Plan to Establish Medicaid Coverage for Ambulance Transports to Alternate Appropriate Care Locations

Session Law 2017-57, Sec. 11H.14A.(b)

Report to the

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

By

NC Department of Health and Human Services

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I. Introduction

Session Law 2017-57, Section 11H.14A.(b) (see ***Appendix A***), requires the Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) to submit a report on a plan to establish Medicaid coverage for ambulance transports to alternative appropriate care locations to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by December 1, 2017.

Currently, Medicaid only covers ambulance transport when medically necessary to hospitals and other facilities capable of rendering emergency care in accordance with the Medicaid State Plan and DMA's Clinical Coverage Policy No. 15, Ambulance Services. Medicaid does not currently cover ambulance transport of beneficiaries in behavioral health crisis to behavioral health clinics or other alternative behavioral health care locations. However, DHHS has examined the Community Behavioral Health Paramedicine Pilot program and its ability to redirect care from hospital emergency departments to alternative locations, such as crisis facilities. DMA believes it is good public policy for the behavioral health system to provide a cost-effective, quality patient care experience which supports a more integrated system.

This report explores expanding Medicaid coverage to allow reimbursement for ambulance transport of beneficiaries in behavioral health crisis to alternate appropriate care locations. It describes current Medicaid coverage, outcomes of the Community Behavioral Health Paramedicine Pilot, and a plan to add coverage for ambulance transport to alternative appropriate care locations, including a proposed provider reimbursement methodology, fiscal impact, and other considerations.

II. Current Medicaid Coverage of Ambulance Transportation Services

The North Carolina Medicaid State Plan[1] and DMA's Clinical Coverage Policy No. 15, Ambulance Services[2] outline the covered services and reimbursement methodologies approved by the federal Centers for Medicare and Medicaid Services (CMS). Emergency ambulance transportation is only covered when determined medically necessary. Medical necessity is indicated when the patient's condition is such that any other means of transportation would endanger the patient's health. Ambulance transportation is not considered medically necessary when any other means of transportation can be safely utilized.

Emergency transportation by an ambulance to a physician's office is covered only if all the following conditions are met:

1. The patient is en route to a hospital;
2. There is medical need for a professional to stabilize the patient's condition; and
3. The ambulance continues the trip to the hospital immediately after stabilization.

Therefore, under the existing North Carolina State Plan, ambulance diversion from hospital emergency departments to alternative appropriate locations for behavioral health care is not currently reimbursable with a federal match from CMS; claims could only be paid with 100% State dollars. If North Carolina wants to draw down a federal match for new coverage, then the State would need to submit a State Plan Amendment to change current coverage and reimbursement policies.

[1] See North Carolina Medicaid State Plan, Attachment 3.1-A.1, Page 18, http://www.ncdhhs.gov/DMA/plan/sp.pdf.
[2] See Clinical Coverage Policy No: 15, Ambulance Services, https://files.nc.gov/ncdma/documents/files/15.pdf.

There are no State Medicaid programs in the country that currently cover ambulance transport to locations like those under consideration here. However, DHHS has initiated conversations with CMS to determine whether ambulance transport to an alternative appropriate care location can be a Medicaid covered benefit within the context of federal regulations. As DHHS prepares this report, CMS is still considering the benefit coverage question.

III. Community Behavioral Health Paramedicine Pilot Program

DHHS has studied the potential benefits of this type of diversion program. The Community Behavioral Health Paramedicine Pilot Program managed by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) began in SFY 2015 with the goal of using specially trained Emergency Medical Services (EMS) staff to intervene with patients experiencing behavioral health crises, and provide incentives for the participating EMS to either treat on-scene or route those patients not needing medical treatment to lower cost alternatives to hospital emergency departments. The program received appropriations of $225,000 and Federal block grant funds to:

- provide awards of $5,000 to establish partnerships and protocols between Emergency Medical Services (EMS), Local Management Entity-Managed Care Organizations (LME-MCOs), and crisis providers;
- provide Crisis Intervention Team (CIT) Training to paramedics in 11 counties;
- draft standardized clinical guidelines and Advanced Practice Paramedic protocols; and
- study and elect reimbursement mechanisms for services provided by EMS agencies.

Wake County EMS was the first system to join the Community Behavioral Health Paramedicine pilot. Since 2009, Wake County EMS has utilized Advanced Practice Paramedics (APP) to redirect care for people with mental health or substance use crises to facilities other than the emergency department when no other medical emergency exists.[3] The goal is to ensure that patients move directly to the care venue that is most appropriate for their condition, ensuring timely care at the right place and time and avoiding a costly emergency department visit. For appropriate beneficiaries, the APP will determine the best alternative treatment location and arrange for the beneficiary's transportation and admission. Beneficiaries may be transported to alternative treatment locations by ambulance, by law enforcement, or by family or friends.

Currently, there are 13 EMS sites participating in the pilot across the seven LME-MCOs. LME-MCOs contract with the EMS providers who serve their catchment area under a two-tiered rate structure. The first tier is $164 per event, where treatment is provided on scene with no transportation. Outside of the pilot program, there is no Medicaid reimbursement mechanism available to pay EMS providers for interventions in which they do not transport an individual to the ED. DMH/DD/SAS data show that approximately 21% of EMS interventions result in the individual being treated on scene and not transported. The second tier is $211 per event, where both treatment and ambulance transport to an alternative site are provided. DMA reviewed SFY2016 and SFY2017 pilot data for Wake County specifically because it has participated in the program for the longest duration and has APPs and existing facilities that serve as alternate transportation destinations. Data from SFY 2016

[3] http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx

show that out of 1,477 transports for both Medicaid and non-Medicaid individuals, 200 (13.5%) were to alternate locations. Among those 200 transports, 35 (17.5%) were for Medicaid beneficiaries. Ambulances were used for 43% of the transports to alternate locations; law enforcement vehicles were used for the remaining 57%. Data from SFY2017 show that out of 1,267 transports, 248 (19.5%) were to alternate locations. Among those 248 transports, 48 (19.3%) were for Medicaid beneficiaries. Ambulances were used for 54% of the transports to alternate locations; law enforcement vehicles were used for the remaining 46%.

Several other states have implemented programs that allow for Medicaid reimbursement of Community Paramedicine programs that treat at the scene without transport. However, no state has received approval for Medicaid reimbursement of behavioral health transportation under ambulance transportation services.

IV. Plan to Add Coverage for Ambulance Transport to Appropriate Alternative Locations

Although it is not yet known whether CMS will approve a State Plan Amendment or Waiver for coverage of ambulance transportation to appropriate alternative care locations for beneficiaries in behavioral health crisis, DMA has drafted the following plan for implementation, including a proposed rate methodology and fiscal impact.

A. Proposed Rate Methodology

The proposed rate methodology for alternative ambulance transport service will be to reimburse in accordance with the current Medicaid State Plan, Attachment 4.19-B, Section 23 and DMA fee schedule.[4] The procedure codes used for these services are shown in **Table 1**.

	TABLE 1	
Procedure Code	**Definition**	**Medicaid Maximum Allowable**
A0425	GROUND MILEAGE, PER STATUTE MILE	$3.03
A0426	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY TRANSPORT, LEVEL 1(ALS 1)	$70.75
A0427	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, EMERGENCY TRANSPORT, LEVEL 1(ALS 1 - EMERGENCY)	$124.68
A0428	AMBULANCE SERVICE, BASIC LIFE SUPPORT, NON-EMERGENCY TRANSPORT (BLS)	$70.75
A0429	AMBULANCE SERVICE, BASIC LIFE SUPPORT, EMERGENCY TRANSPORT (BLS-EMERGENCY)	$70.75
A0433	ADVANCED SERVICE, ADVANCED LIFE SUPPORT, LEVEL 2 (ALS 2)	$129.36

Ambulance transport other than to an emergency department is reimbursable only up to 45 miles by secondary road and 60 miles by primary road from the beneficiary pickup location. If longer distances are required, another transportation method must be used. Mileage is only reimbursable when transport is outside of the limits of the county in which the transport originated.

4 https://dma.ncdhhs.gov/ambulance-services-cpthcpcs

B. Fiscal Impact

In SFY2017, the Medicaid program paid for 21,085 ambulance transports. However, DMA cannot quantify the percentage of those transports that could have been diverted to alternate locations of care because there is currently no reimbursement mechanism. Therefore, there are no corresponding EMS claims in NCTracks to analyze. To determine the potential fiscal impact of adding coverage, DMA applied the known percentage of ambulance transports to alternate locations from the SFY2017 Pilot Program data. The fiscal impact uses the following assumptions:

1. The percentage of Medicaid beneficiary transports to alternative locations will be 11.8%. This assumption is based on SFY2017 data from all participating Pilot Program counties (Buncombe; Durham; Forsyth; Guilford; Halifax; Lincoln; McDowell; Onslow; Stokes; and Wake) where, out of 3,346 transports for Medicaid and non-Medicaid individuals, 396 were to alternate sites.
2. The growth factor for the number of transports will be 4%. This is the compounded annual growth rate (CAGR), defined as the average monthly enrollment growth of Medicaid over the last 3 fiscal years. This accounts for enrollment growth.
3. All alternative transports will be via ground level transport with costs calculated on a per mile basis (procedure code A0425).
4. 75% of the alternative transports will require Basic Life Support and 25% will require Advanced Life Support. Advance Life Support is necessary if the patient needs medication administration during the transport. Basic Life Support requires personnel with less training and has a lower fee.

The full fiscal impact is detailed in **Table 2**. However, based on these assumptions, it is estimated to cost $5,043,957 (federal and State dollars) for SFY2019 and $5,245,715 for SFY2020 for the reimbursement of ambulance transports to alternative locations.

Transporting to a more appropriate alternative location instead of the emergency department (ED) may also save money on the cost of care, as the alternative location is likely to be more cost effective. However, the actual savings would be based on the alternative facilities and the rates of the LME-MCOs who contract with those facilities. Furthermore, those savings would be reflected within the LME-MCO budgets, because DMA pays the LME-MCOs a capitated, per member per month rate for Medicaid beneficiaries who receive behavioral health services.

TABLE 2

Fiscal Impact:	SFY2019	SFY2020
# of Alternative Transports (11.8% of Total Transports)	45,527	47,349
Ground Mileage, Per Statute Mile (Procedure Code A0425):		
Mileage Per Transport	8.76	8.76
Total Mileage Projected	399,030	414,992
Cost Per Mile	$ 3.03	$ 3.03
Fiscal Impact - Subtotal	**1,209,062**	**1,257,425**
Basic Life Support, Emergency Transport (A0429):		
# of Transports (75% of Total)	34,146	35,511
Cost Per Transport	$ 70.75	$ 70.75
Fiscal Impact - Subtotal	**$ 2,415,802**	**$ 2,512,435**
Advanced Life Support, Emergency Transport (A0427):		
# of Transports (25% of Total)	11,382	11,837
Cost Per Transport	$ 124.68	$ 124.68
Fiscal Impact - Subtotal	**$ 1,419,092**	**$ 1,475,856**
Fiscal Impact - Total	$ 5,043,957	$ 5,245,715

C. Additional Considerations

While planning sustainable Medicaid coverage for ambulance transports to alternative care locations, DMA will ensure that Medicaid reimbursement is contingent upon an EMS System's ability to demonstrate that its EMS providers have received appropriate education and training in caring for beneficiaries experiencing a behavioral health crisis. Additionally, the EMS System has at least one partnership with a receiving facility that can provide care appropriate for those beneficiaries. There are currently fewer than ten behavioral health urgent care centers across the State that are open 24 hours a day, 7 days a week, and alternate care locations are not in place in each county, so this initiative will take time to implement. Appropriate training will include, at a minimum, Crisis Intervention Team (CIT) training and training on how to assess beneficiaries experiencing a behavioral health emergency, including mental health, intellectual/development disabilities, and substance use disorders. Each EMS System will also be required to include in its EMS System Plan a report on patient experiences and outcomes in accordance with rules adopted by the Department of Health and Human Services, Division of Health Service Regulation, Office of Emergency Medical Services.

D. Submission of a State Plan Amendment

If CMS determines that ambulance transport to alternative appropriate care locations is reimbursable as a Medicaid covered benefit, DHHS will need recurring appropriations to add this coverage. The timeliness of the response from CMS and legislative action to authorize appropriations for SFY 2019 will dictate the State Plan Amendment submission date.

V. Conclusion

DHHS agrees that the ability to reimburse for ambulance transportation to alternative appropriate care locations for behavioral health emergencies is good public policy because it allows beneficiaries to receive appropriate, timely and cost-effective care. DHHS looks forward to receiving additional guidance from CMS and moving forward with the preliminary plan outlined in this report.

VI. Appendices

Appendix A: Session Law 2017-57, SECTION 11H.14A.

PLAN TO ESTABLISH MEDICAID COVERAGE FOR AMBULANCE TRANSPORTS TO ALTERNATIVE APPROPRIATE CARE LOCATIONS

SECTION 11H.14A.(a) It is the intent of the General Assembly to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to alternative appropriate care locations. Consistent with Option 1 outlined in the Department of Health and Human Services' (Department) March 1, 2015, legislative report entitled "Ambulance Transports to Crisis Centers," the Department shall design a plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The plan shall ensure the following:

(1) Medicaid reimbursement is contingent upon an Emergency Medical Services (EMS) System's ability to demonstrate its EMS providers have received appropriate education in caring for individuals in behavioral health crisis and that the EMS System has at least one partnership with a receiving facility that is able to provide care appropriate for those individuals.

(2) An EMS System shall be required to include in its EMS System Plan a report on patient experiences and outcomes in accordance with rules adopted by the Department of Health and Human Services, Division of Health Regulation, Office of Emergency Medical Services.

SECTION 11H.14A.(b) No later than December 1, 2017, the Department shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The report shall include the following:

(1) The proposed reimbursement methodology to be utilized.

(2) An analysis of the financial impact of adding the coverage, including any anticipated costs to the Medicaid program.

(3) Whether the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e) or whether additional appropriations are required.

(4) If the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e), a time line for submission of any State Plan amendments or any waivers necessary for implementation and expected implementation date.