

# Reimbursement



One source of complication for EMS systems is "frequent flyers" or "super users". These non-emergent frequently seen patients take away EMS resources from those in need. These patients are typically males who abuse alcohol, or have a mental health illness, and are relying on Medicare or Medicaid for health care coverage (Bryan Bledsoe DO, 2016). Not only do "frequent flyers" tax EMS resources, but also cause hospitals to be penalized. Re-hospitalization of the same complaint within 30 days is directly related to poor reimbursement and penalty from Centers of Medicare and Medicaid Services, CMS (Clark, 2016).

Medicare is a federal program that provides health care coverage for those 65 years and older or those with severe disability, despite the level of income. Medicaid is a state and federal level program that provides health care coverage to those with a very low income. In 2012 CMS estimated 19.4 million were covered under Medicaid (McCallion, 2012). For many agencies Medicare and Medicaid are the primary sources for income reimbursement.

Compared to large insurance companies, Medicare and Medicaid tend to have the lowest reimbursement rates. If the majority of the people in an ambulance company's coverage are covered by one of the state or federal programs, it could cause the company to lose so much income that they are forced to close their doors. EMS agencies are not the only ones taking a hit, hospitals are also included in the fines and low reimbursement rates.

In the fiscal year of 2016 more than half of the nation's hospitals were punished by the government. Medicare reported penalties costing five-hundred-twenty-eight million dollars among 2,597 hospitals (Rau, 2016).

Hospital readmissions are the primary reason for being penalized. The fine amounts are based on Medicare patients between July 2012 and June 2015. For each hospital the government calculated how many readmissions it expected and compared it to national rates and the health of the patients at each. The hospitals that received more readmissions for the same medical complaint would receive a reduction in Medicare reimbursement.

These fines and penalties were created under the Affordable Care Act. The maximum penalty allotted is three percent, which forty-nine hospitals received. During the five years of the implementation of the penalties, 1, 621 hospitals had suffered reductions in reimbursements each year. The government excludes Veteran's hospitals, children's hospitals, and psychiatric hospitals, making 1, 400 hospitals safe from Medicare penalties (Rau, 2016).

## **Hospital Admission Rates**

In Pennsylvania alone the hospital admission rates for congestive heartfailure, uncontrolled diabetes, hypertension, and chronic obstructive pulmonary disease are significantly higher than the estimated benchmarks. Per one-hundred-thousand patients, the hospital admissions for CHF in 2016 were three-hundred-fifty-two, with a benchmark of one-hundred-ninety-eight, making the amount seventy-seven percent away from meeting the standard. The admissions per one-hundred-thousand patients for uncontrolled diabetes were an estimated fourteen percent with a benchmark of four, making this statistic two-hundred-thirty-nine percent away from the expectation. Hypertension admissions were one-hundred-forty-six percent away from meeting the benchmark with rates of fifty and a benchmark of twenty.

<https://assignbuster.com/reimbursement/>

COPD admissions for those 40 years and older were four-hundred-seventy-three with a benchmark of two-hundred-eighteen, making it one-hundred-seventeen percent away from hitting the standard (AHRQ, Agency for Healthcare Research and Quality, 2016).

These rates were further broken down in a comparison between low and high income classes. In the low income class hospital admissions for CHF were one-hundred-sixty-four percent away from the benchmark, admissions for uncontrolled diabetes were five-hundred-nine-percent away from uniting with the benchmark, COPD admissions were three-hundred-three percent away from reaching the benchmark, and hypertension admissions were three-hundred-eighty-eight percent away from linking up to the benchmark (AHRQ, Agency for Healthcare Research and Quality, 2016).

Research revealed closer percentages to the benchmarks in the high income class. Admission rates for CHF were only thirty-two percent away from the benchmark, seventy-three percent for uncontrolled diabetes, COPD rates were twenty-two percent from meeting the benchmark, and hypertension rates were thirty-five percent away from reaching set benchmark numbers (AHRQ, Agency for Healthcare Research and Quality, 2016). These statistics pose evidence for obvious correlations between financial class, health, and hospital admission rates. Some attribute this to the lower income class not being able to financially afford medications to manage their chronic illness or disease.

Obtaining reimbursement from insurances and federal programs such as Medicare and Medicaid, can not only become difficult, but also not enough to

cover all of the costs associated with a 9-1-1 call. A company needs to be able to recover the costs for salaries, supplies, equipment, and fuel. Sadly, what is charged is rarely fully recovered. California reported a reimbursement rate of less than one-hundred dollars per ambulance transport in 2012 (McCallion, 2012).

A company could charge eight-hundred dollars for the transport and fifteen dollars per mile and still be forced to accept a small fraction in return. Low reimbursement rates are a major factor in relation to the poor pay for EMS providers. In rural areas the salary for an EMT can range from \$8.00-\$12.00 an hour. It's not much better for Paramedics. They can expect a range from \$12.00-\$18.00 an hour. The low pay rate in combination with unsteady and hectic work hours leads to a decreased amount of people wanting to work in EMS.

Managers and supervisors may be forced to work right along with the regular staff instead of maintaining office duties due to low staffing. When managers are covering ambulance calls this takes them out of the office and allows a disturbance in the upkeep of the agency. This can become an added stress for managers as it forces them to balance two jobs. The compensation for a higher level position, such as an EMS manager, may be minimal as well. Companies struggle to hire and retain employees when they offer low pay, long hours, and stressful work.

A lack of volunteers and a lack of funding also plays a large role in agencies closing. In March 2015 three ambulance companies in Pennsylvania reported they would be closing their doors. The agencies reported there was a

shortage of volunteers to run the ambulances on calls, as well as, not enough funding to maintain the equipment, supplies, and building costs.

It can cost well over one million dollars to start an Advanced Life Support Emergency Medical Services company (Skrapits, 2016). An ALS company requires much more advanced equipment, medications, and higher trained personnel, such as paramedics.

Not only does it cost money to keep the business afloat, but it is a significant financial burden on the provider as well. Whether Advanced Life Support/Paramedic or Basic Life Support/Emergency Medical Technician, each provider is responsible for maintaining all of the required continuing education to stay current with their certification. Managers must maintain their level of certification, as well as, knowledge on billing, protocols, state and local rules and regulations, and state and federal laws. At Luzerne County Community College it costs six-hundred dollars to obtain an Emergency Medical Technician certification and twenty thousand dollars for an Associate's degree with a paramedic certification (Skrapits, 2016). People are not willing to spend that amount of money on a certification and the maintenance to work a job that makes a minimal amount of money in return.

People cannot be stopped from calling 9-1-1 for non-emergent situations. However, healthcare providers can be deployed into the community to follow up with those who were recently admitted and discharged from the hospital, those who may be lonely and frequently call 9-1-1 without having an

emergency, and those with chronic illnesses. This healthcare team is called mobile integrated healthcare, or community paramedicine.

Utilizing paramedics in the community for mobile integrated healthcare is a good fit as they are already established and comfortable responding to patient's homes and it is more cost effective since the rate of pay in EMS is a lot less than it is for registered nurses. According to Bledsoe, EMS providers are among the poorest paid in the United States healthcare system (Bryan Bledsoe DO, 2016). Community paramedicine would require paramedics to obtain further training to expand their scope of practice. In return, managers would have to obtain more education and knowledge, not only in clinical services, but the operations as well. Managers would be required to shift their focus from the emergency response to more of a clinical approach. While community paramedicine is similar to emergency medical services, it has its functional differences.

A study was conducted in Victoria, Australia studying emergency calls that could be forwarded to a nurse, paramedic, or physician for a secondary phone triage if deemed lower acuity. The results revealed that utilizing EMS and paramedics when other options exist was becoming costly and not suitable for the patient. From September 2009-June 2012 19, 041 cases were triaged with the guideline group and it was found that 8, 510 (44. 7%) were not treated or transported with a paramedic ambulance after they received the follow up phone triage (Eastwood, 2018).

There were several variables that were mixed into the initial triage such as age, time of day, and other comorbidities. This study proved that not all

emergency calls are high acuity, require an ambulance, or a highly trained paramedic. Australia was not the only area to conduct a study, the United States began to notice the potential benefits of shifting from EMS responses to community paramedicine.

Maine has deployed a pilot program for community paramedicine. It was noted that because of frequent hospital readmissions and non-urgent/low acuity patients requesting EMS resources, the cost of healthcare was skyrocketing (Pearson ; Shaler, 2017). The primary goal of the community paramedicine program was to reduce the amount of non-urgent 9-1-1 calls. The idea behind that solution is to forward paramedics out into the community to monitor patients who are at a high risk for hospital admission or readmission, help patients manage their chronic illness and diseases, and assist patients in being compliant with their medication and healthcare regimen.

Maine created a " Triple Aim" with their community paramedic program. The triple aim was targeted to decrease healthcare costs, increase the overall health of the population, and enhance the patient quality and experience. In a comparison between rural and urban areas it was noted that the rural areas had a poorer health status and an increase in chronic illnesses. One in five patients were being re-admitted within thirty days of their hospital discharge. These statistics were attributed to a shortage of physicians and healthcare professionals in rural areas (Pearson ; Shaler, 2017). According to the US Health Systems, more than half of the health systems have fewer than 250 total physicians and only have 1-2 hospitals. The largest 5% has 2, 500 physicians and 18+ hospitals (AHRQ, 2017).

<https://assignbuster.com/reimbursement/>



California also experimented with a pilot community paramedicine program. With the focus of utilizing specially trained paramedics combined with other health care providers the program had seven concepts.

1. Post discharge/short term follow up which consisted of home based care to patients who had a recent discharge from the hospital due to a chronic condition. The purpose was to reduce the risk of readmission and improve the ability of the patient to manage the condition.
2. Frequent EMS users were cared for by providing case management to identify the needs of the patient that could be met more effectively than utilizing EMS.
3. Directly observed therapy of tuberculosis assured the effective treatment of TB was being followed by the patient and instructions given to prevent the spread of the disease.
4. Hospice care consisted of collaboration with hospice nurses, patients, and patients' families to treat the patient in home according to their wishes.
5. Alternative Destination and Mental Health assisted and transported patients to a mental health crisis center instead of the Emergency Department.
6. Alternative Destination-Urgent Care is where the patients were deemed to be lower acuity/non-urgent and were transported to an urgent care facility, instead of the Emergency Department.
7. Alternative Destination-Sobering Center was comprised of the transportation of intoxicated patients to a sobering center, instead of the Emergency Department (Coffman, Wides, & Niedzwieki, 2018).

Of the seven concepts that were studied and piloted there were no detrimental outcomes. It was found that they were able to enhance patients' well-being by improving the coordination of medical, behavior, and social services, while decreasing unnecessary ambulance transports, ED visits, and hospital readmissions. From June 2015 to September 2017 approximately fourteen hundred patients were enrolled in the program for post discharge follow up care. This reduced all-cause 30 day readmissions and avoided approximately \$1.4 million in penalties and costs. Approximately fifty-nine percent was saved in Medicare penalty fees (Coffman, Wides, ; Niedzwieki, 2018).

One-hundred-three patients were enlisted in the EMS frequent flyer program from July 2015 to September 2017. Researchers were able to connect patients with organizations and agencies that provided primary care, mental health services, drug abuse services, and food and housing resources. By doing this they reduced the amount of non-urgent 9-1-1 calls and Emergency Department visits, as well as created a potential cost savings of \$580,000.

There was also a savings in uncompensated care, as many as forty-three percent of the participating patients were uninsured.

Between August 2015 and September 2017 two-hundred-seventy patients participated in the hospice portion of the community paramedicine program. It was found that there was a significant decrease in hospice related 9-1-1 calls that resulted in EMS transport. Costs were reduced by \$203,715.

Two-hundred-fifty-one patients participated in the alternative destination-mental health portion from September 2015 to September 2017. Of the two-

hundred-fifty-one participants, twenty-six percent were transported to a mental health crisis center, instead of the ED. This produced a potential cost savings of \$266, 200.

Between September 2015 and September 2017 forty-eight patients were enrolled in the alternative destination-urgent care portion of the program. This concept had a lower number of patients than what was initially expected. It was found that the majority of the eligible patients were calling 9-1-1 when the urgent care centers were closed, therefore they were not able to utilize the concept as planned.

Finally, the alternative destination-sobering center portion of the program enrolled four-hundred patients, of those fifty were repeat patients between February 2017 and September 2017. Out of the four-hundred participants, over ninety-seven percent were directly transported and treated at a sobering center and a little over two percent were transported to the ED within six hours of being at the sobering center. This created a potential savings of \$132, 699 (Coffman, Wides, ; Niedzwieki, 2018). As more and more areas conduct their own studies and research, it is being proven that adding community paramedicine is producing an overwhelming positive effect on the communities from the enhancement of life, significant cost savings, and job opportunities for those once employed in the EMS system.

With community paramedicine, paramedics could fill the gaps where there is a lack of primary care physicians, or healthcare facilities. Researchers in Maine found there was actually an increase in referrals to the community paramedicine program in the urban areas due to a greater population. The

focus was to decrease the amount of unnecessary ambulance transports that were occurring. What is not understood is that EMS providers are not permitted to deny anyone ambulance transportation to the hospital.

No matter the complaint, or lack thereof. If the patient calls 9-1-1 and requests an ambulance transport, EMS must transport. Even when the patient states there is not an emergency, they simply do not have any means of transportation to go to an urgent care facility or a doctor's office, EMS must transport in the ambulance. This becomes frustrating to everyone from the EMS crew to the hospital staff.

The community paramedicine pilot program had several requirements and specifications. The program itself had to be employed with a primary care physician and EMS medical director in order to function. In order for the program to begin an application was to be submitted and was required to specify the plans for patient interaction, staffing, training, medical direction, quality improvement, and data collection, as well as the services required by the community paramedic.

The list of services consisted of medication reconciliation, diabetic care, fall risk assessment, monitoring of vitals, follow up for wound care, hypertension monitoring, blood draws, vaccines, congestive heart failure monitoring, chronic obstructive pulmonary disease monitoring, edema assessment and monitoring, and diet and weight monitoring (Pearson & Shaler, 2017). A patient was required to meet at least one of the criteria in order to qualify for participation in the community paramedicine program.

In order to measure the success or failure of the program a cost avoidance formula was created. Average transport cost (ambulance + Emergency Department) multiplied by the number of transports avoided divided by the numbers of patients enrolled would determine the amount of unnecessary ambulance transports that were avoided due to the care provided by community paramedics. Another formula that was created was the cost avoidance for hospital readmissions. The average hospital readmission cost multiplied by the number of transports avoided divided by the number of patients enrolled would provide a numeric value to the amount saved in penalties and costs due to hospital readmissions within thirty days (Pearson & Shaler, 2017).

.