Transitioning To Transitional Care

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Realigning Reimbursement Policy and Financial Incentives to Support Patient-Centered Out-of-Hospital Care

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INNOVATIVE MODELS OF PAYMENT AND CARE DELIVERY are increasingly being used to expand access, improve quality, and reduce medical costs. Although traditional fee-for-service medicine favors doing more than is necessary, newer payment models aim to realign incentives to decrease utilization and increase efficiency. However, little consideration has been given to how fee-for-service reimbursement in out-of-hospital care limits the ability of emergency medical services (EMS) to provide more patient-centered care and reduce downstream health care costs.

Retrospective studies estimate that between 7% and 34% of Medicare patients transported by ambulance to an emergency department could have been safely treated in an alternate environment.[1,2] However, Medicare and other payers provide no reimbursement for out-of-hospital care including response, triage, and patient assessment and treatment unless the patient is transported to an emergency department. The Medicare ambulance billing guide states, "The Medicare ambulance benefit is a transportation benefit and without a transport there is no benefit."[3] With most private insurers mimicking Medicare,[2] this payment policy significantly affects the behavior of EMS agencies contributing to an inefficient use of out-of-hospital care resources.

Financing Out-of-Hospital Care

National EMS expenditures from Medicare are approximately $5.2 billion per year.[4] Although this is less than 1% of total Medicare expenditures, there are considerable downstream health care costs associated with patients transported to emergency departments.[2] An average EMS agency receives 42% of its operating budget from Medicare fees, 19% from commercial insurers, 12% from Medicaid, and 4% from private pay; it requires approximately 23% in additional subsidization, most often provided by local taxes.[2] Thus, more than three-fourths of EMS revenue is generated from fee-for-service reimbursement, the service being transportation, not necessarily medical care.

However, approximately 26% of EMS responses do not result in a transport,[5] including situations in which patients refuse because their condition was effectively treated by EMS prior to transport (such as resolution of hypoglycemia or treatment of asthma). In 2010, median Medicare reimbursement was $464, slightly above the median cost per transport of $429 after adjusting for nontransported patients.[4] This slim margin must cross-subsidize Medicaid and uninsured patients whose care provides little or no reimbursement and would be quickly eroded by any change in transport rates. This creates a perverse incentive for agencies to transport patients to the hospital emergency department, even if transport is not what a patient needs or wants, and even if other alternatives might be better, less expensive, or more patient centered.

Patient-Centered Out-of-Hospital Care

Out-of-hospital care agencies that are reliant on transportation-based fee-for-service reimbursement are limited in the role they can play within the continuum of health care. Consider a patient with uncomplicated asthma who is without β-agonists or a patient with end-stage renal disease who becomes short of breath secondary to fluid overload on the day of dialysis. In either case, a patient-centered approach might be something other than transport to an emergency department. The patient with asthma might benefit from nebulized albuterol treatments and coordination of care with a primary care physician. The patient with renal disease might benefit from stabilization and transportation to the dialysis center. Neither of these alternative approaches would be reimbursed under existing rules. Instead, for EMS to collect $464 in reimbursement, the EMS agency triggers an extra emergency department visit at an average societal expense of $969.[6] The goal of reimbursement reform should be to realign incentives so that EMS agencies are not financially penalized for offering the patient the most medically appropriate option and offering society the highest value intervention.

Options for the EMS system might include a standard ambulance response, a multipatient transport vehicle, a

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COST & PAYMENT

By Abby Alpert, Kristy G. Morganti, Gregg S. Margolis, Jeffrey Wasserman, and Arthur L. Kellermann

Giving EMS Flexibility In Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings

ABSTRACT Some Medicare beneficiaries who place 911 calls to request an ambulance might safely be cared for in settings other than the emergency department (ED) at lower cost. Using 2005–09 Medicare claims data and a validated algorithm, we estimated that 12.9–16.2 percent of Medicare-covered 911 emergency medical services (EMS) transports involved conditions that were probably nonemergent or primary care treatable. Among beneficiaries not admitted to the hospital, about 34.5 percent had a low-acuity diagnosis that might have been managed outside the ED. Annual Medicare EMS and ED payments for these patients were approximately $1 billion per year. If Medicare had the flexibility to reimburse EMS for managing selected 911 calls in ways other than transport to an ED, we estimate that the federal government could save $283–$560 million or more per year, while improving the continuity of patient care. If private insurance companies followed suit, overall societal savings could be twice as large.

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Wake County EMS APP Program

The Three R's

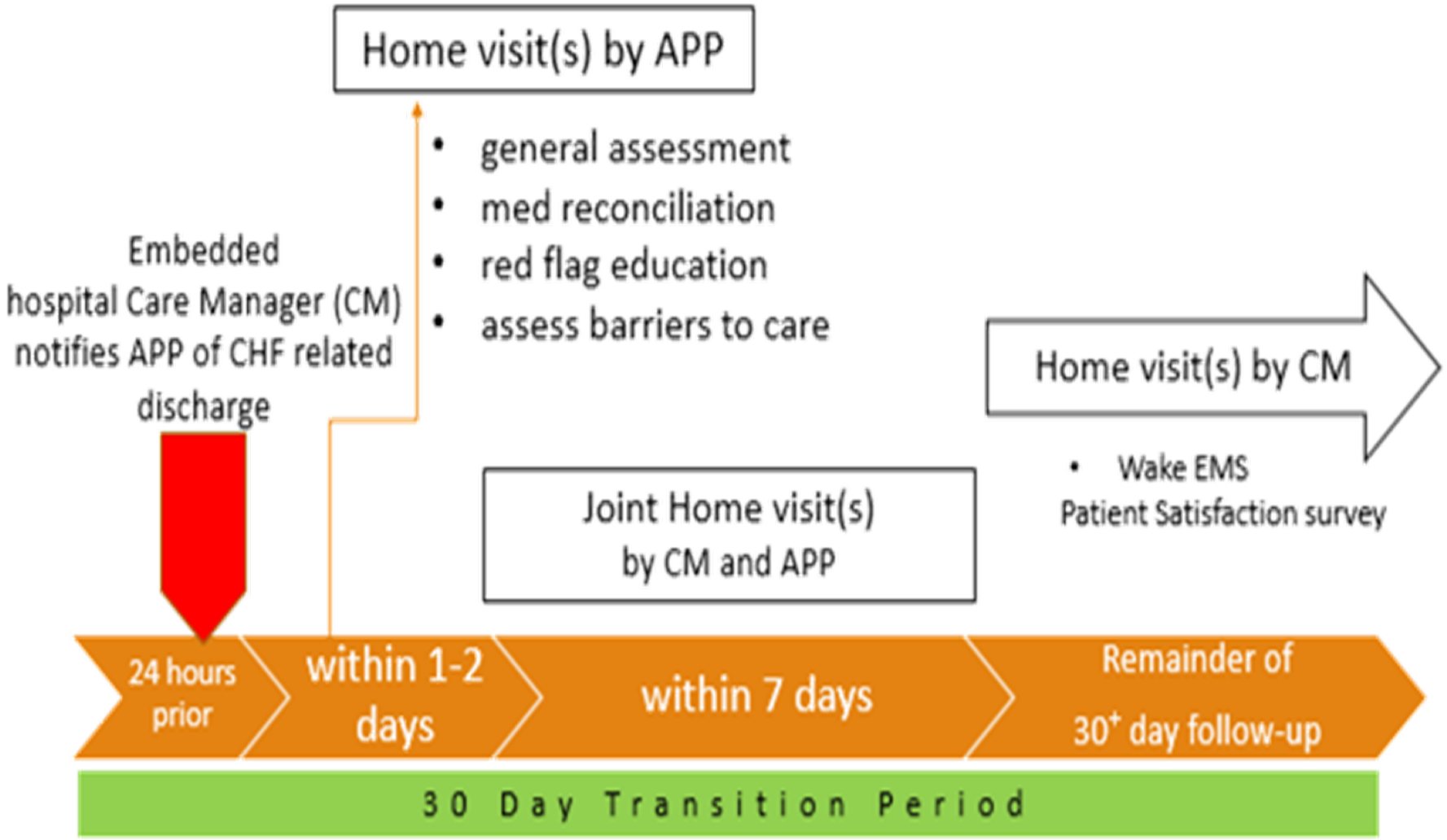
Respond: Critical medical emergencies require an experienced paramedic

Redirect: Not all patients need an emergency dept. evaluation

Reduce: Well-person checks for diabetic patients, CHF patients, etc.

The Opportunity

- **CCWJC is the Community Care network for Wake and Johnston Counties**
  - 170 Primary Care Practices.
- **CCWJC serves approximately 123,000 recipients including:**
  - NC Health Choice
  - Carolina Access Medicaid
  - Carolina Access Medicaid/Medicare
  - Commercially insured patients
  - Uninsured patients

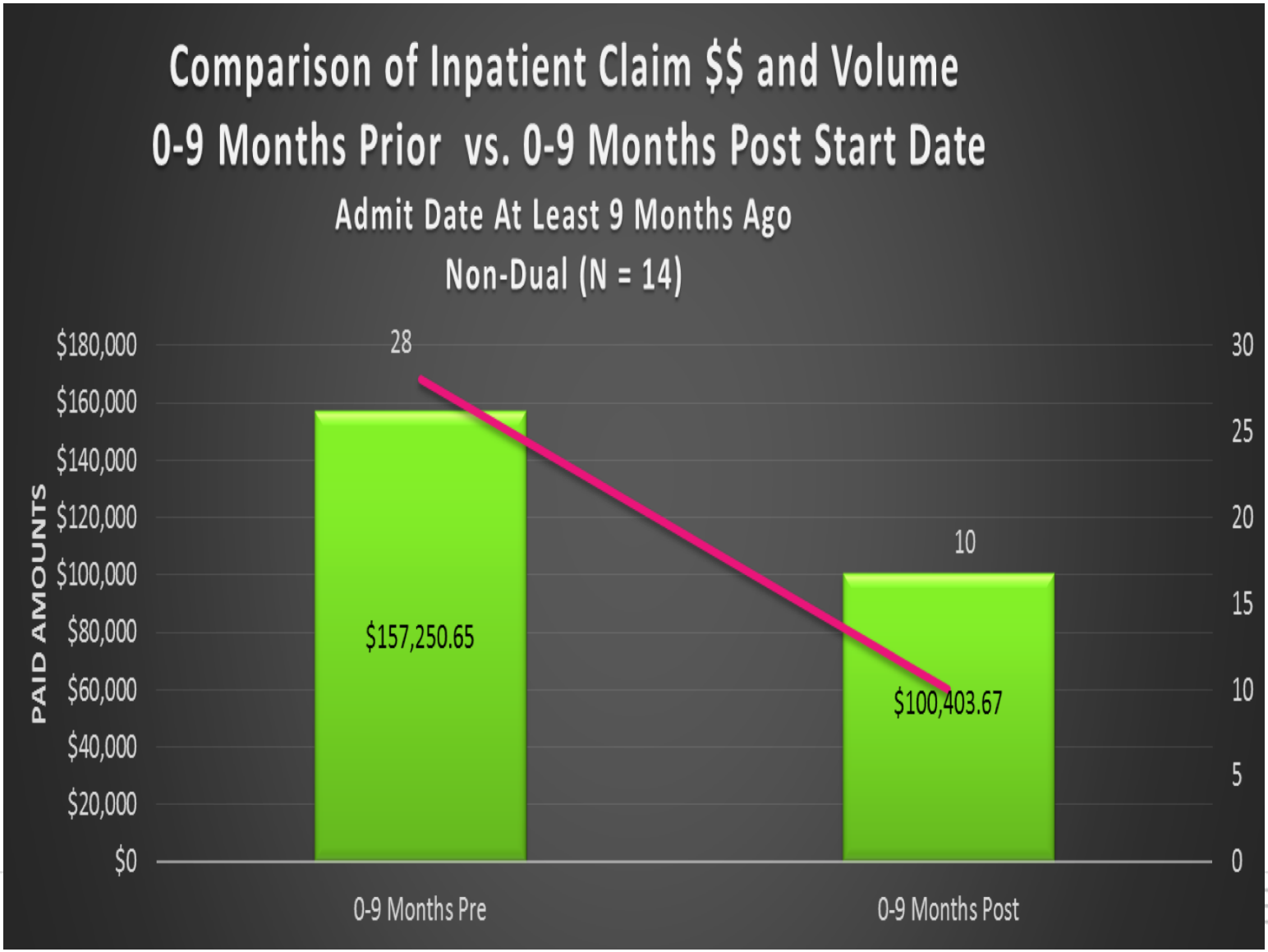

Home visit(s) by APP
• general assessment
• med reconciliation
• red flag education
• assess barriers to care
Embedded hospital Care Manager (CM) notifies APP of CHF related discharge
Home visit(s) by CM
• Wake EMS Patient Satisfaction survey
Joint Home visit(s) by CM and APP
24 hours prior
within 1-2 days
within 7 days
Remainder of 30+ day follow-up
30 Day Transition Period

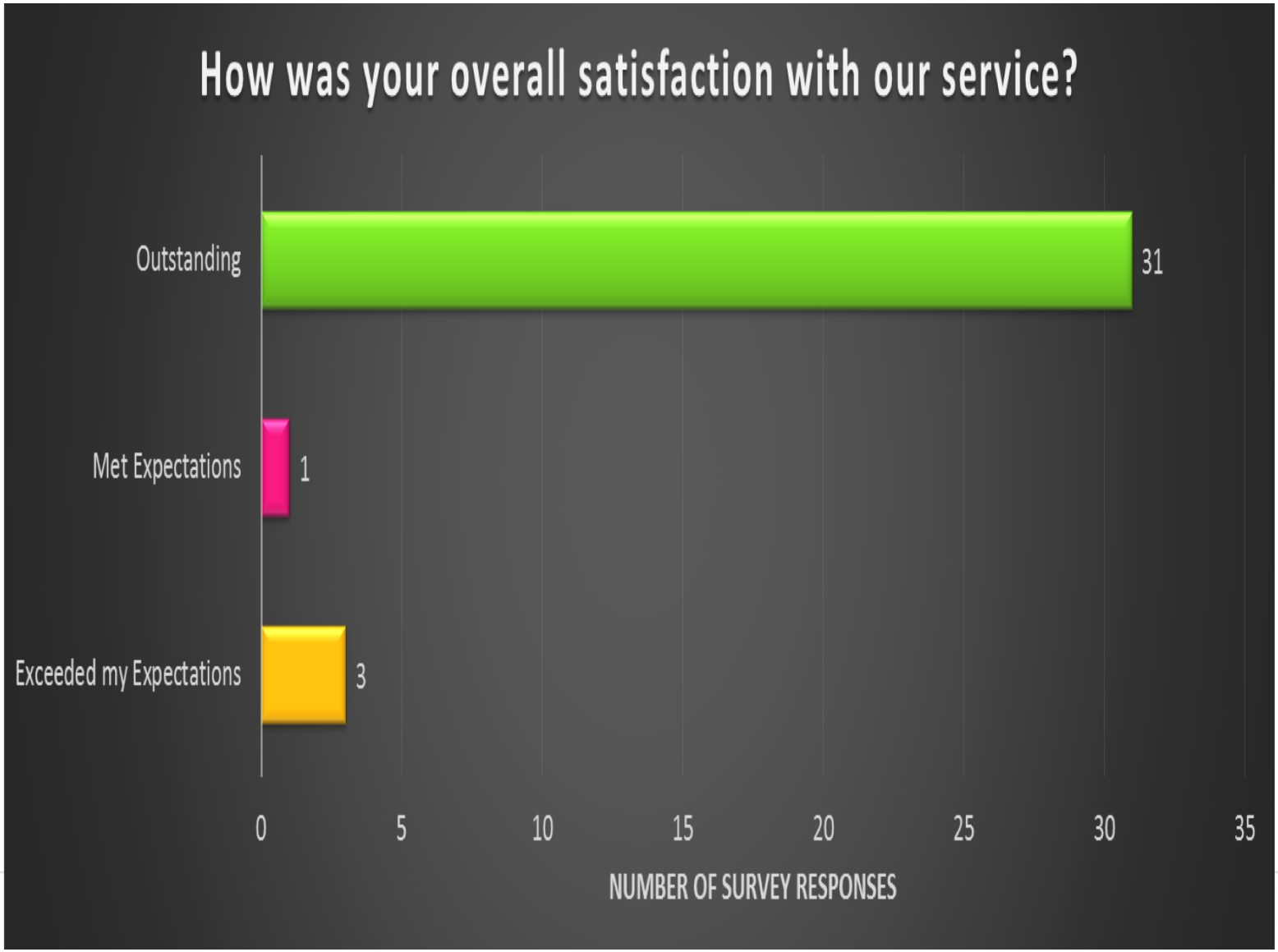
Case - 46 y/o patient with CHF

- **Admitted > 200 days during 2014-2015,**
- **Enrolled in pilot program in April, 2015**
  - Health care expenses:
    - 3 months prior to intervention: **$103,409**
    - 3 months after intervention: **$557**

Initial Actions

- **APPs first visit within 24 hours of discharge**
- **Discovered medication gap and worked with care manager to resolve**
- **Provided immediate red flag education and monitoring**
- **Joint home visit completed by APP/CCWJC within 4 days**


Comparison of Inpatient Claim $$ and Volume
0-9 Months Prior vs. 0-9 Months Post Start Date
Admit Date At Least 9 Months Ago
Non-Dual (N = 14)
PAID AMOUNTS
$180,000
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
30
25
20
15
10
5
0
28
10
$157,250.65
$100,403.67
0-9 Months Pre
0-9 Months Post


How was your overall satisfaction with our service?
Outstanding
31
Met Expectations
1
Exceeded my Expectations
3
0
5
10
15
20
25
30
35
NUMBER OF SURVEY RESPONSES

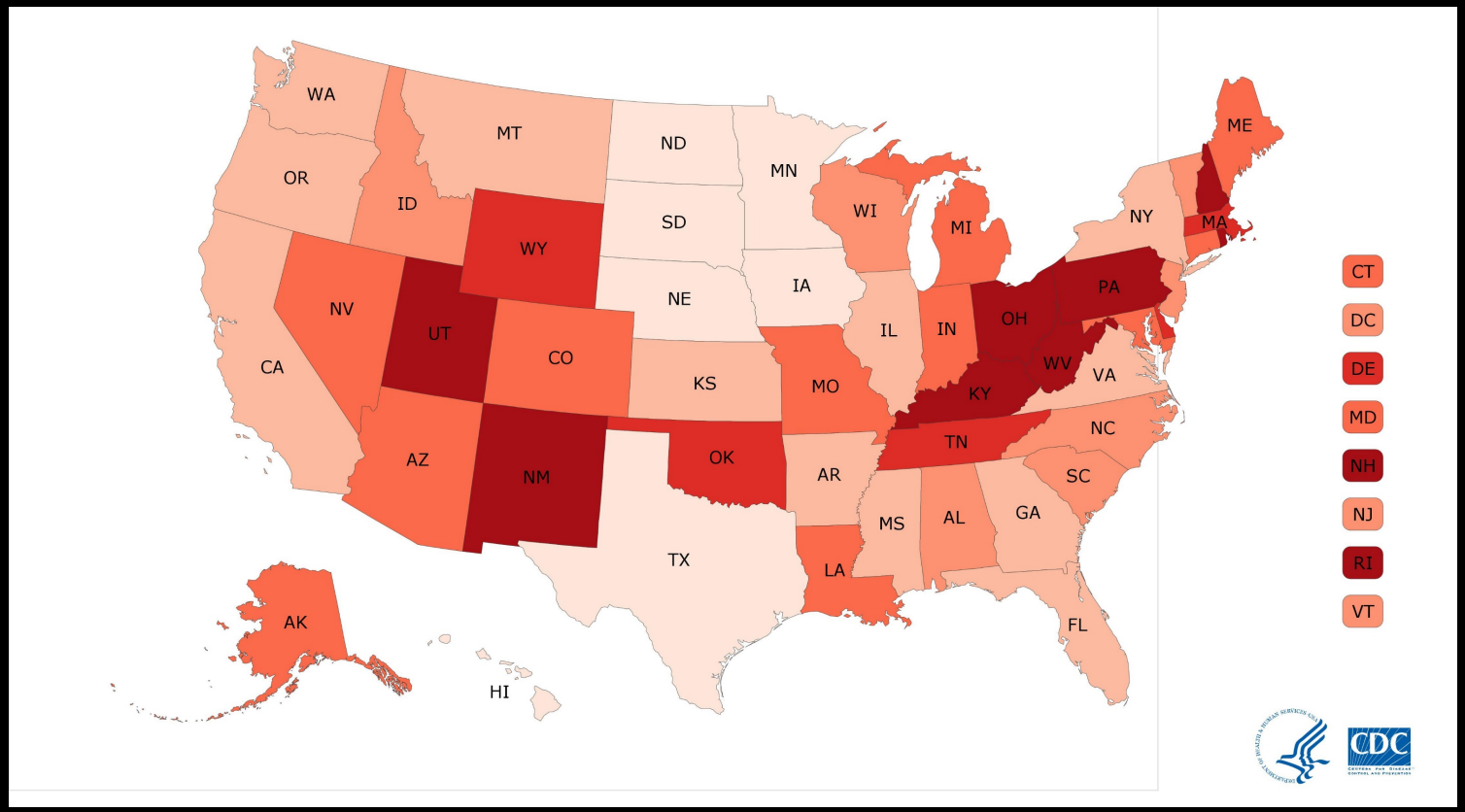
STOPPING THE REVOLVING DOOR OF NARCOTIC ABUSE

Kenneth A Scheppke, MD
Medical Director
Palm Beach County Fire Rescue

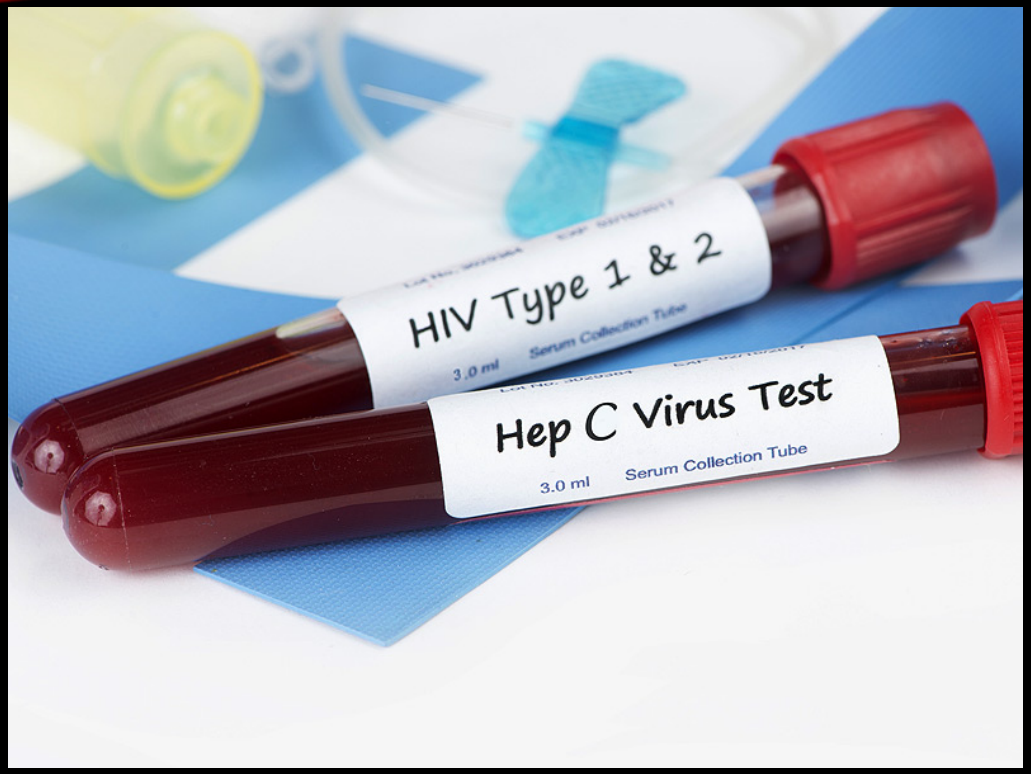
- How do we currently treat narcotic overdose?

- Is there a way to prevent repeat narcotic overdose?

IS THIS A NATIONAL PROBLEM?



THE NEXT EPIDEMIC…



25 Million Substance Users in USA

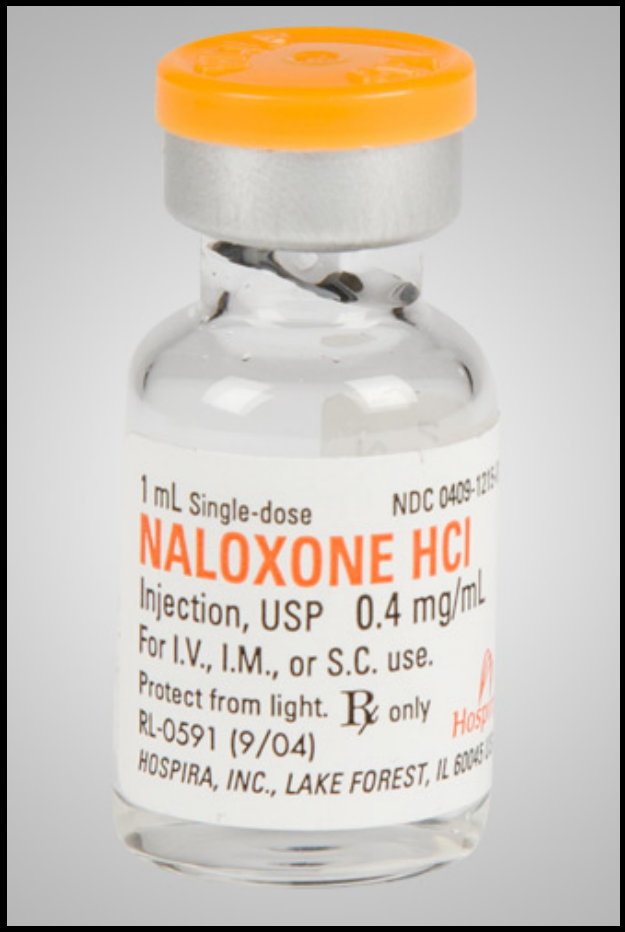
4 Million Addicted

PBC Data: 2/3 have Hep C

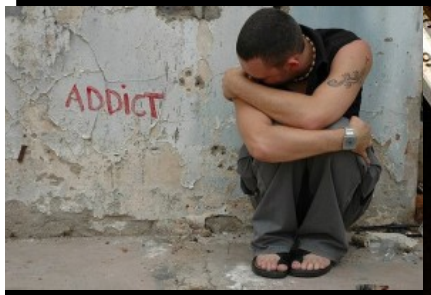
HIV Rates Rising Rapidly

HOW DO WE CURRENTLY DEAL WITH OVERDOSE PATIENTS?

- Palm Beach County EMS Spent about $500,000.00 on Narcan in 2016
- Narcan is over the counter drug now
- Police have Narcan
- Addicts and their friends and family have Narcan
- But the death rate keeps rising…..



THE REVOLVING DOOR



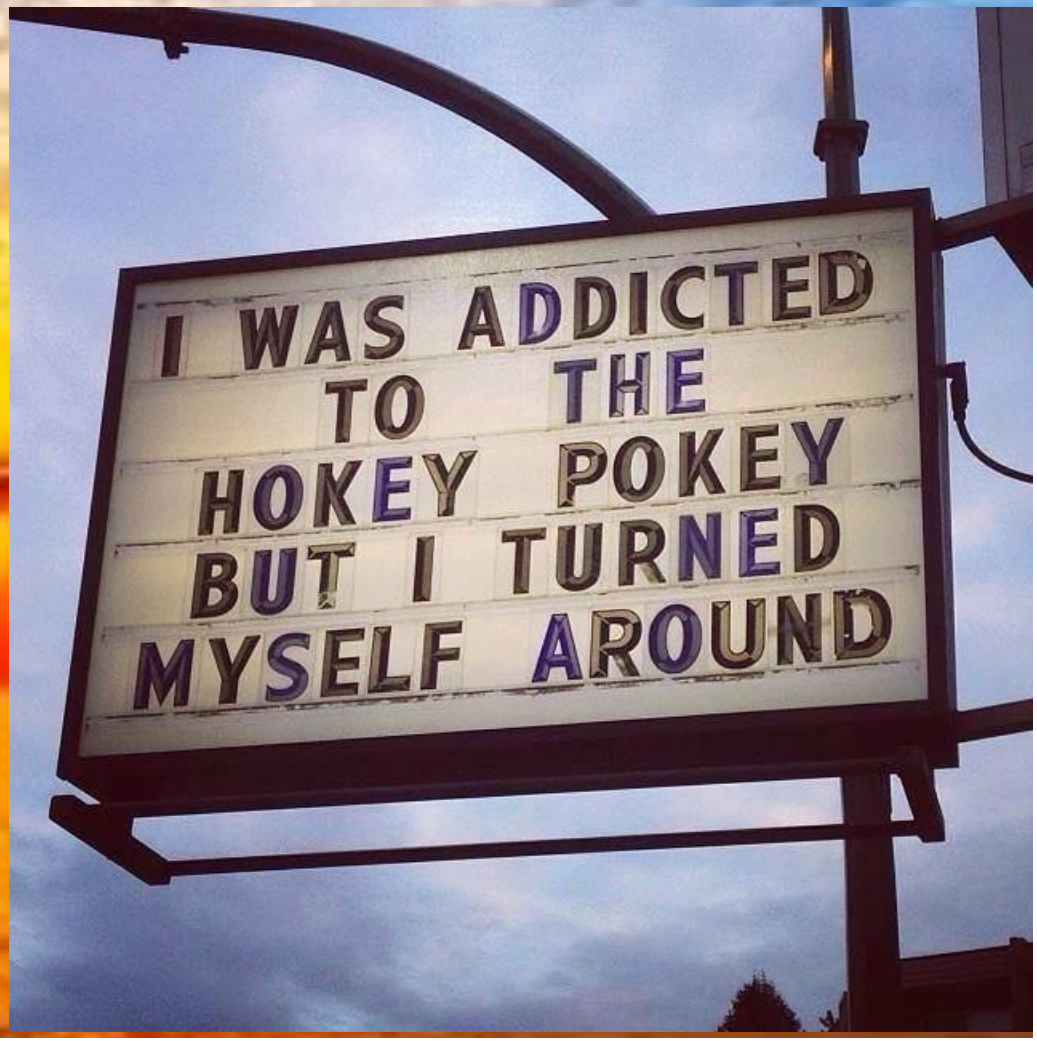
IS SUBSTANCE USE DISORDER A DISEASE OR A CHOICE?

THREE STRIKES RULE FOR DIABETICS??

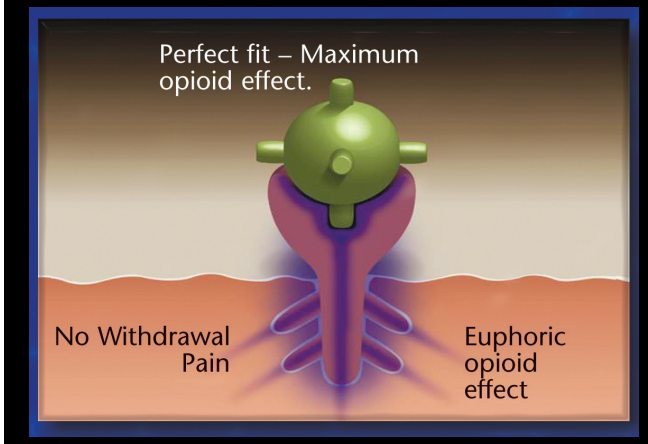
IS OCD A CHOICE?

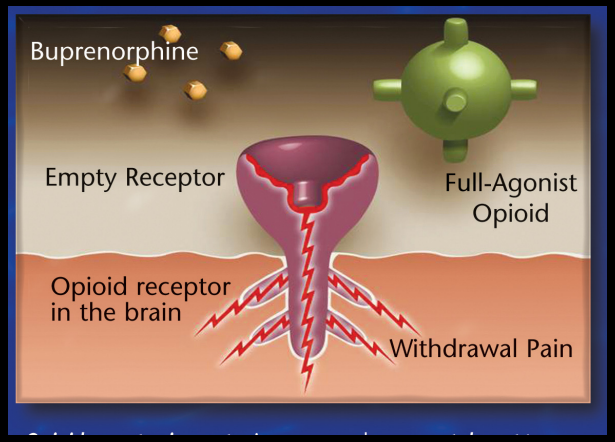
HOPE ON THE HORIZON

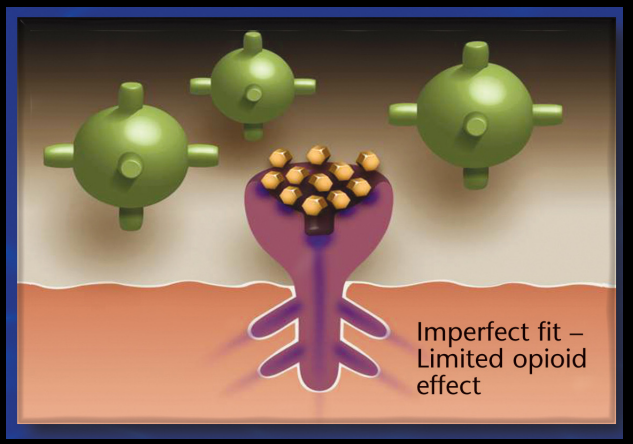
- DATA Passed 2000 Allows for treatment outside of federal drug centers (methadone clinic)
- Buprenorphine approved by DEA for MAT of withdrawal



MAT MODEL


Perfect fit – Maximum opioid effect.
No Withdrawal Pain
Euphoric opioid effect

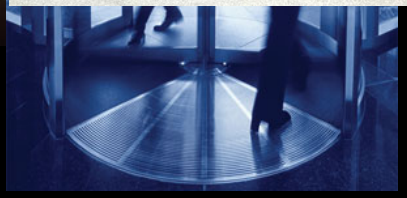

Buprenorphine
Empty Receptor
Full-Agonist Opioid
Opioid receptor in the brain
Withdrawal Pain


Imperfect fit – Limited opioid effect

BARRIERS TO CARE

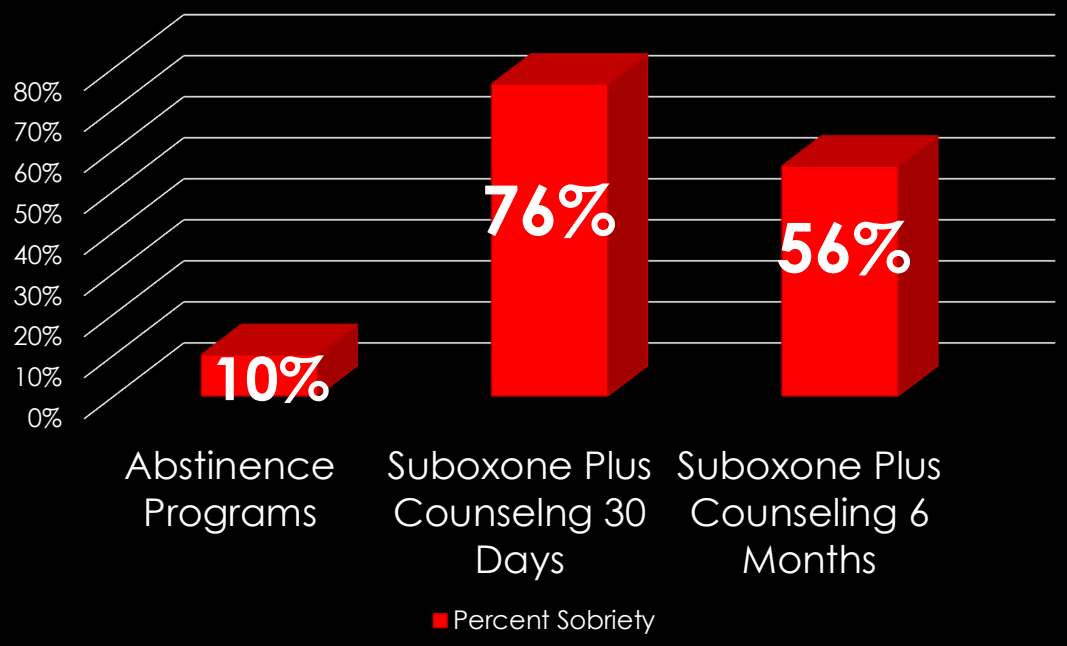
- Lack of insurance/financial resources
- Lack of transportation
- Lack of program space
- Pain/fear of withdrawal
- Lack of positive support structure

PALM BEACH COUNTY MAT PILOT PROGRAM

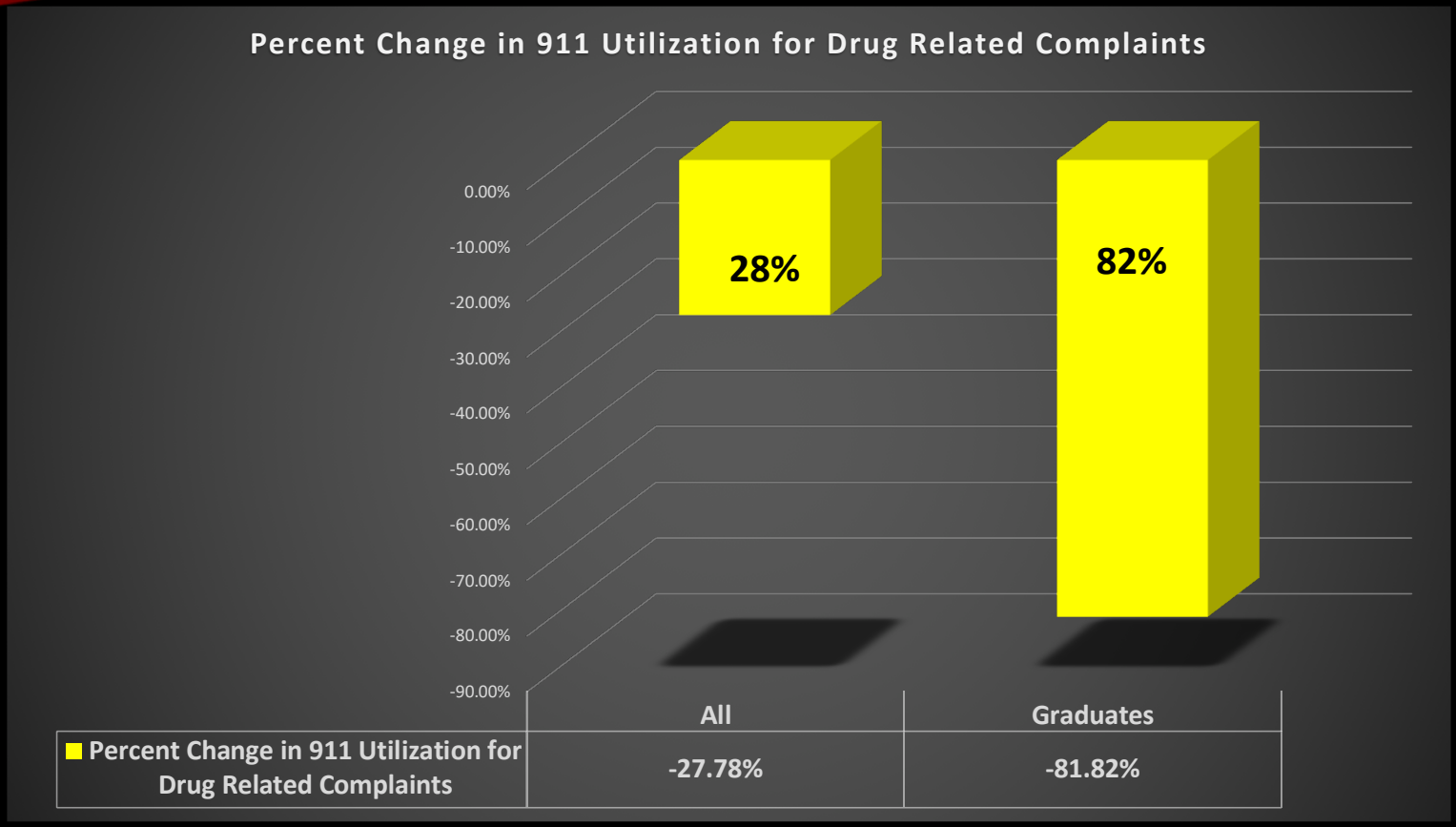


RESULTS TO DATE

- Over 50 Patients enrolled
- 3 lost to homelessness and inability to locate patient
- Several stopped taking meds due to advice of NA support groups since they were not "Clean" while taking it



6 MONTH PRE AND POST 911 UTILIZATION



THE EFFECT OF TREATING CHRONIC ILLNESS WITH EVIDENCED BASED MEDICINE

3 Weeks
Before
After
Treatment
Treatment

RESOURCES FOR MORE INFORMATION

- https://www.naabt.org/education/literature.cfm
- http://www.samhsa.gov/

QUESTIONS?

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