



**GOVERNOR'S EMS AND TRAUMA ADVISORY
COUNCIL
EMERGENCY MEDICAL SERVICES
SUB-COMMITTEE**

FINAL REPORT -

**SOLICITATION OF STAKEHOLDER INPUT ON -
CHANGES TO LAWS AND POLICIES RELATED TO -
THE LICENSURE OF NON-EMERGENCY -
TRANSPORTATION PROVIDERS -**

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GETAC EMS SUB-COMMITTEE -

FINAL REPORT ON THE SOLICITATION OF STAKEHOLDER INPUT REGARDING - CHANGES TO LAWS AND POLICIES RELATED TO THE LICENSURE OF NON- EMERGENCY TRANSPORTATION PROVIDERS -

The 83rd Legislature of Texas passed Senate Bill 8 which had a wide range of changes to the current laws regulating EMS. This was done to address and lower the instances of fraud throughout the Texas medical assistance program (Medicaid) including the ambulance industry. In addition, there were several directives to study different areas of health care provision to identify additional methods of reducing fraud, waste and abuse. Included in Section 14 was a directive to the Department of State Health Services (DSHS), in cooperation with the Health and Human Services Commission and the Texas Medical Board to conduct a thorough review including the solicitation of stakeholder input regarding the laws and policies related to the licensure of nonemergency transportation providers. DSHS was then tasked to make recommendations to the legislature regarding needed changes to the law and to implement identified policy changes.

DSHS asked the Governor's EMS and Trauma Advisory Council to utilize its available resources to solicit stakeholder input on behalf of DSHS. GETAC's EMS Committee took on this task at the August meetings. To accomplish this charge, the EMS Committee held meetings in the following locations:

- Houston
- Harlingen
- Amarillo
- Dallas
- Austin
- San Angelo

These meetings had attendance from approximately 400 licensed EMS Providers and had a wide variety of organizational types represented. Three to five hours were spent in each meeting both reviewing all the changes being implemented to Chapter 157.11 as a result of SB 8 and HB 3556 as well as taking stakeholder input as directed above. The new State EMS Director attended all of these meetings and was a tremendous asset to the EMS Committee and the stakeholders.

Although each location had differing primary concerns with this charge, throughout them all there emerged five recurring themes in which all stakeholder suggestions could be placed. This report is broken down into these five themes with specific ideas for new rules or laws listed under each topic.

I. Increased education and accountability on EMS personnel, healthcare facility personnel (i.e. hospitals and nursing homes), Medicaid managed care personnel and patients:

In every location the EMS Committee met, this group of suggestions was repeated and refined by all providers of all types. No one excused the behavior of fraudulent EMS Providers across the State, but there was strong consensus that all of the parties involved in the request for or the provision of non-emergency ambulance transportation should be provided increased education and be held to a higher level of accountability where appropriate.

• **EMS Personnel**

- Education on the laws and regulations related to EMS billing practices, medical necessity and proper use of the State's medical assistance program should be required in all initial EMS certification programs from EMT through Paramedic.
- An EMS jurisprudence exam should be developed and implemented for all EMS certified personnel at their initial certification.
- Regulations should be put into place so that EMS personnel are held accountable when they violate DSHS rules if their employing agency can prove that the violation rested upon the crew member or if the employee knew that they were violating a rule and chose to do so anyway. This would include policies in place that require the employee to abide by the rule and a system in place to inspect and insure that employees are following the established policies. This input was offered by many stakeholders who felt that employees who have no personal risk to their certification will not stand up or leave an employer who regularly expects them to violate DSHS rules and regulations.
- Laws should be developed to provide increased whistle-blower protections for EMS personnel.
- Laws should be developed to protect EMS Providers from inappropriate whistle-blower allegations.

• **Healthcare facilities, Medicaid managed care organizations and their personnel**

- EMS Providers who commit fraud are responsible for their own actions. Those agencies make choices that result in violations of the law without coercion or deception.
- The first bullet notwithstanding, one of the suggestions voiced most adamantly and most commonly for improvement in non-emergency ambulance transportation was to require training for nursing home and hospital personnel who request ambulances, mandate increased accountability for facilities and Medicaid

managed care organizations who are a party to inappropriate ambulance transports and the implementation of new methods to track these inappropriate transports prior to them being paid.

- Nursing home and hospital personnel whose job requires them to arrange for non-emergency ambulance transportation should be required to undergo training on ambulance medical necessity to help guide them on using the proper mode of transportation when an ambulance is not required.
 - When a healthcare facility requests an ambulance for a patient that does not meet medical necessity or requests a transport at a rate that is not legal and the agency denies their request; the facility will then call around to other agencies until they find an ambulance to perform the transport fraudulently. The healthcare facility should be held accountable for this practice.
 - If a Medicaid managed care organization refuses to utilize the normal or local transport agency for an ambulance transport out of a healthcare facility due to the rate they quote and calls multiple agencies until they find one that is willing to do the transport at a rate significantly below the Medicaid fee schedule, they should be held accountable for this practice.
 - Regulations should be enacted by DSHS-Hospital Licensing, the Department of Aging and Disability Services and the Health and Human Services Commission that requires healthcare facilities and Medicaid managed care organizations be held accountable if they use an inappropriately licensed EMS Provider (licensed below the level of care required by the patient, an unlicensed or expired Provider, etc). When this is discovered, DSHS should be required to report that organization to their specific regulatory organization for enforcement and discipline.
- If an EMS Provider refuses to transport a patient from a facility due to the lack of medical necessity, that refusal must be documented within a tracking system to be developed by the Health and Human Services Commission that would allow other providers to discover the refusal prior to accepting the call. This HHSC “refusal system” would also be used for enforcement of EMS Providers, healthcare facilities and Medicaid managed care organizations.

- **Patients**
 - The State medical assistance program should work with ambulance stakeholders to develop new and updated education for patients regarding the proper utilization of ambulances in the non-emergency environment.

II. Increase the number, ability and processes of DSHS EMS Regulatory Personnel

A large amount of input was received on the inability of DSHS to appropriately regulate EMS Providers and a multitude of ideas were provided on how to improve this.

- More regulatory personnel are needed to enforce the current rules and regulations effectively across the State of Texas.
 - All EMS regulatory personnel should be dedicated to enforcing the EMS rules and regulations and not used in other regulatory strategies.
 - EMS regulatory personnel should be used for investigations, inspections, licensing, regulating and providing technical assistance to EMS Providers, First Responders and education providers.
- DSHS should develop and publish a discipline manual so that all EMS Providers and personnel will understand how the discipline and regulatory process works for both agencies and individuals.
- DSHS should work with stakeholders to develop a process to utilize EMS stakeholders in the regulatory and enforcement process. The development of a peer process involved in the regulatory process will bring credibility to the process with all providers, increase the level of accountability and provide a more consistent process like other healthcare providers regulation.
- DSHS should task GETAC with developing a “deadly sin” list of EMS Provider rule violations. Then when EMS providers violate one or more of these, their licensing reverts back to all the requirements placed on new applicants as a result of HB 3556 and SB 8. The reversion back to “New Applicant” status would apply to all providers regardless of their business type or longevity.
- If an EMS Provider has multiple enforcement actions in a specific amount of time (i.e. 3 violations in two years), their Provider license should be revoked or the Provider should be required to revert back to all the

requirements placed on new applicants as a result of HB 3556 and SB 8. The reversion back to “New Applicant” status would apply to all providers regardless of their business type or longevity.

- DSHS should work with GETAC, RAC’s and EMS stakeholders to find appropriate ways to require higher levels of participation with RAC’s, Emergency Medical Task Forces and other regional organizations by all EMS Providers, not just 911 providers. More local and regional participation with other EMS Providers will lead to higher levels of integration and peer pressure to perform appropriately in their business practices.
- With additional regulatory personnel, DSHS should implement mandatory unannounced visits to new providers within their first six-months of operation.
- With additional regulatory personnel, DSHS should initiate routine “blitz” inspections where they inspect a majority of Providers for critical patient care equipment such as oxygen, suction, defibrillators/monitors, etc.
- When a new applicant submits their initial license packet, they should only be given two additional attempts to submit any missing or incorrect pieces of that license packet. If this cannot be done in these two additional attempts, their application process and fees are forfeited and the applicant has to begin the process again.
- DSHS should put into rule the timelines for the initial licensing process and the re-licensing process. These timelines should include the amount of time agencies have to correct deficiencies in their licensing or re-licensing packets before the process is stopped for lack of response.
- Stakeholders across the State agreed that intent cannot be regulated. If people intend to violate the law, they will regardless of the regulations. The key is to provide more regulators with the tools to effectively and efficiently enforce the rules and regulations that are currently in place.

III. There should be one type of license for ALL ambulance providers, regardless of their primary service type:

- Across the State, all stakeholders agreed that there should be one type of EMS Provider license.

- The general public does not know one ambulance from another. A different license may impact the provider or the regulatory agency, but will not make any difference in how that agency performs and will only confuse the consumers.
- If there was a desire to regulate ambulance transport by emergency or non-emergency, determining what definition of emergency and non-emergency would be the deciding factor:
 - How the vehicle responds to the call
 - How the transport is billed
 - The reason for the request for transport
- The largest area of fraud is in the provision of non-emergency ambulance services. There was overwhelming consensus among stakeholders that if that part of the industry were segregated, the focus of DSHS with limited enforcement staff would still be on the emergency providers because of the perceived impact to public safety. As a result, the “non-emergency” provider would become less and less regulated just exacerbating the fraud issue.
- Several stakeholders suggested that all types of medical transport be regulated including wheelchair and non-medical stretcher transport
 - Wheelchair transportation is used to move individuals who do not meet medical necessity for ambulance.
 - This saves money for facilities and 3rd party payers such as the State’s medical assistance program. Unfortunately this can also be abused by providers who offer wheelchair transport at very low rates in exchange for getting all of the ambulance transports out of a facility or the facility can entice the ambulance provider to do this.
 - This mode of transport routinely moves medically fragile patients with no requirements on equipment, training or safety for the patient placed upon the provider. Things like operating wheelchair lifts, properly securing patients in their wheelchair and their wheelchair into the vehicle and recognizing a patient who is having a medical emergency should be required for wheelchair transport providers.
 - Several years ago, non-medical stretcher transport (gurney car) was outlawed in Texas. This was done because individuals who were medical patients were being inappropriately transported via this type of service to achieve cost savings for facilities that were responsible for the cost of the transport. There was no medical oversight or regulation on what type of individual could appropriately be moved by non-medical stretcher transport.
 - Today, no agency has responsibility for enforcing the ban on non-medical stretcher transport. As a result, these services

- are still being offered but being an illegal mode of transport, the patient is at risk as the service is offered below the radar.
- As the healthcare system continues to look for better efficiencies, stakeholders believe there is a role for non-medical stretcher transport if it is regulated by DSHS and by local healthcare systems. This would ensure that stretcher bound individuals who are “patients” (needing medical care or monitoring) are moved via ambulance while those who are not “patients” are moved by lower cost methods.
 - Stakeholders have asked that the State consider additional regulatory personnel for EMS transportation regulation and that laws and rules be passed to regulate wheelchair and non-medical stretcher transport.

IV. Updates, enhancements and refinements to changes resulting from HB 3556 and SB 8 from the 83rd Legislature:

These two pieces of legislation are making large changes and improvements to the ambulance industry, but now that the dust is settling, there are areas that stakeholders feel need to be adjusted to further address fraud while removing some possible unintended consequences of these new laws.

- Exemptions to providers that are “directly operated by a governmental entity” should be expanded to include not-for-profit corporations whose primary purpose is the provision of 9-1-1 EMS services utilizing volunteers or a combination of paid and volunteer personnel.
 - Stakeholders understand the exemption, but believe the same reasoning can be applied to these not-for-profit agencies that primarily provide 9-1-1 EMS services to governmental entities.
 - If exempting these agencies is not deemed feasible, rural and frontier stakeholders suggested applying these new items based upon county population.
- The requirement for new providers to only operate in the jurisdiction where they have a letter of approval from the local governmental entity for their first two years should be expanded to require this for several more years if not permanently.
- The new Administrator of Record requirements of an initial education course, continuing education hours and the ability to only serve as the Administrator of Record for one agency should apply to **all** EMS Providers including governmental entities and should not have an exemption for tenure in the industry.

- These requirements have the potential to increase the level of education and sophistication of EMS leadership and stakeholders strongly felt these should apply to all provider types to assist in moving the entire industry forward.
- As laws and regulations continue to increase, there should be a tie between compliance with DSHS regulations to incentives in the State’s medical assistance program, the Medicaid managed care program and the child health plan program. This would provide higher reimbursement rates to those agencies that are strongly compliant through announced and unannounced DSHS inspections.
- Provide an up-to-date listing of Administrators of Record for all agencies readily available on the website so that local governments who implement ordinances or provide letters of approval to new providers can contact agencies they see in their jurisdiction to advise them of their ordinances and laws.
- DSHS should approve all providers of Administrator of Record Continuing Education.

V. Increase the requirements on legitimate business practices

This type of increased regulation will, theoretically, not impact Providers who are working to be compliant, but it may increase the level of effort required of fraudulent providers to a level that could preclude some of them from entering the field.

- Require all providers to supply proof of ownership or lease of a legitimate place of business in their licensing packet. This must be the same as the agency’s primary place of business.
- Rules should be put in place that only allows one EMS Provider at one specific address.
- Require Providers to show proof of ownership or lease of all capital inventory items such as ambulances, EKG monitors, defibrillators, and stretchers necessary for operation under their protocols and equipment lists.
- Develop a five year plan to require all EMS Providers to have electronic Patient Care Reports that integrate into the State EMS Data Registry,

their regional registry and the receiving hospital's electronic medical record.

The EMS Sub-Committee of GETAC respectfully submits this report on behalf of EMS stakeholders across the State of Texas. The Committee deems that this document represents the best consensus of ideas presented by EMS Providers of all types (private, public, fire, non-fire, hospital, for-profit, not-for-profit, paid and volunteer) from across the State. The stakeholders all agreed that the ambulance industry has been through a dark period over the last several years, but it is recovering. The ideas presented here along with the willingness and diligence of EMS Providers from across the State to continue improving themselves and their agency will further the recovery of the EMS industry. After completing this journey, the EMS Committee believes brighter days are ahead for our industry. We thank you for the opportunity to have seen this first hand from EMS Providers all across the great State of Texas.