 2010). Payments to the various providers will be based on performance and quality of the care provided (Zavadsky & Hooten, 2014). This could mean penalties for some providers and bonuses for others.

Readmission penalties are not the only reductions in payment that hospitals will see. According to the Zavadsky and Hooten (2014) there is a 30% penalty or bonus based on patient satisfaction scores. Hospitals with long ER wait times will see penalties from low patient satisfaction scores (Zavadsky & Hooten, 2014). They will have to come up with new and innovative programs in order to reduce ER wait times and/or address other patient satisfaction issues which may arise.

A meeting was held with Ladd Udy from Mercy Health System's Accountable Care organization on December 12, 2014. The information presented to Mr. Udy was very similar in nature to the information for the first research question (Appendix D). Mr. Udy was used as a source to help confirm the information and how at least one local healthcare system was interpreting the penalties mentioned in the ACA.

The second research question to be answered was what are the potential revenue losses to EMS for a hospital readmission? The ACA was the first source to be researched. Of the twenty sections reviewed only two pertained to EMS. Sections 3105 and 3504 were reviewed to answer this research question. Section 3105 included language and dates that needed to be changed in

current legislation to extend percentage payments for EMS services in rural and super-rural areas (Congress, 2010). There is no other mention of funding in this section.

Section 3504 establishes a grant funding program for regionalization of emergency services. The grant assists a region with providing medical control and consolidating Public Service Answering Points (PSAP). There is no mention of payment reductions to EMS providers for hospital readmissions in.

A search was conducted for on-line material of how EMS will be affected by the ACA. Much of this material was speculative. The authors reviewed had opinions of what they felt will happen to EMS reimbursement under the ACA, but there was no cases proving their theories. The journal and periodical articles reviewed stated that EMS was going to be pushed in to providing some form of community medicine program. The 2012 conference proceedings from the National Consensus Conference on Community Paramedicine were reviewed for information pertaining to the second research question. The information found in these proceedings stated that EMS agencies would eventually lose money based on a reduction in payments under the current fee-for-service reimbursement model (Patterson & Skillman, 2012). EMS agencies will be forced to transition to alternative forms of providing service similar to MIH programs (Patterson & Skillman, 2012).

An article in the February 2013 edition of JAMA stated that EMS agencies are currently reimbursed on a fee-for-service model (Munjal & Carr, 2013). The fee-for-service is described as EMS agencies only being reimbursed by Medicare and Medicaid if they transport their patients to the local hospital emergency room (Munjal & Carr, 2013). CMS will not cover other means of transport by EMS agencies to facilities that could provide more appropriate care (Munjal & Carr,

2013). The ACA does not change this current model of funding which in turn will continue to drive healthcare costs higher because EMS is still incentivized to transport (Munjal & Carr, 2013). The unintended consequence of this funding model is that patients may be readmitted within the 30 day time period for chronic conditions. The readmission will not cause a direct loss in revenue for EMS but could lead to a change in reimbursements based on ACO rules (Zavadsky & Hooten, 2014).

Hospitals and other healthcare providers are beginning to combine services develop Accountable Care Organizations. The purpose of the ACO is to provide a value-based service to their patients (Zavadsky & Hooten, 2014). The ACO will have the authority to reduce or increase payments to its providers based on performance (Ludwig, 2013). Under the Medicare Shared Savings Program an ACO can contract with Medicare to become responsible for all of the costs, care and quality assurance of patients they serve (Ludwig, 2013). The EMS agency would then have to bill the ACO for the patient's transport under this program and be subjected to the ACO's definition of quality care (Zavadsky & Hooten, 2014). Under the Accountable Care Organizations EMS agencies would have to prove that they are a value based system or possibly lose reimbursement dollars (Zavadsky & Hooten, 2014).

Patterson and Skillman (2012) published notes from the Nationals Consensus Conference on Community Paramedicine that correlate with the idea of ACO reimbursements to EMS agencies. They perceived that value-based purchasing was going to replace the fee-for-service model currently used (Patterson & Skillman, 2012). The conference report also states that there is likely to be a shift away from current fee-for service models, bringing reimbursement more in line with incentive style programs that hospitals are required to participate in (Patterson & Skillman, 2012). EMS agencies will have to know their detailed costs in order to negotiate

payment under and ACO or bundled payment system (Patterson & Skillman, 2012). The incentive based reimbursement program will also force EMS agencies to prove that they are a value based service.

The most realistic loss that EMS agencies will see will be from non-payment for services. The non-payment will not be due to insurance companies' refusal to pay instead the patients will not be able to afford to pay the premiums. Title I of the ACA addresses changes in insurance coverage (Congress, 2010). Under Title I people who did not have insurance will be required to purchase insurance coverage or be penalized (Congress, 2010). A search of healthcare plans in the State of Wisconsin showed that there were over ninety options for coverage from various providers (getinsured.com, 2014). Many of the lower cost plans researched had high deductibles and co-pays. Some of the plan's deductibles were as high as \$12,000 in addition to co-pays and premium payments (getinsured.com, 2014). A look at specific details of approximately 20 of these plans showed that ambulance transports were subject to the deductible and co-pay rules (getinsured.com, 2014). Patients may not be able to pay for the EMS services on top of many of their other medical bills which are not covered until the deductible is met.

During the meeting with Pat Mannix from Andres Medical Billing the issue of more patients going to collections was discussed. Mr. Mannix agreed that many of the patients who have high deductibles and co-pays will go to collections because they are unable to pay (Mannix, 2014). He also stated that due to the changes in the ACA the definition of the poverty level was raised by 133% as it applied to insurance coverage and assistance (Mannix, 2014). He also stated because of the rise in the poverty level more people were being moved in to Medicaid coverage from private insurance (Mannix, 2014). With more people moving in to Medicaid coverage from private insurance EMS agencies will lose money because of lower reimbursement rates.

The third research question was how can the hospitals help fund a Mobile Integrated Healthcare Program? Under current Medicare and Medicaid rules there is no funding source for an EMS based MIH program. During the meeting with Pat Mannix he did state that there is a HCPCS code for MIH programs but it is currently unfunded by Medicare and Medicaid (Mannix, 2014). He also stated that EMS agencies could bill Medicare and Medicaid for home health services under HCPCS codes. EMS agencies would have to prove through their policies and protocols that they are providing this level of care and not going beyond their scope of practice in order to be considered for reimbursement (Mannix, 2014). Mannix also stated that the Medicare payment was not guaranteed (Mannix, 2014). EMS agencies would have to look at other means to fund MIH programs which could include having hospitals help fund the programs through user or referral fees (Zavadsky & Hooten, 2014).

Hospitals will lose the most money from the funding changes in the ACA and should consider being the initial funding source for new MIH programs. They can fund MIH programs as a way to help lessen the impact of the Readmissions Reduction Program under the ACA (Zavadsky & Hooten, 2014). Funding can be achieved through user and referral fees that would be paid to EMS agencies for services provided (Zavadsky & Hooten, 2014). Grants given to EMS agencies through a hospital's charity foundation could also be a means to get MIH programs running (Zavadsky & Hooten, 2014). Christian Hospital EMS in St. Louis, Mo is one such agency that received a \$100,000 donation from the hospital's foundation (Zavadsky & Hooten, 2014). The initial donation helped fund the training for the program and proved to be an overall cost savings to the hospital (Zavadsky & Hooten, 2014).

A referral fee is described as a per patient fee, paid to the EMS agency by the hospital or ACO, that would cover the costs of at home care for a patient for a predetermined time period

(Zavadsky & Hooten, 2014). The amount paid by the ACO or hospital would vary on the patient's condition being treated (Zavadsky & Hooten, 2014). An example would be a patient that was discharged from the hospital after being treated for COPD. The ACO or hospital would contact the EMS agency to set up a series of home visits for the patient being discharged. The ACO or hospital would be billed a preset amount for no more than a preset number of home visits for this patient. The number of visits and amount billed would be according to the contract between the ACO/hospital and EMS agency. The objective of the program would be to prevent readmission of the high-risk patient. An added end of year bonus payment could be negotiated between the ACO/hospital and EMS agency if all program goals and objectives are met.

The shared savings model of reimbursement is another way that ACO's and hospitals can fund MIH programs. According to Zavadsky and Hooten (2014) the shared savings model is the future of healthcare reimbursement. The ACO or hospital realizes a cost savings under bundled payment models and shares that savings with the EMS agency (Zavadsky & Hooten, 2014). MedStar is using this form of funding for its Observation Admission Avoidance Program (Zavadsky & Hooten, 2014). The program is designed to provide a cost savings for the ACO by referring them to MedStar's program (Zavadsky & Hooten, 2014). The patient is provided proper care at home instead of being admitted to the hospital for a short term admission (Zavadsky & Hooten, 2014). The at-home-care saves the ACO money and a percentage of that savings is shared with MedStar (Zavadsky & Hooten, 2014).

The funding models mentioned are new and currently being tested. Some programs have been more successful than others. The key component to success is the relationship between the ACO/hospital and the EMS agency providing the service. Such funding models will assist EMS

agencies in generating revenue to help offset potential losses they may see as a result of the ACA funding changes.

The fourth research question is what funding sources are available to help offset the impact of the ACA? The true impact of the ACA on EMS agencies is unknown. There has been speculation that the current fee-for-service model of reimbursement will be replaced with a model similar to bundled payments or shared savings models (Patterson & Skillman, 2012). Fire Service and EMS leaders have also speculated that fee-for-service payments will decrease over the next few years unless EMS agencies show they are providing a value-based service to their patients (Patterson & Skillman, 2012). The only relatively known impact of the ACA is the changes to insurance plans under the exchanges.

In order to make up lost revenue EMS agencies will have to be creative in developing new programs that are outside the traditional role of EMS in the United States. EMS agencies that develop Mobile Integrated Healthcare programs will have the ability to develop innovative ways of taking care of patients in their community as well as adding additional funding. Partnerships with ACO's and hospitals can be formed to help with reducing costly patient readmissions under a referral fee system (Zavadsky & Hooten, 2014). According to Zavadsky and Hooten (2014) some additional forms of generating revenue are sponsorship funding, patient contact fees, outcome-based payments, individual subscriptions and corporate subscriptions.

Sponsorship funding for MIH programs would help EMS agencies develop and implement MIH programs. This form of funding is only meant to be temporary and not a permanent means to fund the program (Zavadsky & Hooten, 2014). A partnership would first be formed with an ACO/hospital. The ACO/hospital would provide limited funding through grants

to the EMS agency meant to take care of initial start-up costs for a MIH program (Zavadsky & Hooten, 2014).

Outcome-based payments would be used by agencies like hospice that would lose revenue if patients do not stay enrolled in their program. The objective of the program is to assist families who are defined as being at a higher risk of disenrollment from hospice by providing them with support should they become scared or panicked during any time (Zavadsky & Hooten, 2014). There would be minimal interaction with the family by MIH personnel but assistance would be available twenty-four hours a day. If the patient dies without a voluntary disenrollment or revocation of their hospice status then the EMS agency would get paid (Zavadsky & Hooten, 2014). If the patient does not stay in the hospice program then the EMS agency would not get paid (Zavadsky & Hooten, 2014).

Patient contact fees would be similar to a referral fee and would assist an ACO/hospital with preventing patients from being readmitted (Zavadsky & Hooten, 2014). Under this form of revenue program a patient who had recently been discharged from a hospital would be referred to the EMS agency for follow-up (Zavadsky & Hooten, 2014). The type of patient referred would be those who are at risk of being readmitted including those patients in the high-risk categories. The follow-up would include working with home healthcare services and be meant to supplement the care they already provide (Zavadsky & Hooten, 2014). Each time the EMS agency would visit the patient a fee would be charged to the home healthcare agency, ACO or referring hospital. It is more cost effective to send the EMS agency's MIH practitioner out than to pay a nurse overtime thereby creating a cost savings for the payer (Zavadsky & Hooten, 2014).

Individual and corporate subscription fees are another means to supplement EMS agency revenue losses. Under the individual subscription fee a family would pay the EMS agency to conduct a pre-determined number of visits in a year for low-acuity assessments, newborn checks and care as well as check-ups for elderly (Zavadsky & Hooten, 2014). These programs are designed to give people peace of mind as well as prevent them from having to pay insurance deductibles and co-pays (Zavadsky & Hooten, 2014). The corporate subscription fees would be similar in nature to the individual fees but concentrate more on check-ups for low-acuity conditions or general health screenings which may help reduce employer healthcare costs (Zavadsky & Hooten, 2014). These fees would be based on the needs of the individual or corporation.

During the meeting with Pat Mannix the issue of treatment and non-transport fees was discussed. Mr. Mannix stated that this could be a source of revenue for all EMS agencies and would help eliminate some of the unnecessary ambulance trips to the local emergency department (Mannix, 2014). He also stated that there is a HCPCS code for treatment and no-transport of patients but it is currently unfunded by Medicare and Medicaid (Mannix, 2014). HCPCS codes were searched and the treatment no-transport code is designated as A0998 (CMS, (HCPCS) codes, 2012).

The funding mechanisms EMS agencies can use to offset the losses from ACA funding will be dependent on how aggressive each agency designs its MIH program. The individual MIH programs will be based upon the needs of the community and in accordance with the community assessment conducted. EMS agencies should therefore use all resources and partnerships available to assist in the development of a MIH program in order to maximize the revenue generated.

## Discussion

According to the Patient Protection and Affordable Care Act hospitals and healthcare providers will be penalized for excessive patient readmissions (Congress, 2010). This penalty includes patients who are non-compliant with their discharge instructions and follow-up care. According to the ACA hospitals are responsible for all aspects of patient care including ensuring compliance with physician orders (CMS, Readmissions Reduction Program, 2014). Currently the maximum penalty a hospital could see is 3% (Zavadsky & Hooten, 2014). This percentage would be based on all Medicare and Medicaid money the hospital receives (Zavadsky & Hooten, 2014). A 3% penalty could be considered significant if the hospital is operating on a 2-3% profit margin (Zavadsky & Hooten, 2014). The author considers this an unfair practice under the ACA and a reason by CMS to further reduce reimbursement to hospitals and other healthcare providers.

Hospitals and ACO's will have to deal with potential penalties if their patient satisfactions scores are low (Congress, 2010). The scores could be low due to long ER wait times, patient's not getting the care they think they deserve or a number of other subjective criteria (Zavadsky & Hooten, 2014). Even though the hospital may be providing appropriate care to the community the subjective nature of patient satisfaction penalty will cause the healthcare providers to still lose money. The ACA is not intended to be healthcare reform but healthcare funding reform (Zavadsky & Hooten, 2014).

The research on the ACA that pertained to reimbursement loss to EMS revealed no language that specifically stated EMS agencies would not be reimbursed for transporting patients who were readmitted within 30 days (Congress, 2010). No mention was found in the ACA about any penalties to EMS agencies. Research of other journals and articles on penalties to EMS

agencies was speculative and did not yield any substantial information on definitive reimbursement loss. The only funding loss to EMS could be from changes in healthcare coverage required under the ACA. Zavadsky and Hooten (2014) stated that if a bundled payment system were implemented then EMS agencies would have to bill individual ACO's for reimbursement. Zavadsky and Hooten (2014) go on to say that the ACO would determine the amount of money the EMS agency would receive. This may be another reduction in payment to EMS agencies.

The ACA mandates that all Americans have health insurance (Congress, 2010). If they do not purchase health insurance Americans will have to pay penalties or be covered under government programs dependent upon their current income levels (Ambulance Billing Services, 2013). The insurance can be purchased under various government websites. The majority of the health insurance plans requires high deductible rates, co-pays and premiums and generally provides poor coverage (getinsured.com, 2014). Even though the patient is technically covered by insurance they may still not be able to afford the co-pays and other payments required under their health insurance plan (Zavadsky & Hooten, 2014). The patients that cannot afford to pay the premiums will go in to collections status which will limit the money the EMS agency will collect (Mannix, 2014).

According to Patterson and Skillman (2012) the ACA could be seen as an opportunity for EMS agencies and hospitals to work together to develop innovative programs that will address patient readmission rates. However there is limited government funding for these programs with no funding available from the federal government for MIH programs.

A Mobile Integrated Healthcare program would be solution to the readmission problem (Ludwig, 2013). Hospitals would pay a fee to an EMS agency, for providing MIH services to

recently discharged patients that are in the high-risk category group (Goodwin, 2013). This fee would pay for the added services of the EMS agency and help the hospital save on readmission penalties. This same service could be used to treat low-acuity patients at home so that ER wait times are reduced and patient satisfaction increased (Zavadsky & Hooten, 2014). Hospitals would receive bonuses for increased patient satisfaction and share a portion of that bonus with the treating EMS agency (Goodwin, 2013). The hospital would benefit from the bonus payment and the EMS agency would be able to provide MIH services with the additional funding provided.

In addition to hospitals helping fund a MIH program each individual EMS agency can develop funding mechanisms to increase income to the MIH program or the EMS agency itself. These programs will have to be developed in accordance to the community needs and ability of individuals to pay.

CMS should be urged to fund MIH programs through additional HCPCS codes. Expanding Medicare and Medicaid funding is a long process but needs to begin in each state. Allowing EMS agencies to bill CMS for MIH services will create a sustainable funding source for MIH programs (Zavadsky & Hooten, 2014). Laws may not necessarily need to be changed in each state or at the federal level but rule changes governing Medicare and Medicaid reimbursement will need to address MIH funding.

The lack of funding from the federal government as well as the failure in acknowledging EMS as a healthcare provider may leave EMS underfunded. EMS agencies may also be subject to unfunded mandates by CMS for future MIH programs development. EMS agencies will need to be proactive in developing MIH programs and look for alternative funding sources. Working

with local healthcare providers and hospitals to address the needs of the community and reduce readmissions will be necessary in order to prevent the ACA from affecting all healthcare stakeholders in the community. EMS will not be affected immediately by the ACA but will be if a bundled payment system is made mandatory. EMS agencies will depend on reimbursement from an ACO and subject to the ACO rules on quality patient care and value-based programs. EMS may also be affected by unfunded mandates for alternative services like the development of a MIH program.

### **Recommendations**

The recommendations for this ARP will remain on file within the Beloit Fire Department as a reference for MIH services the department's EMS program may provide and how the program can be funded. The recommendations are as follows: (a) Work with the Beloit Fire Department's billing company to monitor the EMS division's revenue streams. (b) Schedule meetings with regional ACO's and hospitals to discuss the development of MIH programs and the initial funding for the program. (c) Perform a community assessment using the Office of Rural Health's Community Paramedic Assessment Tool to look at the financial efficacy of a MIH program. (d) Work with the Beloit Fire Department's medical director to develop a Mobile Integrated Health program based on the results of the assessment. (e) Develop a fee schedule for the MIH programs that will be implemented by the Beloit Fire Department. (f) Continue to work with Wisconsin state legislators and the Wisconsin Legislative Leadership Council to pass legislation or change Medicaid billing rules to include MIH programs (Appendix C and D).

As a result of the information gathered for this ARP the author is in the process of working with the State of Wisconsin's Medicaid Director on potentially funding an MIH program through Medicaid rule changes.

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## Appendix A

### **Andres Medical Billing Meeting Notes**

**In attendance:** Deputy Chief Joe Murray and Pat Mannix

**December 4, 2014**

#### **What changes have been made to insurance under the ACA?**

Changes have been made to who is eligible for Medicaid. The poverty level was lowered by 133% so more people are eligible for Medicaid and Medicare program. This has caused more people to move towards Medicaid from private insurance.

Higher deductibles, co-pays and premiums are also seen in private insurance and under the exchanges. People will have a harder time paying their bills even with government aid. There have been no specific downward trends seen in reimbursement or collection rates for the City of Beloit as a result of changes to healthcare coverage under the ACA. It is still very early to tell what the trend will be.

#### **What are you seeing with ACO's?**

They are moving to a bundled payment system to have more control of reimbursement as well how money is given out to the providers. This is the future of Medicare reimbursement. There will be control over readmission penalties and bonuses which the ACO will keep more for itself. The ACO will also have different provider types such as acute, post-acute and hospital based care. EMS will probably be left out of this initially.

**Is there a current fee schedule for MIH programs?**

CMS has a HCPCS code of AO998 for treatment and no-transport. This is an unbillable code and CMS will not pay. You can bill for home health services but have to show in your policies and procedures that you are capable of conducting the programs. This is not a guaranteed payment and will more than likely be denied. There are some states that have adopted MIH reimbursement under Medicaid. Minnesota is not a good system because they only reimburse \$14/quarter hr. Michigan's reimbursement is better because it is a flat fee. Look in to the possibility of talking with legislators or those in charge of Medicare and Medicaid.

There needs to be a push to fund AO998, MIH programs and no-transport fees. It is a savings to CMS.

**What are other sources of funding?**

Billing hospitals for at home health services, patient contact services. Subscription services are a possibility for the public but they will have to be studied. Show the hospitals how you can save them money on reimbursements and do it cheaper. Look in to the readmission penalties for a hospital and what they can save.

**What other information is there on the ACA and EMS?**

This is still new territory for EMS billing and we are not sure what will happen. There is a high possibility because of the changes to insurance coverage that patients will not pay the ambulance services for transport if they have not met their deductible and they are paying on other expenses. We could wait till the end of the year to bill these patients which may guarantee payment.

## Appendix B

### **Mercy Hospital ACO Meeting**

**In Attendance:** Dr. James MacNeal, Deputy Chief Joe Murray, Deputy Chief Jim Ponkouskas, Chief Gene Wright, Ladd Udy

**Date:** December 12, 2014

### Affordable Care Act, EMS and MIH

- **Healthcare in the US**
  - Not centered on the patient
    - Causes of high healthcare costs. Patient care is based on volume of services provided not on making the patient better. EMS is not different. We are a fee-for-service provider. The more patients we transport the higher our reimbursements. Is this best for the patient? Are we providing a value based service?
  - Fragmented – Patients have a hard time navigating
    - Patients are unable to navigate the health care system because it is so complicated. Not sure what services to use when, HMO require pre-approval and getting that can be complicated. Denial of claims. Once again volume based and not what is best for the patient. Causes patients to call EMS to go to the ER for primary care because they do not know where to get proper care.
  - Amount of money spent on Healthcare in the U.S. compared to other countries
    - Public and Private costs
      - US \$8223 annually – Life expectancy is 79 yrs
      - European Union – on average less than \$5000 annually with average life expectancy of 80 yrs.
      - US one of the highest infant mortality rates in the industrialized world
        - 6.7 U.S
        - 4.8 UK
        - 3.8 France
        - Sweden 2.5
      - Physician Shortage 2025 – 130,000
  - ACA is a new way of paying for healthcare not providing it.

## - **Affordable Care Act**

- Institute for Healthcare Improvement (IHI) Triple Aim
  - Improve patient experience
  - Improve the health of the population
  - Reduce per capita cost of healthcare
    - What Medicare and Medicaid is basing reimbursement levels on.
- Accountable Care Organizations and Integrated Delivery Systems
  - Right care, right time, right cost, right outcome
  - Organization shares in savings it achieves for Medicare
    - Penalties and Bonuses – this will be the driving force behind home based healthcare and reducing patient admissions.
    - The ACO is designed to share the savings it achieves for Medicare. Will they really do that though?
    - Being part of an ACO include steering the patient to the right care taker and not by ambulance which is the most expensive form of transportation. Reduction in runs and revenue possibly. How do we make that up?
- Bundled payments
  - One lump sum payment
  - Payment arrangements
    - How will we bill healthcare systems and
  - Future of reimbursement – value of care objective vs. subjective?
    - If healthcare systems are going to be in charge of reimbursing EMS how does EMS prove worth? Through 12 lead transmissions, improved trauma care? It will be up to the healthcare system to make that determination. This will be subjective at best.
    - Multiple hospitals and only one is your medical control hospital?

## - **Current Status of EMS Funding**

- Current reimbursement as a fee for service.
- Revenue incentive to transport – Cost of transport plus ER visit
  - \$464 for the ambulance (average what EMS collects from CMS. \$969 for the ER visit. Is the patient any better off? They still have to follow up with a primary care provider
  - Treatment at home by a CP could bill at \$250-300 with no ER visit and patient stays home.
- Business strategy of increased transports
  - This is the current strategy for all EMS agencies that are starting up.
- Why people call EMS – Low Acuity and how this affects reimbursement

- National Average 30% no-transport rate
    - Treat and no-transport – No reimbursement from CMS unless it is a cardiac arrest
    - Lost revenue to EMS and high collection status rates.
  - Medicare Part B ambulance payments have grown faster than any other Part B service since 2002
  - Medicare beneficiaries receiving ambulance transports increased by 34%
    - Total number of fee for service beneficiaries increased by only 7%
  - \$6 Billion a year spent on ambulance transports by Medicare
- **The Future of EMS**
  - Mobile Integrated Healthcare
    - No such thing as an inappropriate 911 call. Inappropriate responses
    - Patient centered, mobile resources in the out of hospital environment
    - Integrated with the entire spectrum of healthcare and social service resources
    - Provide care in the patient’s home rather than the hospital
      - Cheaper and provides better care to the patient
    - Help hospitals reduce excessive readmissions and unnecessary ER visits
  - Reimbursement of EMS will move from fee for service to VBP model
    - Look at the true value of EMS and what we do
    - Bundled Payments- May have to bill hospitals?
    - Prove what EMS does will improve patient outcome?
    - Satisfaction Based Reimbursement – 30% of bonus payment
- **MIH Reimbursement Options**
  - Depends on the needs of the community
  - Start-up Funding
    - Local grants
    - ACA grants – Hard to get
  - Cost Avoidance
    - Reducing the calls for the frequent flyer
    - Re-direction to appropriate care
  - Sponsorship Funding
    - Funding partner – hospitals?
      - Readmission reductions
      - Increase patient satisfaction
  - Patient Contact fees
    - Hospitals pay the fee which helps reduce unnecessary ED visits
    - Home Health Agencies – reduce their OT costs, expand coverage

- **Pass legislation**
  - **Minnesota example - \$14 per quarter hour**
  - **Is this sustainable?**
  - **Expand to federal legislation?**
- Anti-kickback laws (42 USC 1320a-7(b))
- Referral fees
- Outcome based fees – Hospice Partnership
- Shared Savings Model – Observation Admission Avoidance Program
- Individual Subscriptions
  - New Born wellness checks
  - Elderly Check
  - Corporate Subscriptions

## Appendix C

### Medicaid Savings and Mobile Integrated Healthcare

#### Wisconsin Legislative Liaison meeting notes

**In attendance:** Deputy Chief Joe Murray, Chief Dave Bloom, Deej Lundgren

**Date:** December 18, 2014

#### **Background and Significance-**

##### *Use of 911 services and the Emergency Department*

- People in to the healthcare system
- Unable to get an appointment with Primary Care Provider (PCP) or have no PCP
- Do not know how to navigate the healthcare system
- Ease of access
- They get instant gratification
- Lack of transportation – (Under Medicare rules this is not considered to be a reason for transport)
- National Average of the patients have low-acuity ailments and are transported by EMS is 37%
- Regular Emergency Department (ED) use for low-acuity ailments have a negative impact on overall care that the patient receives.
- Many times they have to follow up with a PCP and fail to do so.
- This creates another trip to the ED and another charge.
- ED is the highest cost resource a patient can use compared to a physician office /clinic visit.
- ED is not being used the way it was designed.
- Ambulances are necessary sometimes but many times good effective care can be delivered in the home by qualified, trained personnel.

##### *Cost averages (Nationally) for Services (AHRQ, 2014)*

Approximate numbers based on national averages

<b>Service Provided</b>	<b>Average Cost</b>
<b>Ambulance</b>	<b>\$464</b>
<b>ED Visit</b>	<b>\$969</b>
<b>Clinic / PCP</b>	<b>\$125</b>

**WPS Medicare Medical Necessity definition**

- The patient's condition would be jeopardized if he/she was not transported by ambulance
- The patient must lie flat or otherwise be immobilized or is incapable of sitting up unassisted, or
- The patient requires a service (e.g. intravenous drugs) that is available in the ambulance but not in a vehicle such as a private automobile, taxi, or Medi-car.

**A solution and cost savings for Medicaid****Mobile Integrated Healthcare/Community Paramedic**

- The following table represents data collected on Medicaid transports from 01/01/ 2014 to 06/30/2014 from the following municipal EMS services:
  - Bloomfield Genoa City Fire Rescue
  - Beloit FD
  - Janesville FD
  - Menomonie FD
  - Waukesha FD
  - Wauwatosa FD
  - Portage County EMS
- Represented 11.42% of payor mix in these services
- Total of 1,101 patient contacts.

<b>Response Level</b>	<b>BLS</b>	<b>ALS</b>	<b>ALS 2</b>	<b>No – Transport</b>
<b>Reimbursement</b>	\$172.63	\$196.28	\$318.53	\$137.43
<b>Number of patients</b>	537	540	20	4

- Using the National Low-Acuity average of 37% the following table shows how many patients could be treated effectively in the home. These are approximate numbers once again and may vary depending on the patient condition.

Response Level	BLS	ALS	Treatment No-transport	Totals
Number of Patients	198	202	4	404
ED Visit Savings	\$191,182	\$195,738	\$3876	\$390,796.00
EMS transport Savings	\$34,180.74	\$39,648.56	\$549.73	\$73,279.57
Fee for MIH \$75.00	\$14,850	\$15,150	\$0	\$30,000
Total Cost Savings	\$210,512.74	\$220,236.56	\$3,326.27	\$434,075.57

- Use of Community Paramedics/Mobile Integrated Healthcare (CP/MIH) services will save Medicaid money over time.
- A fee code needs to be funded (currently AO998 is available under CMS HCPCS codes) so that CP/MIH services can be funded and made sustainable.
- Treatment/No-Transport will not see a savings for the ambulance visit but will prevent an ED charge. An example of this would be for diabetic patients who are experiencing insulin reactions.
- Further cost savings to Medicaid based on prevention of reoccurring hospital readmissions for chronic illnesses as described by CMS are the following;
  - Congestive Heart Failure
  - Pneumonia
  - COPD
  - AMI
  - Various venous diseases
  - CABG
  - Example –
    - Beloit Memorial Hospital discharged 3900 patients in 2013
    - Payor mix for Medicaid patients in Beloit 11.68%
    - 454 of the discharged patients are covered under Medicaid
    - 20% national average for 30 day readmission – 90 patients readmitted
    - Averaged cost for hospital admission – approx. \$15,000 (this is an average cost for high risk conditions)

- Potential to save \$1.35 million in Medicaid costs by preventing 90 high risk patients from being hospitalized (this is the potential savings for just 1 hospital)
- Community Paramedic/Mobile Integrated Healthcare services could also be used to fund fall prevention programs.
  - In Beloit alone there were 250 older adults who had fallen and required transport to the local ED
  - This program would serve as an opportunity to reduce ED admissions and well as downstream healthcare costs associated with physicians visits, x-rays, MRI, CT scans, skilled nursing facility care (long term), surgery care etc...

Appendix DLetter to the Governor

## Wisconsin State Fire Chiefs' Association, Inc.

- Education
- Prevention
- Safety
- Suppression
- EMS

Together We Can Make A Difference

DATE: December 18, 2014

TO: Governor Walker

FROM: Wisconsin State Fire Chiefs' Association

RE: Budget Issues

The Wisconsin State Fire Chiefs Association would like you to consider an initiative for the 2015/2016 budget that we believe will help communities provide more efficient emergency medical care and also allow for savings within Medicare.

### **Funding for Mobile Integrated Healthcare/Community Paramedic Programs**

Mobile Integrated Healthcare and Community Paramedic (MIH/CP) programs are services that are designed to provide a patient centered mobile resource in the out-of-hospital environment. These services are delivered by a core group of highly trained paramedic personnel. The programs would be integrated within the entire spectrum of healthcare and the social service system. MIH and CP programs have seen great success in other countries around the world and within a number of municipalities in the United States. The success by many of the current programs have been in providing care to patients who have chronic health conditions and limited access to primary care providers for follow-up care. Paramedics that have been trained in mobile integrated healthcare would work directly with a patient's primary care provider to make sure that the patient is compliant with medications, follow-up visits, fall prevention, dietary restrictions and other instructions the patient must follow to improve their overall health.

A second aim of the MIH/CP program would be to help reduce hospital readmissions for patients with chronic high-risk diseases. This additional benefit of the MIH/CP programs will allow for a cost savings to Medicare, Medicaid, private insurance carriers, hospitals, and local healthcare systems. These savings would be realized through the prevention of costly readmissions which in turn would save millions of dollars in healthcare costs. A very simple example of this savings for the State of Wisconsin is the use of MIH/CP versus repeated emergency department visits for patients recently discharged from the hospital with the same condition. Medicaid patients with low-acuity ailments are seen every day in the emergency department (ED) which cost the state millions of dollars in unnecessary costs. Emergency department visits are by far the most expensive form of providing healthcare to patients and the ED is not designed to handle conditions that should be handled by a primary care physician. Once a patient is discharged from the ED they are told to follow-up with a primary care provider which many do not do and therefore return to the ED when their condition does not improve. Since they are covered under Medicaid, their carrier now receives 2 separate and expensive ED charges for the same condition. One of these charges may also have an ambulance transport attached to it if the patient felt it was necessary to go by ambulance. These low-acuity patients could be seen at home and/or redirected to a less costly and more efficient means of receiving healthcare. The redirection of the patient by the community paramedic/MIH personnel would free up ambulance resources and ED staff to handle more critical incidents.

By allowing EMS services to develop MIH/CP programs and bill Medicaid for MIH services the State of Wisconsin would see a significant savings to its Medicaid program. Savings would also be seen in the private insurance industry if they adopt the same billable service. The ability to bill Medicaid for these services would provide a sustainable funding source for Emergency Medical Services to provide improved and more efficient healthcare to the communities they serve.

We would be happy to discuss these issues in more detail if you are interested. Please contact:

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