**The National Emergency Medical Services Council**

**Draft Advisory Revised Aug 6, 2020**

**COVID 19 Public Health Emergency Treatment in Place Reimbursement**

**Committee: EMS Sustainability and Efficiency**

**Problem Statement/Executive Summary:**

**Our nations Emergency Medical Services struggle to complete their mission of immediate response to life threatening emergencies due to financial hardship as a result of inadequate and outdated payment mechanisms.**

Emergency Medical Services is defined as “pre-hospital and out of hospital EMS, including 911 and dispatch, emergency medical response, field triage and stabilization, and transport by ambulance or helicopter to a hospital and between facilities” (IOM 2007). Ambulance services are a critical component of an EMS System and the health care safety net. Emergency Medical Services (EMS) system design is incredibly diverse across the United States. EMS varies in clinical sophistication, deployment strategies, performance standards, and governance. Emergency ambulance service is provided by a locally designated response agency which may be a government, private, non-profit, or hospital owned entity, to name a few (RAND 2019). Regardless of model or geography, the rate of emergency ambulance transport per capita does not vary significantly across the country. (RAND 2019).

Medicare, and subsequently most other insurance, classify ambulance service only as a transportation benefit. The reimbursement is for the ride, not the response, assessment, and medical care the patient receives. In general terms, the ambulance must transport the patient to a hospital emergency department (ED) to receive compensation from federal payers and most commercial insurance companies.

One aspect of the COVID-19 outbreak is the quarantining of patients in their home. While the vast majority of patients, especially those under the age of 60, will not require monitoring or care during the quarantine period, the most vulnerable patients (which includes Medicare beneficiaries) may need in-home treatment options. CMS has piloted “treatment in place” models already and is about to begin another one that incorporates additional onsite (either in-person or through telehealth services) health care providers. Many commercial and State Medicaid plans already reimburse for treatment in place without a physician or similar health care provider’s direct oversight, so long as there is an approved medical protocol written by the Medical Director of the ambulance service provider or supplier and approved by the local or State governing bodies in place. The value of these services has been proven. For example, local public health bodies are asking ground ambulance service provider sand suppliers to assist with testing patients suspected of having contracted the virus. Such tests may be performed at home or through mobile units set up in the community to provide patients with an alternative to seeking testing in their local hospital or through a physician’s office where there are others in close proximity that could be exposed to COVID-19.

Of significant impact to ambulance services are the number of 911 patients seeking care and subsequently not being transported to a hospital. While there are typically a small percentage of 911 call that result in this, during the PHE it has spiked to as much as 50% of calls in some areas, and is widely increasing by over 15% across the nation. This places considerable economic strain on local services as the expense of personnel, equipment, dispatch, PPE and so on goes completely unreimbursed.

“This spring,the IAFC surveyed its membership to understand the budgetary effects of the COVID-19 pandemic. We found that fire departments will suffer a $16.9 billion shortfall in budget revenue in 2021. Our members also reported that approximately 1,000 fire department personnel had been laid off already this year. We estimate that almost 30,000 fire department personnel will lose their jobs in the next twelve months. Fire departments are caught in a vise, where the cost of supplies and personnel to provideservice totheircommunitiesis increasing whilerevenue to support these operations is decreasing.” (Gary Ludwig IAFC Congressional Testimony June12, 2020)

**Recommended Actions:**

NHTSA, through FICEMS, should support efforts to authorize CMS to make payment for ground ambulance services whether provided directly by a supplier or provider or under arrangement with a provider for services provided without a transport, including but not limited to testing and screening for COVID-19, providing home monitoring, care coordination/care management services, or other service the Secretary determines is appropriate through the duration of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)) or consistent with State or local scope of practice requirements for ground ambulance personnel.

A longer term proposed solution to this barrier would be to classify ambulance services as a provider type in the Social Security Act (Berwick 2016).

**Summary:**

The delivery of effective EMS will remain in jeopardy as long as adequate financial stability remains elusive. Regardless of delivery system model, governance structure, or geography, current fee for service reimbursement is known to be below the cost of providing service (RAND 2019).

The proposed payment for services without transport will address significant added expenses and reduced revenue that have been a hallmark of the COVID 19 PHE and are destabilizing ambulance services and EMS delivery nationwide.

CMMI has undertaken a pilot to explore payment for services without transport known as ET3(2019). This recommendation for payment during the PHE is complementary to this effort by CMMI to demonstrate similar enhancements to EMS revenue.

Previous NEMSAC recommendations from 2009, 2012, and 2016 should be viewed as white paper documents more fully exploring existing and alternative models for EMS finance.