# National EMS Advisory Council Committee Report DRAFT Submitted on September 8, 2016

**Committee:** Innovative Practices of the EMS Workforce

**Title: Recognizing the EMS Workforce as Essential Decision Makers within the Health Care Industry and Assuring Adequate Fiscal Support**

## Issue Synopsis

### A: Problem Statement

EMS personnel can not properly fulfill their roles as essential health care providers if they and their agencies are not adequately funded. Insufficent funding of EMS will likely result in low wages and exacerbating an already dimished national labor pool.

### B. Background; General-

NEMSAC has previously advised NHTSA that EMS needed to be recognized as an essential service, which resulted in the publication of two white papers; 1) “An Analysis of Prehospital Emergency Medical Services as an Essential Service and as a Public Good in Economic Theory.”, and, 2) “EMS Makes a Difference: Improved Clinical Outcomes and Downstream Health Care Savings.”

These documents provided the evidence based conclusion that modern day pre-hospital emergency medical care is a critically important component of health care in the United States. The EMS workforce is, therefore, essential to the public health and makes decisions that significantly alter the path of care and outcomes of patients, while directly affecting the total cost to society for all of health care[1]. Unfortunately, EMS still received little attention in the debate over health care reform, despite its relevance to health care access, medical outcomes, and health care costs[2]. From the recognition of EMS and its workforce as essential and vitally important to the whole health care system, flows a logical understanding for the need to assure adequacy of availability and access through appropriate fiscal support.

### I. Background; Adequate Funding-

The NEMSAC issued a final report to DOT and FICEMS in 2009 that stated “It is generally recognized that financing EMS has many challenges and that the way the system is funded is fragmented, conflicted and often underfunded.”[3] This report made

[1] (National Highway Traffic Safety Administration, 2009)
[2] (National Highway Traffic Safety Adminstration, 2014)
[3] (National EMS Advisory Council, 2009)

several recommendations to improve the mechanism and methodology used to determine reimbursement for EMS services. However, one area not addressed in the report was the classification of “ambulance service” (ie: EMS) by the Centers for Medicare and Medicaid Services (CMS) as a “Supplier” and not a “Provider”.

In 2012, the Government Accountability Office issued a report to Congressional Committees on their research related to the cost of “ambulance services” around the country. They concluded “The variability of costs per transport reflected differences in certain provider characteristics, such as volume of transports, intensity of Medicare transports, and level of government subsidies received. Providers reported that personnel costs accounted for the largest percentage of their total costs…”[4]

Medicare recognizes health care service agencies and professionals as “suppliers” or “providers” depending on their definitions and functions. Federal regulations define **Provider** as “a hospital, a critical access hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.” and **Supplier** as “a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare”.[5]

Currently under CMS regulations, EMS and medical transportation entities (ambulance services) are recognized as "suppliers." CMS has maintained that this designation is the interpretation of language embedded in legislative statute. However, interpretation of the meaning of legislative language can, and has, changed over time based on the evolving nature of our society. When the Social Security Act was originally written in the mid-1960’s, ambulance services were little more than entities that provided rapid conveyance of ill or injured people to a hospital. Virtually no care was rendered to patients during transportation, beyond basic first aid. Today, ambulance services are fundamentally different and constitute out-of-hospital mobile health care entities, providing advanced medical care which used to only be available in a hospital. A new, contemporary interpretation of the Social Security Act pertaining to ambulance services is appropriate.

If EMS agencies were to be recognized as providers, the mechanism by which their reimbursement rates are determined by CMS would change. For ambulance services the current “supplier” reimbursement structure reflects this distinction by focusing on the transport rather than the medical services being provided. Hospitals, and other Providers, are reimbursed through various forms of CMS’ “Prospective Payment System” which takes into account, over time, changes in cost, patient condition severity,

[4] (Government Accountability Office, 2012)
[5] U.S. Administrative Code Title 42, Chapter IV, Subchapter A, Part 400, Subpart B, Section 400.202, cited as 42 CFR 400.202 - Definitions specific to Medicare.

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health care technology and treatment modalities[6]. This process is more intrinsically appropriate for modern day EMS agencies, since they focus on providing medical care rather than transporting patients, continually evolve to include new clinical treatment modalities, medications and equipment, are constantly affected by significant changes in health care provision costs that are not accommodated through the current National Fee Schedule, and incorporate an ever increasing, extensive scope of practitioner practice not previously envisioned for ambulance services.

In 2013 and 2014, a team of researchers published two reports that examined the cost to Medicare of its current reimbursement restriction requiring patient transport to a hospital by ambulance services in order to qualify for payment. Their research, examining Medicare claims and other research literature previously published on the topic, concluded there was strong potential benefit, both in reducing cost to Medicare and to promoting improved patient outcomes, in altering CMS reimbursement restrictions to permit treatment of patients at the scene then releasing them for follow-up with their primary care physician, or transporting them to a medical facility other than a hospital emergency department, such as an urgent care center.[7,8]

Given the evolution of ambulance services from merely transportation purveyors to multi-level, sophisticated clinical care entities providing mobile health care, and the importance of the national initiative to pursue innovative solutions to help bend the overall health care cost curve downward, designating ambulance services as Providers will allow the Medicare program to more directly recognize and adequately reimburse the actual medical care services being provided, hold ambulance services accountable for quality as CMS does with other Providers, and actually reduce aggregate Medicare expenditures.

## II. Background; Practitioner Classification-

In addition, we recognize that there are substantially different definitions, scopes of practice and delivery models of EMS practitioners and the sectors which they represent across the country. As medical professionals with significantly different levels of clinical knowledge and sophistication of medical practice, they each warrant specific and delineated recognition by title and classification, not only within the health care community, but within the national workforce compendium.

The federal government maintains a standardized data base of the country's different jobs, which includes titles and functional descriptions, through the Department of Labor's Bureau of Labor Statistics. Presently the Bureau of Labor Statistics combines "Emergency Medical Technicians" (EMT) of all levels with "Paramedics", into the same statistical category. The "*BLS Occupational Employment Statistics*" report combines the

[6] Cost variables are regularly assessed by the Medicare Payment Advisory Commission, and reported to Congress with recommendations on improving Medicare and reimbursements.
[7] (Alpert, Morganti, Margolis, Wasserman, & Kellermen, 2013)
[8] (Morganti, Alpert PhD, Margolis PhD NREMT-P, Wasserman PhD MS, & Kellermen MD MPH, 2014)



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wage and workforce data, as well as projected demand, of all EMS practitioners with no differentiation between their various individual professional levels. However, EMTs and Paramedics have demonstrably different education and training requirements, responsibilities for patient care, compensation levels and future projected industry career demands.

The Joint National EMS Leadership Forum (JNEMSLF) made the following pertinent statement in a letter dated July 21, 2014 to the Department of Labor recommending changes in the classification of EMS practitioners by the Bureau of Labor Statistics:

> “The *Occupational Outlook Handbook* produced by the Bureau of Labor Statistics is used by high school counselors across the nation to guide youth in selecting career options. The handbook utilizes the BLS data regarding wages. The reasonable wage a student could expect to earn as a paramedic is underreported due to wage data combining EMT and Paramedic wages. Paramedics generally earn significantly more than EMTs. Consequently, counselors may be less likely to recommend a career as a paramedic and students may be less likely to pursue such a career path. The total number of personnel the Bureau considers in the EMS workforce is also underreported due to the exclusion of volunteers who provide critical EMS services. Although volunteers who are injured or killed in the line of duty are reported as part of the national data collection process, volunteers are not counted as part of the EMS workforce. Workplace injury and death rates are therefore flawed and comparisons to other vocations injury and death rate are likewise flawed. This aspect alone impacts insurance ratings as well as worker compensation issues.”

Aside from clarifying projected national workforce demand, career income expectations, educational requirements and job function descriptions, more specific definitions of practitioners’ titles are professionally meaningful within the health care industry and speak to the sophistication and essentiality of the EMS workforce in general.

**B. Recommendations:**

1. All Federal government partners should set aside portions of, and emphasize EMS within, health care workforce grant funding portfolios including expansion of the financial opportunities currently provided to all health care sectors for education, research and infrastructure.

2. Federal grant programs that encourage innovation in the delivery and provision of EMS and enhance the decision making opportunities of EMS practitioners to the benefit of the patient, especially when those innovations and enhancements

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promote overall health care cost reduction, should be developed, made available and promoted aggressively.

3. DOT and FICEMS should adopt the Joint National EMS Leadership Forum's (JNEMSLF) position statement, published on July 21, 2014, concerning the classifications and definitions of the EMS workforce and work with the Department of Labor's Bureau of Labor Statistics(DOL BLS) on a more exacting description of the EMS workforce to include Emergency Medical Responder (EMR, or First Medical Responder [FMR]), EMT, Advanced EMT, Paramedic, Flight Paramedics and Flight Nurses, as separate categories within the health care workforce sector.

4. FICEMS should pursue discussions with CMS to recognize EMS (ambulance services) as Providers under Medicare regulations and develop a plan for comprehensive payment reform to account for changes in prehospital standards of care, inclusive of technology and clinical care advancements as well as more delineated classifications of patient severity and practitioner scope of practice.

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