

**Recommendations to the Legislature
Related to the Provision of Non-Emergency
Transportation Services by Ambulance Providers**

February 2014



As Required By S.B. 8, Sections 13-15, 83rd Legislature, Regular Session, 2013

**Health and Human Services Commission
Department of State Health Services
Texas Medical Board**

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INTRODUCTION

S.B. 8, Sections 13-15, 83rd Legislature, Regular Session, 2013, require the Health and Human Services Commission (HHSC), the Department of State Health Services (DSHS), and the Texas Medical Board (TMB) respectively to make recommendations to the Legislature that would reduce the incidence of fraud, waste, and abuse with respect to:

- the laws and policies related to the use of non-emergent services provided by ambulance providers under Medicaid (S.B. 8, Section 13);
- the laws and policies related to the licensure of nonemergency transportation providers (S.B. 8, Section 14); and
- the laws and policies related to the delegation of health care services by physicians or medical directors to qualified emergency medical services personnel and physicians' assessment of patients' needs for purposes of ambulatory transfer or transport or other purposes (S.B. 8, Section 15).

The legislation further requires that the recommendations are developed in cooperation among HHSC, DSHS, and TMB. HHSC, DSHS, and TMB began meeting in July 2013 to discuss and develop the recommendations. This report is a composite of information cooperatively contributed by the HHSC, TMB and DSHS.

As each agency was in a different point of the process in the development of their approaches, the sections contributed by each entity reflect that. At the time of this legislation's passage, HHSC had begun reviewing and modifying its Medicaid policies related to non-emergent services, TMB had recently completed a rule amendment that addressed the issues highlighted by the bill, and DSHS had been conducting research and begun discussions with the Governor's EMS and Trauma Advisory Council (GETAC) related to fraud prevention measures for nonemergency transportation providers.

HHSC, DSHS, and TMB will continue to monitor current policies and practices for opportunities to reduce fraud, waste and abuse related to these services.

BACKGROUND

HISTORY OF EMS AND EMS REGULATION IN TEXAS

In 1943, the 48th Legislature passed ambulance permitting legislation in Vernon's Texas Civil Statutes (V.T.C.S), Article 4590-b, which required a permit, issued by the State Board of Health, to operate an ambulance. In 1973, an Attorney General's Opinion H-102 confirmed that the operator of a private ambulance which does not normally answer calls from the police dispatcher to pick up victims of crashes and illness, but which does transfer private patients from home to hospital and from one hospital to another, was required to have a permit from the State Board of Health under (V.T C. S.) Article 4590b.

In 1983, the 68th Legislature amended The EMS Act, (V.T C. S.), Article 4447o which addressed EMS regulation through personnel certification, required vehicle permitting, and established the Bureau of Emergency Management.

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Because of issues related to receiving EMS provider Medicare reimbursement, which requires state licensure as a condition of participation, in the mid to late 1980s, non-emergency medical transportation providers applied for and received an EMS provider license under the EMS Act. The fee charged for a provider license is \$500.00, and fixed per statute. This minimal licensing fee created low barriers to entry and has made it relatively easy to establish an EMS service in Texas and to obtain the required license.

As early as 2004, GETAC recognized the need to closely look at issues related to EMS provider licensing. As a result, the GETAC created a Medical Transportation Task Force to review the issue of “licensing problems” related to non-emergency inter-facility transport services and unregulated general medical transportation. The findings of that task force were used as the starting point for the current stakeholder review and feedback as well as the recommendations found in this report.

FRAUD-RELATED INCIDENTS AND CONCERNS

In 2005, DSHS staff participated in the North Texas Healthcare Fraud Work Group, hosted by the Federal Bureau of Investigations (FBI). The participants included representatives from the health insurance industry; EMS licensed providers, trade organizations, advocacy groups and other governmental agencies that had an interest in combating fraud, waste and abuse committed by EMS providers. DSHS has had discussions about interventions intended to decrease or stop fraud in EMS with the FBI, HHS Office of the Inspector General (OIG) and the Office of the Attorney General (AG). Areas of particular interest were in the Dallas/Fort Worth and East Texas areas of the state. In December 2006, DSHS staff participated in a federal seizure at 17 EMS provider locations that were suspected of committing Medicaid fraud. This resulted in multiple criminal convictions, fines, restitution and company closures.

In June 2011, DSHS conducted 24 inspections in a single Houston zip code to verify EMS provider compliance with Texas Administrative Code §157.11. As a result, DSHS identified 62 EMS providers that were not located at the physical address of record. Based on inspection findings, these providers were sent to enforcement for appropriate action. The proliferation of EMS providers in the Houston area reached an all-time high in the fall of 2011 when, of the 1,241 licensed providers statewide, 396 were located in Harris County alone, and 569 were located in Health Services Region 6, which includes Harris County.

The Houston Chronicle spotlighted the issue of Medicaid fraud when it ran a series of articles in October 2011, highlighting fraud and suspected fraud by EMS providers in the Houston area. As a result, DSHS staff implemented a number of strategies to combat EMS fraud from a regulatory perspective. Actions by DSHS included the increase of unannounced provider inspections in targeted areas, expediting enforcement actions for violators, collaboration with the Texas Medical Board to strengthen the EMS medical director requirements, placing a cap on the number of EMS firms for which a single physician could serve as a medical director, and re-educating medical directors regarding their roles and responsibilities. DSHS is in the process of developing stronger provider licensing rules and evaluating the role of consultants for new EMS firms.

A temporary moratorium was issued under S.B. 8, Section 9, which prohibits DSHS from issuing any new emergency medical services provider licenses for the period beginning on September 1, 2013, and ending on August 31, 2014. This provision applies to applications submitted on or after the effective date of S.B. 8.

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In addition to S.B. 8, H.B. 3556 was passed during the 83rd Legislature, with the intent of implementing new requirements and identifying other potential strategies to prevent fraud, waste and abuse in the Medicaid program related to emergency medical services (EMS) providers.

In July 2013, the Centers of Medicare & Medicaid Services (CMS) issued a notice announcing the first temporary enrollment moratorium under the Affordable Care Act to fight fraud in Medicare, Medicaid and CHIP. The moratorium temporarily halted the enrollment of new ground ambulance suppliers in the Houston metropolitan area for six months in accordance with the moratorium. CMS and Texas are denying all new or pending applications from ground ambulance suppliers with practice locations in Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller counties. Applications that were received from these affected suppliers prior to the moratorium announcement were denied and returned (along with fees, if applicable).¹ The temporary moratorium was extended on January 31, 2014, for an additional six months.²

The combined interventions of CMS, DSHS, TMB, and HHSC had a significant impact on the number of EMS firms doing business in the Houston area by decreasing the number of providers over the last 2 years. This decrease in the number of providers in the Houston area has not negatively impacted the emergency response by the 911 provider, City of Houston EMS. The number of providers in Harris County has dropped to 242 as of December 2013.

HHSC is required to make recommendations to the Legislature that would reduce the incidence of fraud, waste, and abuse with respect to the laws and policies related to the use of non-emergent services provided by ambulance providers under Medicaid.

This report outlines HHSC stakeholder outreach and Medicaid policy changes aimed at achieving the goal required by the legislation.

According to 1 TAC §354.1111, nonemergency transport is defined as “Transport provided by an ambulance provider for a Medicaid recipient to or from a scheduled medical appointment, to or from another licensed facility for treatment, or to the recipient's home after discharge from a hospital. Non-emergency transport is appropriate when the Medicaid recipient's medical condition is such that the use of an ambulance is the only appropriate means of transport, e.g., alternate means of transport are medically contraindicated.”

Per Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain prior authorization before an ambulance is used to

¹ CMS imposes first Affordable Care Act enrollment moratorium on Houston-area ground ambulance suppliers to combat fraud and safeguard taxpayer dollars. <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-07-26-2.html>, accessed February 4, 2014.

² Medicare, Medicaid, and Children’s Health Insurance Programs: Announcement of New and Extended Temporary Moratoria on Enrollment of Ambulances and Home Health Agencies in Designated Geographic Locations. <https://www.federalregister.gov/articles/2014/02/04/2014-02166/medicare-medicare-and-childrens-health-insurance-programs-announcement-of-new-and-extended-temporary>, accessed February 4, 2014.

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transport a client in circumstances not involving an emergency. Medical necessity must be established through prior authorization for all nonemergency ambulance transports. Clients who do not meet medical necessity requirements for nonemergency ambulance transport may be able to receive transport through the Medical Transportation Program (MTP).

HHSC STAKEHOLDER INPUT/SOLICITATION

To request public input regarding strategies, policies, and changes to state law that would help reduce the opportunity for fraud, waste, and abuse in Medicaid non-emergent services provided by ambulance providers, HHSC reached out to stakeholders in a variety of ways. A presentation regarding this initiative was made at the January 2014 HHSC stakeholder forum which is a quarterly meeting held by HHSC to inform and get feedback from stakeholders about HHSC initiatives. Staff also requested input from attendees of the fourth quarter Governor's EMS and Trauma Advisory Council (GETAC) meetings, and at Medicaid and Children's Health Insurance Program (CHIP) HHSC Regional Advisory Committee (RAC) meetings throughout the state during the fourth quarter of 2013. Input will also be requested at future GETAC and RAC meetings, as needed. HHSC also solicited comments regarding non-emergent ambulance transport from Medicaid managed care health plans.

DSHS and HHSC staff reviewed the comments and are considering changes to policy and procedures. Once the review is complete, HHSC staff will continue to work with DSHS to review utilization of non-emergent ambulance services and seek opportunities to reduce any overutilization, if necessary.

HHSC RESPONSE

Medicaid non-emergent ambulance services are provided to a client for whom an ambulance is the only appropriate means of transportation or when alternate means of transportation are medically contraindicated and would endanger the individual's health. To address client and provider concerns and to provide Medicaid clients with the most current standards of medical practice, HHSC regularly conducts medical policy and utilization reviews for its Medicaid and CHIP programs. HHSC performed comprehensive reviews of its Medicaid ambulance services policy in May 2011 and June 2013. As a result of these reviews, HHSC changed the Medicaid ambulance services policy to reduce the incidence of and opportunities for fraud, waste, and abuse, and address non-emergent services provided by ambulance providers.

Prior to February 2014, prior authorization was granted for up to 180 days, however because a client's health condition can change, long-term prior authorization approvals (more than 60 days) are no longer issued for non-emergent services provided by ambulance providers. Providers are now required to submit documentation describing a client's condition and their need for non-emergent ambulance services with each prior authorization request. Prior authorization is now issued based on a one-time request for clients who require a one-time transport or for recurring transports for those clients whose ambulance transportation needs are anticipated to last as long as 60 days. Clients may qualify on a case-by-case basis for an exception to the 60-day prior authorization request if their medical or behavioral health provider has documented a debilitating condition that requires recurring trips for more than 60 days.

HHSC also determined that the person who can best describe a client's current condition and the need for non-emergent ambulance transport is the client's medical or behavioral health provider. An ambulance service

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provider will no longer be allowed to complete or submit any portion of this form. Prior authorization forms are now only accepted from a medical or behavioral health facility or provider most familiar with the client's condition.

During its review, HHSC further found that the medical necessity criteria used for non-emergent ambulance services could be strengthened by requiring ambulance providers to include a description of a client's ability to sit, stand, or walk. This criteria helps to determine if non-emergent ambulance services are warranted and mirrors criteria used in the Medicare ambulance services policy. Medicaid non-emergency ambulance service requests that do not meet medical necessity requirements may be provided through alternate means such as the Medical Transportation Program.

The policy changes described above were implemented on April 1, 2013, and February 1, 2014.

DSHS is required to make recommendations to the Legislature that would reduce the incidence of fraud, waste, and abuse with respect to the laws and policies related to the licensure of nonemergency transportation providers.

DSHS, through collaborative efforts with GETAC, solicited stakeholder input related to non-emergency transportation services provided by ambulance providers and the licensure of such providers. These findings and recommendations are included in this report.

DSHS STAKEHOLDER INPUT/SOLICITATION

The GETAC meets on a quarterly basis and utilizes ten standing committees, consisting of at least 11 members that represent diverse geographical coverage and professional expertise within the EMS and trauma community. Committees seek input from stakeholders and provide information back to the GETAC. Input from stakeholders was solicited through stakeholder meetings, through each agency's respective website, GovDelivery e-mail blasts, the use of EMS list serve announcements and at the GETAC meetings. Additional stakeholders that were notified and asked to provide feedback included the Texas Municipal League, Texas Association of Counties, Texas Ambulance Association, Texas Hospital Association, Texas AARP, Texas Judges and Commissioners Association of Texas, Texas Association of School Administrators, and public citizens.

DSHS, in collaboration with the GETAC received feedback from EMS stakeholders throughout the state regarding the laws and policies related to the licensure of nonemergency transportation providers, as mandated by Senate Bill 8. GETAC's EMS Committee held multiple meetings between August and November 2013 that were conducted in accordance with The Open Meetings Act. One discussion was held during the general meeting of the Regional Advisory Council of the Trauma Service Area. These stakeholder meetings were held in Houston, Harlingen, Amarillo, Dallas, Austin, San Angelo, and El Paso.

Collectively these meetings were well attended by approximately 400 licensed EMS providers, representing thirty percent of the total number of the licensed EMS providers in the state and a wide variety of provider organizational types.

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The EMS Committee report of these meetings was reviewed and accepted by GETAC in a unanimous vote at its November 24, 2013 meeting (see Appendix A).

DSHS RECOMMENDED PRIORITIES

DSHS staff attended all stakeholder meetings, reviewed the EMS Committee report and presents the following list of recommended priorities.

1. Enact statutory whistleblower protections for EMS personnel when reporting violations to the state oversight agencies.
2. Increase Medicaid managed care organization requirements for providing training and education to managed care organization staff, members and providers regarding non-emergency and emergency ambulance services.
3. Implement a Texas EMS jurisprudence exam as a requirement for the administrator of record and all EMS personnel for initial certification and as needed for recertification.
4. Require an EMS provider to have a physical location of their business establishment when the provider submits a licensing application. The physical location of the business establishment may be owned or leased; however, it must be maintained throughout the licensure period. The business establishment must be the same as the agency's primary place to conduct business and include normal business hours of operation. This location should be where all patient care records are maintained unless an alternative location for storage of patient care records is approved. The address of the primary location cannot be shared by other EMS providers.
5. Require prior written approval from a governmental authority in the area in which the EMS provider plans to operate prior to expansion of an EMS provider's service area.
6. Enact statutory authority that would allow disciplinary action to be proposed against EMS providers or personnel based on inspections/complaint investigation findings/evidence collected by another recognized governmental entity.
7. Require EMS providers to provide proof of ownership or long-term lease agreement for all capital equipment and inventory items (e.g. ambulances, EKG monitors, defibrillators, stretchers) that are necessary for the operation of a viable EMS operation.
8. Require EMS providers to implement electronic patient care records that integrate into a receiving hospital's electronic medical record, the State EMS Data Registry, and their regional registry.
9. Regulation of wheelchair and non-medical stretcher transportation in Texas should be considered.
10. Enforce current regulations and adopt additional regulations as needed to assure EMS providers and personnel are held accountable when they violate licensing rules. Compliance activities should include routine unannounced inspections of EMS providers.

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TMB is required to make recommendations to the Legislature that would reduce the incidence of fraud, waste, and abuse with respect to the delegation of health care services by physicians or medical directors to qualified emergency medical services personnel and physicians' assessment of patients' needs for purposes of ambulatory transfer or transport or other purposes.

REQUIREMENTS IN TEXAS MEDICAL PRACTICE ACT AND TEXAS MEDICAL BOARD RULES

The Texas Medical Practice Act (Occupations Code, Section 157.003) expressly authorizes physician delegation of medical acts related to emergency care to emergency medical personnel certified by DSHS. The corresponding board rules for emergency medical service (Texas Administrative Code, Title 22, Part 9, Chapter 197) address the responsibilities of physicians who supervise pre-hospital care by EMS personnel as well as those who serve as off-line medical directors, and address components of on-line medical direction (direct medical control), including the responsibilities of physicians providing on-line medical direction. The rules are meant to enhance the ability of EMS systems to ensure adequate medical direction of all advanced pre-hospital providers and many basic-level providers, as well as compliance by personnel and facilities with minimum criteria to implement medical direction of pre-hospital services.

In July 2011, the board held a stakeholder meeting to address needed updates to the board rules in response to concerns about Medicaid fraud and EMS providers. In November 2012, the board adopted the proposed rule amendments as reviewed by the stakeholders, including:

- Adding the definition for EMS provider consistent with rules by DSHS.
- Creating additional requirements to be an off-line medical director, including continuing medical education.
- Requiring off-line medical directors to register with the board.
- Requiring off-line medical directors to have written protocols for those they supervise.
- Directing off-line medical directors to approve care only for times when employed as an off-line medical director.
- Setting limits on the number of EMS providers a physician may serve as an off-line medical director.

The rule amendments (Appendix B) also provide a waiver process to allow a physician to serve as an off-line medical director for more than 20 EMS providers based on certain criteria. The board, in conjunction with DSHS, is currently developing the process for waiver requests. The board is also working toward online registration for EMS medical directors to report the names of EMS providers and businesses for which they serve as the medical director. These systems are estimated to be operational at the end of fiscal year 2014.

Appendix A



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

REPORT DELIVERED
NOVEMBER 25, 2013

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.

Appendix B

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Chapter 197. Emergency Medical Service
§§197.1-197.6

§197.1. Purpose.

(a) The purpose of this chapter is to facilitate the most appropriate utilization of the skills of physicians who delegate health care tasks to qualified emergency medical services (EMS) personnel. Such delegation shall be consistent with the patient's health and welfare and shall be undertaken pursuant to supervisory guidelines, which take into account the skill, training, and experience of both physicians and EMS personnel.

(b) This chapter addresses:

(1) the qualifications, responsibilities, and authority of physicians who provide medical direction and/or supervision of prehospital care by EMS personnel;

(2) the qualifications, authority, and responsibilities of physicians who serve as medical directors (off-line);

(3) the relationship of EMS providers to the off-line medical director;

(4) components of on-line medical direction (direct medical control), including the qualifications and responsibilities of physicians who provide on-line medical direction and the relationship of prehospital providers to those physicians; and

(5) the responsibility of EMS personnel to private and intervenor physicians.

(c) This chapter is not intended, and shall not be construed to restrict a physician from delegating administrative and technical or clinical tasks not involving the exercise of independent medical judgment to those specially trained individuals instructed and directed by a licensed physician who accepts responsibility for the acts of such allied health personnel. Likewise, nothing in this chapter shall be construed to prohibit a physician from instructing a technician, assistant, or other employee, who is not among the classes of EMS personnel, as defined in §197.2 of this title (relating to Definitions), to perform delegated tasks so long as the physician retains supervision and control of the technician, assistant, or employee.

(d) Nothing in this chapter shall be construed to relieve the supervising physician of the professional or legal responsibility for the care and treatment of his or her patients. A physician who, after agreeing to supervise EMS personnel, fails to do so adequately and properly, may be subject to disciplinary action pursuant to the Medical Practice Act.

(e) Implementation of this chapter will enhance the ability of EMS systems to assure adequate medical direction of all advanced prehospital providers and

many basic level providers, as well as compliance by personnel and facilities with minimum criteria to implement medical direction of prehospital services. A medical director shall not be held responsible for noncompliance with this chapter if the EMS administration fails to provide the necessary administrative support to permit compliance with the provisions of this chapter.

Source Note: The provisions of this §197.1 adopted to be effective January 2, 1991, 15 TexReg 7368; amended to be effective September 20, 2007, 32 TexReg 6316.

§197.2. Definitions.

The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Advanced life support--Emergency prehospital care that involves invasive medical interventions including, but not limited to, the delivery or assisted delivery of medications, defibrillation, and advanced airway management. The provision of advanced life support shall be under the medical direction and/or supervision and control of a licensed physician.

(2) Basic life support--Emergency prehospital care that involves noninvasive medical interventions. The provision of basic life support may be under the medical direction and/or supervision and control of a licensed physician.

(3) Board--The Texas Medical Board.

(4) Delegated practice--Permission given by a physician licensed by the board, either in person or by treatment protocols or standing orders to a specific prehospital provider to provide medical care.

(5) Direct medical control--Immediate and concurrent clinical direction either on-scene or via electronic communication from a physician licensed by the board and designated by the EMS medical director. If an EMS system does not have an EMS Medical Director, then such designation should be by a physician advisor, or in his or her absence, the director of the EMS system.

(6) Emergency medical services personnel--Those individuals certified or licensed by the Texas Department of State Health Services (DSHS) to provide emergency medical care.

(7) Emergency medical services (EMS) provider--As defined under 25 TAC §157.2(30) (relating to Definitions), a provider that uses, operates

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or maintains EMS vehicles and EMS personnel to provide EMS.

(8) Emergency medical services system--All components needed to provide a continuum of prehospital medical care including, but not limited to, a medical director, transport vehicles, trained personnel, access and dispatch, communications, and receiving medical facilities.

(9) Intervenor physician--A physician licensed by the board, who, without having established a prior physician/patient relationship with the emergency patient, accepts responsibility for the prehospital care, and who shall provide proof of a current medical license when requested.

(10) Medical director--A physician licensed by the board who is responsible for all aspects of the operation of an EMS system concerning provision of medical care. This physician may also be referred to as the off-line medical director.

(11) Prehospital providers--All DSHS certified or licensed personnel providing medical care in an out-of-hospital environment.

(12) Protocols--Written instructions providing prehospital personnel with a standardized approach to commonly encountered problems in the out-of-hospital setting, typically in regard to patient care. Protocols may include standing orders to be implemented prior to, or in lieu of, establishing communication with direct medical control.

(13) Standing delegation orders--Instructions or orders provided by the EMS medical director to EMS personnel, directing them to perform certain medical care in the absence of any communication with direct medical control.

Source Note: The provisions of this §197.2 adopted to be effective February 28, 1999, 24 TexReg 1157; amended to be effective January 9, 2003, 28 TexReg 73; amended to be effective September 20, 2007, 32 TexReg 6316; amended to be effective January 2, 2013, 37 TexReg 10213

§197.3. Off-line Medical Director.

(a) An off-line medical director shall be:

(1) a physician licensed to practice in Texas and shall be registered as an EMS medical director with the Texas Department of State Health Services;

(2) familiar with the design and operation of EMS systems;

(3) experienced in prehospital emergency care and emergency management of ill and injured patients;

(4) actively involved in:

(A) the training and/or continuing education of EMS personnel, under his or her direct supervision, at their respective levels of certification;

(B) the medical audit, review, and critique of the performance of EMS personnel under his or her direct supervision;

(C) the administrative and legislative environments affecting regional and/or state prehospital EMS organizations;

(5) knowledgeable about local multi-casualty plans;

(6) familiar with dispatch and communications operations of prehospital emergency units; and

(7) knowledgeable about laws and regulations affecting local, regional, and state EMS operations.

(b) The off-line medical director shall be required to:

(1) approve the level of prehospital care which may be rendered locally by each of the EMS personnel employed by and/or volunteering with the EMS under the medical director's supervision, regardless of the level of state certification or licensure, before the certificant or licensee is permitted to provide such care to the public;

(2) establish and monitor compliance with field performance guidelines for EMS personnel;

(3) establish and monitor compliance with training guidelines which meet or exceed the minimum standards set forth in the Texas Department of State Health Services EMS certification regulations;

(4) develop, implement, and revise protocols and/or standing delegation orders, if appropriate, governing prehospital care and medical aspects of patient triage, transport, transfer, dispatch, extrication, rescue, and radio-telephone-telemetry communication by the EMS;

(5) direct an effective system audit and quality assurance program;

(6) determine standards and objectives for all medically related aspects of operation of the EMS including the inspection, evaluation, and approval of the system's performance specifications;

(7) function as the primary liaison between the EMS administration and the local medical community, ascertaining and being responsive to the needs of each;

(8) develop a letter or agreement or contract between the medical director(s) and the EMS administration outlining the specific responsibilities and authority of each. The agreement should describe the process or procedure by which a medical director may withdraw responsibility for EMS personnel for noncompliance with the Emergency Medical Services Act, the Health and Safety Code, Chapter 773, the rules

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adopted in this chapter, and/or accepted medical standards;

(9) take or recommend appropriate remedial or corrective measures for EMS personnel, in conjunction with local EMS administration, which may include, but are not limited to, counseling, retraining, testing, probation, and/or field preceptorship;

(10) suspend a certified EMS individual from medical care duties for due cause pending review and evaluation;

(11) establish the circumstances under which a patient might not be transported;

(12) establish the circumstances under which a patient may be transported against his or her will in accordance with state law, including approval of appropriate procedures, forms, and a review process;

(13) establish criteria for selection of a patient's destination;

(14) develop and implement a comprehensive mechanism for management of patient care incidents, including patient complaints, allegations of substandard care, and deviations from established protocols and patient care standards;

(15) only approve care or activity that was provided at the time the medical director was employed, contracted or volunteering as a medical director;

(16) notify the board at time of licensure registration under §166.1 of this title (relating to Physician Registration) of the physician's position as medical director and the names of all EMS providers for whom that physician holds the position of off-line medical director;

(17) complete the following educational requirements:

(A) within two years, either before or after initial notification to the board of holding the position as off-line medical director:

(i) 12 hours of formal continuing medical education (CME) as defined under §166.2 of this title (relating to Continuing Medical Education) in the area of EMS medical direction;

(ii) board certification in Emergency Medical Services by the American Board of Medical Specialties or a Certificate of Added Qualification in EMS by the American Osteopathic Association Bureau of Osteopathic Specialists; or

(iii) a DSHS approved EMS medical director course; and

(B) every two years after meeting the requirements of subparagraph (A) of this paragraph, one hour of formal CME in the area of EMS medical direction.

(c) A physician may not hold the position of off-line medical director:

(1) for more than 20 EMS providers unless the physician obtains a waiver under subsection (d) of this section; or

(2) for any EMS provider if the physician has been suspended or revoked for cause by any governmental agency or the physician has been excluded from Medicare, Medicaid, or CHIP.

(d) The board may grant a waiver to allow a physician to serve as an off-line medical director for more than 20 EMS providers, if the physician provides evidence that:

(1) the Department of State Health Services has reviewed the waiver request and has determined that the waiver is in the best interest of the public;

(2) the physician is in compliance with this chapter, by submitting documentation of protocols and standing orders upon request; and

(3) appropriate safeguards exist for patient care and adequate supervision of all EMS personnel under the physician's supervision.

Source Note: The provisions of this §197.3 adopted to be effective February 28, 1999, 24 TexReg 1157; amended to be effective January 9, 2003, 28 TexReg 73; amended to be effective September 20, 2007, 32 TexReg 6316; amended to be effective January 2, 2013, 37 TexReg 10213; amended to be effective May 6, 2013, 38 TexReg 2760.

§197.4. On-Line Medical Direction.

(a) The EMS medical director shall assign the prehospital provider under his or her direction to a specific on-line communication resource by a predetermined policy.

(b) Specific local protocols shall define the circumstances under which on-line medical direction is required.

(c) A physician providing or delegating on-line medical direction ("on-line physician") shall be appropriately trained in the use of prehospital protocols.

(d) A physician providing or delegating on-line medical direction shall have personal expertise in the emergency care of ill and injured patients.

(e) A physician providing or delegating on-line medical direction for particular patients assumes responsibility for the appropriateness of prehospital care provided under his or her direction by EMS personnel.

Source Note: The provisions of this §197.4 adopted to be effective February 28, 1999, 24 TexReg 1157;

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amended to be effective September 20, 2007, 32 TexReg 6316.

§197.5. Authority for Control of Medical Services at the Scene of a Medical Emergency.

(a) Control at the scene of a medical emergency shall be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport.

(b) The pre-hospital provider on the scene is responsible for the management of the patient(s) and acts as the agent of the physician providing medical direction.

(c) If the patient's personal physician is present and assumes responsibility for the patient's care, the pre-hospital provider should defer to the orders of said physician unless those orders conflict with established protocols. The patient's personal physician shall document in his or her orders in a manner acceptable to the EMS system. The physician providing on-line medical direction shall be notified of the participation of the patient's personal physician.

(d) If the medical orders of the patient's personal physician conflict with system protocols, the personal physician shall be placed in communication with the physician providing on-line medical direction. If the personal physician and the on-line medical director cannot agree on treatment, the personal physician must either continue to provide direct patient care and accompany the patient to the hospital or must defer all remaining care to the on-line medical director.

(e) The system's medical director or on-line medical control shall assume responsibility for directing the activities of pre-hospital providers at any time the patient's personal physician is not in attendance.

(f) If an intervenor physician is present at the scene and has been satisfactorily identified as a licensed physician and has expressed his or her willingness to assume responsibility for care of the patient, the on-line physician should be contacted. Once the on-line physician is contacted, he or she is ultimately responsible for the care of the patient unless or until the on-line physician allows the intervenor physician to assume responsibility for the patient.

(g) The on-line physician has the option of managing the case exclusively, working with the intervenor physician, or allowing the intervenor physician to assume complete responsibility for the patient.

(h) If there is any disagreement between the intervenor physician and the on-line physician, the pre-hospital provider shall be responsible to the on-line

physician and shall place the intervenor physician in contact with the on-line physician.

(i) If the intervenor physician is authorized to assume responsibility, all orders to the pre-hospital provider by the intervenor physician shall also be repeated to medical control for recordkeeping purposes.

(j) The intervenor physician must document his or her intervention in a manner acceptable to the local EMS.

(k) The decision of the intervenor physician not to accompany the patient to the hospital shall be made with the approval of the on-line physician.

(l) Nothing in this section implies that the pre-hospital provider can be required to deviate from standard protocols.

Source Note: The provisions of this §197.5 adopted to be effective February 28, 1999, 24 TexReg 1157.

§197.6. Authority To Conduct Research and/or Educational Studies.

(a) The medical director has the authority to design research projects and educational studies. Such studies should be approved by:

(1) EMS administrative officials; and

(2) an independent review panel if the project/study may have a differential impact on patient care.

(b) The results of the study should be made available through publications to the EMS community.

Source Note: The provisions of this §197.6 adopted to be effective January 2, 1991, 15 TexReg 7368; amended to be effective January 20, 2014, 39 TexReg 298