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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delayed response, or even no response (with telephone triage, advice, and coordination of outpatient care) depending on the nature and severity of the medical symptoms. Once EMS is with the patient, alternatives to the traditional model include coordination of treatment with a patient's medical home or primary care physician. If transportation is necessary, payment reform could allow for expanded destination protocols including the physician's office, community health centers, urgent care, dialysis, substance abuse treatment centers, shelters, or even a nearby relative's house. While these options may increase the liability exposure of prehospital care agencies, this risk could be mitigated through the increased use of medical direction, evidence-based treatment guidelines, telemedicine, and coordination of care with other clinicians as part of a clinically integrated delivery system. This type of patient-centered response is just one example of the untapped potential of out-of-hospital care systems to add value and quality to the health care system.

Health Care Reform and Out-of-Hospital Care

Although the Affordable Care Act authorizes a diverse portfolio of grant opportunities and several initiatives such as the shared savings and bundled payment programs to help realign incentives for inpatient and ambulatory care systems, it does not directly address EMS reimbursement. While much of health reform emphasizes avoiding emergency department visits, EMS remains paradoxically incentivized to transport any and all patients who call 9-1-1 to the emergency department. Despite several previous pilot projects that were found to be either cost effective or cost saving,[7] innovative out-of-hospital care models will not become widespread without EMS reimbursement policy reform.

There are 2 primary means by which out-of-hospital care reimbursement policy could be modified to realign incentives and enable patient-centered EMS: (1) retain a fee-for-service model, but decouple payment for care and transportation; and (2) convert out-of-hospital care reimbursement to a population-based payment model.

Detaching payment from transport could occur by modifying the existing ambulance fee schedule to separate payment rates for the various components of a typical EMS response. A response fee would cover readiness, response, triage, patient assessment, and treatment while a transport fee would reimburse for transport. Although this policy change would be helpful, its overall effect on redesigning the system would likely be modest because it would still rely on fee-for-service billing providing an incentive to transport.

The other option would involve a fundamental overhaul of out-of-hospital reimbursement policy to create a population-based payment system such as global payments, a geographically based bundled payment, or shared savings model similar to the accountable care organization. This reimbursement model would be more likely to provide the incentives necessary to reorganize out-of-hospital care delivery into a more patient-centered model that would decrease overall Medicare expenditures by reducing downstream costs. Patient transports would no longer be a source of revenue and realigned health systems would find willing partners in out-of-hospital care agencies to help achieve shared savings by coordinating care and creating a more rational approach to meeting unscheduled care needs. This partnership would fulfill the vision of the *EMS Agenda for the Future*[8] and the Institute of Medicine report[2] that advocated for a change in reimbursement policy and the clinical integration of EMS into the larger health care context.

Conclusions

Current Medicare reimbursement policies for out-of-hospital care link payment to transport to an emergency department. This provides a disincentive for EMS agencies to work to reduce avoidable visits to emergency departments, limits the role of prehospital care in the US health system, is not responsive to patients' needs, and generates downstream health care costs. Financial and delivery model reforms that address EMS payment policy may allow out-of-hospital care systems to deliver higher-quality, patient-centered, coordinated health care that could improve the public health and lower costs.

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