The Expanded Role for Emergency Medical Services under Health Care Reform

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Prepared by Bill Lindsay and Leo Tokar, Lockton Companies

This white paper was prepared at the request of and for use by the International Association of Fire Fighters to address the greater and expanded role for Emergency Medical Services under the Patient Protection and Affordable Care Act and the implications for local fire departments. It has been written to apply to employers in general; specific organizations may have situations that require special consideration.

Is there a greater and expanded role for EMS (Emergency Medical Services) under the ACA (Affordable Care Act)?

If so, what is it?

What are the implications for local Fire Departments?

BACKGROUND

The Affordable Care Act seeks to accomplish the following:

- Reduce the number of uninsured in America
- Enhance the level and quality of primary care providers to citizens
- Provide expanded benefits to covered individuals

In this effort, the primary, initial road-block is the adequacy of the primary care network, including physicians, nurses and mid-level providers. Simply stated, there are not enough primary care providers to serve the needs of a society with expanded insurance coverage. Furthermore, it will be years (or generations) before the supply side becomes adequate.

COST PARADIGM

Today, the emergency room of the local hospital fills the void of inadequate provider access. The problem then is cost; aka the Emergency Department (ED) costs too much.

As a solution, many entrepreneurial efforts have taken hold. These have included: employer onsite clinics; big-box stores’ “in-store” clinics; and independent urgent care (“doc-in-the-box”) centers. The problem? These options have increased cost with no resulting economic benefit.

As another example, in some cities, hospitals are actually advertising emergency room “wait times” on bill boards to encourage consumers to seek care there. They are doing this to capture the revenue from diagnostic testing and surgical minutes.

In the current environment, providers react to market needs as a method to drive revenue. As the ACA is implemented, we expect reimbursement will drop for these substitute “primary care” visits. Yet, health care consultants argue that such visits are vital if we want to reduce the
overall cost of care while enhancing quality. The balance between these two paradigms will create opportunity.

**ACO - MEDICAL HOMES**

The ACA incents the creation of new provider care and health care financing models. These include “Accountable Care Organizations” (ACO) which are collaborative ventures between hospitals and physicians. The notion is to have integrated health ventures which provide the patients with a full-service health care continuum.

Reimbursement under these arrangements is envisioned to be for the total episode of care, not just for the specific service in question. Because of these arrangements, providers will seek to control all aspects of the patient experience (i.e., price, quality, access, satisfaction), and thus capture all aspects of the patient’s needs.

**IMPACT: IS THE GLASS HALF EMPTY?**

Some have speculated that the advent of the ACA, with its ACO’s (too many acronyms), will result in providers seeking to control emergency services as a feeder service.

Others question this because the access to primary care for those not currently being served may result in a disproportionate share of those unable to pay, or chronically ill. The reimbursement for these individuals is lower (because of Medicaid) and thus these individuals are a risk to the system promoting this approach.

All of this being said, some hospitals/ACO’s may take this approach to growing their market share. Others may want it because they desire to contract for “episodes of care” and receiving global payments for such episodes. Under this approach, having access to high quality, low cost, EMS services will enable the receiving emergency department with stabilized, triaged patients for treatment.

**CHALLENGES**

There are multiple challenges with this evolution.

1. The opportunity is not uniform. Highly competitive, urban markets will be the most likely to be early adopters of such a strategy. Other areas will move slower and may never evolve to this point.

2. Some of these urban centers already have their own ambulance capability and although ambulance transport is not the same as high quality EMS service, some may not understand the difference.

3. The typical hospital approach is to “control” rather than “partner.” Strategic partnership opportunities will need to be sold (so that the hospital can understand the value to them).

4. In markets with competing hospitals, having a neutral third party service that would be shared by all players may not enable the competitors to distinguish themselves.
5. In most markets, an expanded role for EMS will compete with private ambulance services. The notion of government competing with private industry will heat policy concerns for some elected officials.

THE OPPORTUNITY

While ACA says little about EMS, it creates significant opportunity by influencing the payment and delivery of care, which in turn allows providers such as the EMS community to assume a much different role that traditionally pursued.

EMS can potentially expand its scope to sophisticated care delivery organization that can take advantage of close geographic proximity to a community of patients both to drive revenue and to become much more integrated into the health care system. This view is reflected in recent acquisitions of several ambulance providers by private equity firms.

As a starting point, EMS providers are well-positioned to offer a distinct value proposition through the following services:

- Transportation to alternate (non-emergent) facilities
- Post-discharge monitoring
- Disease management monitoring and assessment
- At home services (augment traditional in home care)
- Patient triage in local community (e.g., limited service retail clinic)
- Patient and community education
- Public health support (government programs)
- Participation in demonstration projects funded by the Center for Medicare and Medicaid Innovation

Whether a particular provider is positioned to deliver one or more of these services depends on many factors including available resources, community needs, and competition, all of which need to explored through an exploration process.

EXPLORATION PROCESS

A number of steps can be conducted as part of an opportunity assessment process. While the following list is not intended to be comprehensive, it provides a starting point for exploring a number of key facets that will dictate whether more concerted effort is warranted.

- Legal and political obstacles (Are there state statutes that prohibit EMTs and paramedics from providing certain types of care, which in turn will require lobbying? Do municipalities have restrictions on how publically funded staff and facilities can be used? Are there competitive/tax implications for public entities competing in a commercial space?)
- Operational readiness (What expanded services can be provided based on available expertise, or without significant additional effort? What is the staff capacity for service expansion? What systems (e.g., billing, medical records receipt and transmission) and other operating requirements (e.g., coordination with other providers) need to be put in place?)
• Operational prioritization (How will core EMS responsibilities be balanced with new services being explored?)
• Market needs assessment
  - Community health care needs
  - Services currently being provided through other means or not be adequately addressed
  - Competition (e.g., other providers positioned to offer the services being considered)
• Financial modeling (basic pro-forma)
  - Incremental start-up costs
  - On-going operating costs
  - Demand (expected utilization)
  - Preliminary reimbursement model
  - Profit/loss position
• Explore possible partnerships (e.g., hospitals, delivery system, public health, etc.)

This process does not need to be as linear as presented here. In some cases, the EMS provider may choose to focus on the first and last steps before conducting the steps in between to get an initial feel for whether to devote any additional effort. Should a group choose to proceed with putting a plan into operation, the work required both politically and operationally, will undoubtedly greatly overshadow the simplicity of these few steps. However, this approach can provide the EMS community a foundation for exploring its options.

CONSIDERING AGREEMENTS

Once the exploration process is complete and a determination is made that viable opportunities exist, how can EMS provider organizations explore partnerships? The first step is to engage professional support to help guide the process. EMS providers should begin by assessing the areas mentioned above including services currently provided and health care organizations that are positioned in your market to use such services. These organizations will be market-specific but could range from well-organized physician groups to hospitals and health care delivery systems. The organizations that are taking on financial risk (e.g., capitation, shared risk arrangements, episode bundled payments) and have large geographic overlap with your target area are the more likely targets.

The process should begin by simply having an initial conversation with executives of the organizations to introduce the potential of a partnership, understand the organization's strategy with regard to managing health and utilization, and give an example of the value the fire department can provide. Should sufficient common ground be found, fire department leaders should pursue further dialogue, and retain support from organizations that are experienced in provider practice management and provider contracting to help you begin to develop operating and reimbursement proposals. Unfortunately, there is no one approach or template that will work in every instance. Each situation will be different which is why enlisting appropriate professional support will be essential.

As fire departments consider this approach, there are several topics that should be explored internally, before attempting to finalize an arrangement.
• Determine whether there is the potential for improved quality and lower cost using a fire department model versus the current options now being utilized. Having hard data to show this point will be important.

• Assess the impact the opportunity may have on existing for-profit entities. The fact that a public resource may be used to compete with companies that pay taxes could create significant issues for the local elected officials. However, under the concept of a “public-private partnership,” if the opportunity for improved efficiency and greater value can be demonstrated this issue may be muted.

• The method of reimbursement for emergency services will be important to this analysis. Since the concept of “global payment” is so prevalent among hospitals today, they may desire to pay for emergency services by using a flat fee versus a charge per service. Financial analysis will be important to determine if this method of reimbursement is reasonable and whether safeguards can be built in to protect against unanticipated surges in utilization or severity.

• There are other services, besides emergency treatment and transportation, which local EMS resources may be able to provide on a cost effective basis. These services may include post-discharge patient consultation and care management services for patients with chronic conditions. Although this opportunity may be enticing as a way to broaden the scope of services, departments should consider whether these services can be offered within the current resource deployment model or whether a new resource deployment configuration is necessary.

• The terms of the initial agreement will be important. Since changes to the healthcare system and to the EMS system continue to evolve, the fire department should assure an adequate termination clause in any agreement in case the financial terms turn-out to be unfavorable.