The Affordable Care Act
Impacts on California Emergency Medical Services

Risks:

The Affordable Care Act (ACA) presents challenges to Emergency Medical Services (EMS) as it exists today.

One of the most significant is the conversion from volume based to value based EMS and healthcare reimbursement.

Ambulance services nationally and locally are reporting Medicare is already doing one year 'look back' medical necessity reviews of both ground and air transports resulting in withholding payment of future claims based on denial of past claims. MediCal and third party payers historically follow Medicare.

Many experts predict an evolution to a one payer system and capitated payment arrangements.

Medicare/MediCal and other insurers already have capitated contracts in place with many healthcare providers. EMS can anticipate the same for ambulance providers. In the case of MediCal, reimbursement is far below the cost of providing service, creating potential losses associated with the payer mix of the communities served. Currently, there are communities with payer mixes that support sustainable services vs. those communities that do not. However, if the EMS reimbursement schema changes from fee for service to fully capitated models, all EMS system managers and transport providers will be forced to explore new delivery systems to achieve economies in order to survive.

Accountable care organizations (ACOs) and payers are obviously incentivized to manage patient transportation resources and points of care, including the increased utilization of non-ambulances and alternate destinations to control costs resulting in threats to traditional emergency ambulance revenue streams.

The challenges are clear; the changes to historical transportation reimbursement models that sustain EMS could result in the wholesale collapse of current systems.

Improved efficiency and the remodeling the EMS patient delivery systems must occur to maintain economic viability.

Opportunities:

In addition to the threats, the ACA also presents tremendous opportunities to "redefine" EMS and create the future in a proactive vs. reactive scenario.

Central to that objective is to partner with other stakeholders to fully integrate EMS into the overall healthcare system. This would also be an opportunity to change the perception that EMS merely provides transportation to the understanding that it is a component of the healthcare delivery system as both a gateway to patient care and potentially a component of post discharge

follow up. This will lay the foundation of changing transportation only based reimbursement to include payment for a host of EMS provided services.

The provision of value based EMS, aligned with the ACA's 'Triple Aim' of improved quality, decreased costs and increased patient satisfaction is key to this integration. This will likely shift the current reimbursement model to an ACO type EMS system.

To facilitate this evolution, local EMS agencies (LEMSAs), as the system leaders, must immediately engage all stakeholders to identify and acknowledge everyone's needs and perspectives, including real or perceived threats while prioritizing and supporting the appropriate matching of transportation resources with patient care requirements.

The ACA presents the opportunity to remodel, update and evolve current EMS systems to support the goal of a true patient centric approach to healthcare.

Operations:

Fully utilize Emergency Medical Dispatch (EMD) including call prioritization and resource allocation. This includes implementing the EMD Omega level caller interrogation, triage and patient placement into the right venue of care, including securing appropriate transportation.

Develop integrated, alternative transportation options such as wheelchair/gurney vans, taxicabs and other modes, in addition to traditional ALS and BLS ambulances.

Develop alternatives to the traditional acute care hospital emergency departments (EDs) destinations including; urgent cares, clinics, physician offices and other venues.

Develop EMS system managed patient redirection policies when an ED is truly overcrowded and experiencing ambulance patient offload delays.

Develop centralized medical control in the form of a single or regional base hospital or alternate station to provide online medical control to EMS personnel for; treatment orders, community paramedicine, patient flow management including alternative destinations, ambulance patient offload delay situations and multi-casualty incidents. The centralized base would also provide real-time situational awareness and EMS system management.

Technology:

Develop, leverage, and incorporate existing and emerging technological options, e.g., telemedicine, Google Glass, etc. The use of these technologies would assist in the decision making regarding patient transportation necessity, options, destinations and treatments.

Develop, update or implement communication tools such as mobile data terminals or smart phones to facilitate EMS medical control, managed patient redirection and other system operational needs.

Fully develop and implement uniform electronic patient care report (ePCR) driven data collection systems.

Integrate EMS data systems with Health Information Exchanges with the goal of bidirectional data flow including real-time patient information available to EMS personnel and other healthcare providers in the continuum of patient care and for outcome data for continuous quality improvement utilization.

Develop or modify patient centric, performance based, ambulance contracts or request for proposals with extreme flexibility to respond to changing environments.

Conclusion:

LEMSAs must take the lead to engage all stakeholders to achieve a future environment where sustainable EMS systems are fully integrated into the healthcare mainstream.