Implementing IOM EMS Recommendations

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Rural/Metro
- Improve EMS Financing
- Reduce the Impact of ED Overcrowding
- Enhance Disaster Preparedness and Response
Improve EMS Financing

- Address Uncompensated Care
- Rationalize Medicaid and Medicare
- Recognize the Cost of Readiness
- Separately Fund First Response and Ambulance Services
- Fund EMS Infrastructure Development
Uncompensated Care

- Uncompensated care results from the 46.6 million uninsured and below-cost Medicaid
- Private pay (uninsured) represents 26% of ambulance transports; 18% collection rate
- IOM recommends increased disproportionate share (DSH) funding for ED’s
- **Congress needs to create DSH funding for ambulance**
Medicaid and Medicare

- Medicare reimburses below average cost
- Medicaid reimburses generally 50% of Medicare
- Below Cost Medicare/Medicaid + Uncompensated Care = Cost Shift to Commercial Payer
  - Commercial Payer: 18% transports; 32% revenue
- Congress/ states must increase Medicare/ Medicaid rates to cover cost
Cost of Readiness

- Ambulance service must provide clinically meaningful response times
- Response time requirements are powerful cost drivers
- Rural coverage requirements are also powerful cost drivers
- Reimbursement by all payers needs to account for cost of readiness
Funding First Response

- First response infrastructure largely funded by community tax support
- Ambulance transport fees designed to fund ambulance service infrastructure
- Trend to extract dollars from ambulance transport fees to fund first response supported by OIG rulings
- OIG rulings should be reversed; first response needs separate funding stream
EMS Infrastructure

- Currently no EMS infrastructure grant program
- Fire Act has significantly improved the infrastructure of the U.S. Fire Service
- DHS and FICEMS directed by Congress to complete EMS needs assessments
- Congress should fund EMS infrastructure grant program ("EMS Act")
Reduce Impact of ED Overcrowding

- Outcome
  - No delays in patient care
- Potential EMS Solutions
- Hospital Performance Standards
Outcomes

- No delays in patient care
  - Assure timely intervention in-hospital
  - Prevent delays in EMS response
- Diversion may be short-term solution
  - Local factors impact potential solutions
  - Not just an in-hospital issue
- Establish solutions that end ambulance parking
Potential EMS Solutions

- Fund pilot projects
  - Alternative Destinations
  - Treat and Refer
- Research patient safety and system impact
- Include lessons from current programs such as Idaho and Orange County NC
Hospital Performance Standards

- Why not—EMS has response time standards
- What’s measured improves
  - Nevada Law—30 minute off-load requirement
  - JCAHCO standards
  - CMS could include in hospital pay-for-performance
- Unintended consequences?
- **Establish and enforce 30-minute patient off-load requirement**
Disaster Preparedness and Response

- Improve EMAC effectiveness
- Establish EMS Set Aside in Homeland Security Grants
- Build national ambulance surge capacity
EMAC Improvements

- Improve activation and deployment process
- Resolve interstate payment issues
- Only 16 states utilize nongovernmental ambulance resources
- DHS needs to commit to EMAC or not
- **Research and remove state barriers to non-governmental EMS involvement**
EMS Set Aside

- Congress acknowledges shortfall and requires another DHS report 1-23-07
  - While EMS is 1/3 first responder workforce, EMS receives only 4% homeland security funding
- EMS Caucus to be formed in 2007
- EMS must master the planning game at the state and local level; Congress should establish EMS set aside
Build National Ambulance Surge Capacity

- 2005—Successful EMS response to Katrina and Rita
- 2006—FEMA/HHS/GSA Federal Ambulance Support RFP not integrated with NIMS or EMAC
- Serious policy issues remain to maximize EMS surge capacity
- DHHS and DHS should host stakeholder summit to address federal response policy issues