

Report to the Legislature

**Reimbursement  
for Healthcare  
Services  
Provided by Fire  
Departments  
(CARES)**

2019

RCW 43.70.750



Prepared by  
Office of Community Health Systems  
EMS & Trauma Section





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## Executive Summary

In 2017, the Washington State Legislature passed [E2SHB 1358](#) (Chapter 273, Laws of 2017) which provided for Medicaid reimbursement of health care services provided to eligible clients by fire departments pursuant to a community assistance referral and education services (CARES) program under [RCW 35.21.930](#). The Department of Health (department) is required to submit a report including the following:

- Review professional certification and training of health professionals in CARES programs;
- Review certification and training requirements in other states with similar programs;
- Coordinate with the Health Care Authority (authority) to link certification requirements with covered health care services recommended for payment; and
- Submit recommendations for changes and suggestions for implementation to the appropriate committees of the legislature.

The types of health professionals participating in CARES programs vary, however all programs report use of certified EMS professionals. There are a few national training programs emerging. However, most CARES programs have developed and provided their own training.

Only Minnesota and Arizona have programs similar to CARES and utilize Medicaid reimbursement for services. Their models were implemented using Medicaid state plan amendments that defined provider types, coverage policy, and maximum allowable fee schedules.

The department coordinated with the authority to link certification requirements with covered services recommended for payment. The activities that qualified for reimbursement are referred to as treat and refer activities (found in Table 2 on page 6). To receive reimbursement for treat and refer activities, the organization must be a licensed EMS service under chapter [18.73](#) RCW and have an established CARES program under RCW [35.21.930](#). The authority began reimbursement on July 1, 2019.

While there are several CARES programs in operation, there is little guidance for the programs on what constitutes best practice or an evidence-based model. A standardized approach would allow the department and program participants to better assess the impact of the programs on communities, as well as identify areas for improvement.

Given this, the department recommends, resource dependent, that it work with the EMS and Trauma Care Steering Committee to establish a workgroup to develop a CARES Program pilot project. The pilot project would be based on an evidence-based practice model that includes standards for care, training, and protocol.

## Introduction

In 2017, the legislature passed [E2SHB 1358](#) (Chapter 273, Laws of 2017), which provided for Medicaid reimbursement of health care services provided to eligible clients by fire departments pursuant to a community assistance referral and education services (CARES) program under [RCW 35.21.930](#). Programs can be created by fire departments, providers of EMS eligible to levy a tax under [RCW 84.52.069](#), and federally recognized tribes. These entities can also seek grants and private gifts to support the programs.

Under RCW 35.21.930, CARES programs may:

- Provide community outreach to improve population health;
- Advance injury and illness prevention within the community;
- Identify community members who use 911 for low-acuity assistance and help direct these patients to appropriate health care providers and services; and
- Partner with hospitals to reduce readmissions.

The Department of Health (department) is required to submit a report including the following:

- Review professional certification and training of health professionals in CARES programs;
- Review certification and training requirements in other states with similar programs;
- Coordinate with the Health Care Authority (authority) to link certification requirements with covered health care services recommended for payment; and
- Submit recommendations for changes and suggestions for implementation to the appropriate committees of the legislature.

## Background

CARES programs are a subset of community based Emergency Medical Services (EMS) programs. “Community based EMS” is a term used to describe a broad category of collaborative programs between EMS providers and various components of healthcare systems that use EMS providers in an expanded role and environment. These programs vary by community need, but are designed to reduce hospital re-admissions, reduce over utilization of EMS for non-emergent conditions, and connect patients with the appropriate resources to serve their needs.

CARES programs address important community needs, but their effectiveness may be enhanced if there was a standardized set of activities or scope of practice. Most programs have

common characteristics which include conducting community needs assessments<sup>1</sup>, creating local coalitions to provide access to community resources including local public health and law enforcement, and having an intensive case manager for people enrolled in the programs.

Certified EMS providers may participate in a CARES program if they are supervised by a department-certified physician EMS medical program director, provided their participation does not exceed their scope of practice. The legislation provides medical directors and certified EMS providers immunity from liability for good faith acts or omissions as part of participation in a CARES program. There are no requirements for additional training, expectations for provider coordination, or standard program elements for CARES programs. There is no statewide mechanism that identifies, tracks, or regulates the programs.

## Review of certification and training of health professionals participating in a CARES program

To gather information needed to complete this report, the department consulted with the Washington State Prehospital Technical Advisory Committee, the EMS Medical Program Directors workgroup, and representatives of CARES programs in Spokane, Whatcom, Pierce, King, and Snohomish Counties. These organizations reported they all use certified EMS professionals as core team members in their CARES programs. Some programs reported they contract with or hire other healthcare professionals including registered nurses, social workers, mental health counselors, and peer counselors.

There is no national or state list of services that defines the work of a CARES program or provider, and there is not a standard scope of practice.

There are four levels of EMS certification recognized in Washington State: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT) and Paramedic. The comparison for training and recertification requirements is listed below in table 1.

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<sup>1</sup> A community health assessment, also known as community health needs assessment, refers to a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.

**Table 1: Hours of initial training and continuing education for EMS**

Level of Care	Initial Training Hours	Recertification (Hours required over a three year period)
EMR	48-60	15
EMT	150-190	30
AEMT	150-250	30
PARAMEDIC	1200-2500	150

Most CARES programs use paramedic level providers. Paramedics are trained in evaluating an emergency situation and developing a plan to treat injuries. They can perform some intricate medical procedures, such as intubation, in emergency settings. They are not trained in preventative or primary care, and are not considered independent practitioners.

## Review of requirements in states with similar programs

Only Minnesota and Arizona have programs similar to CARES and utilize Medicaid reimbursement for services. Both states implemented their programs using Medicaid state plan amendments that defined provider types, coverage policy, and maximum allowable fee schedules. Minnesota covered its program under the physician services benefit while Arizona covered its programs under other licensed practitioner authority. Alternative payment models were not reported for either state. Information about private pay reimbursement is unknown.

### Arizona Treat and Refer Program

Arizona established a treat and refer program. The goal of the program is to incentivize EMS services to improve the quality of care by matching treatment, transport, and care destination options to the needs of the patient. Arizona defines a treat and refer interaction as a “healthcare event with an individual that has accessed 911 or similar public emergency dispatch number, but whose illness or injury does not require an ambulance transport to an emergency department based on the clinical information available at the time.”

The Arizona Medicaid program reimburses licensed EMS services for:

- Response and treatment, no transport
- Treat at home, refer to primary care provider / specialist
- Treat at home, refer to behavioral health provider
- Treat at home, refer to urgent care

Arizona worked with stakeholders to develop and adopt [Treat and Refer Program](#) standards and guidelines. The guidelines address physician medical oversight, standing orders and protocols for patient care, performance monitoring and improvement plans, data collection and submission requirements, patient follow up requirements, and information about how an organization can apply for and maintain a Treat and Refer program. Arizona did not amend statute or rule to address treat and refer program standards, training requirements, or medical oversight of certified EMS providers operating within these programs.

### **Minnesota Community EMS Model**

Minnesota provides for community EMS as a covered service using Medicaid state plan amendments that defined provider types, coverage policy, and maximum allowable fee schedules. The program is covered under the physician services benefit. Minnesota’s program was established under a broad definition of community paramedic services “to meet the health care needs of recipients living in underserved communities.”<sup>2</sup> The community paramedic credential was created for Medicaid reimbursement to assist in the care of members who:

- Receive hospital emergency department services three or more times in four consecutive months within a twelve month period;
- Are identified by their primary care provider as at risk of nursing home placement;
- May require set up of services for discharge from a nursing home or hospitals; or
- May require services to prevent readmission to a nursing home or hospital.

To become certified as a community paramedic by the EMS Regulatory Board (EMSRB) in Minnesota, a paramedic must have two years of full-time experience as a paramedic or part-time equivalent and complete a community paramedic education program from an EMSRB-approved college or university that includes clinical experience provided under the supervision of an ambulance services medical director. The community paramedic must provide services as directed by a patient care plan if the plan has been developed by the patient’s primary physician or by an advanced practice registered nurse or a physician assistant, and approved by the ambulance service medical director.

The community paramedic can perform health assessments, chronic disease monitoring and education, medication compliance, immunization and vaccinations, laboratory specimen collection, hospital discharge follow-up care and minor medical procedures approved by the ambulance medical director.

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<sup>2</sup> Minnesota Department of Human Services, Community Paramedic Services, [https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16\\_177475](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_177475), accessed October 21, 2019.

## Link certification requirements with covered health care services

CARES activities that qualify for reimbursement are referred to as treat and refer activities and are found in table 2 below. The authority established billing codes and modifiers<sup>3</sup> for each activity and amended the State Medicaid Plan (19-0007) to reflect the additions. The established reimbursement rate is \$115.34 for A0998<sup>4</sup> and modifiers. The authority began reimbursement on July 1, 2019.

**Table 2: CARES Treat and Refer Activities and Billing Modifiers**

Billing Modifier	CARES activity to be reimbursed
A0998	Response and Treatment, No Transport
A0998U1	Treat at home, refer to licensed health care provider
A0998U2	Treat at home, refer to Crisis Response (i.e. Designated Crisis Responder (DCR) called to scene)
A0998U3	Treat at home, refer to BH Provider
A0998U4	Treat at home, refer to Chemical Dependency
A0998U5	Treat at home, refer to Urgent Care
A0998U6	Treat at home, refer to CARES team

To receive reimbursement for treat and refer activities, the organization must be a licensed EMS service under chapter [18.73](#) RCW and have an established CARES program under RCW [35.21.930](#).

The authority conducted rulemaking to create a new section, [WAC 182-531-1740](#), and amend [WAC 182-546-0200](#), [WAC 182-546-0250](#), and [WAC 182-546-0400](#) to propose changes reflecting the treat and refer model. The rules were adopted September 18, 2019 and effective October 19, 2019.

<sup>3</sup> A modifier is a mechanism HCA uses to provide more information about a claim.

<sup>4</sup> The reimbursement rate for all A0998 activities U1-U5 is the same

## Recommendation

The primary role of EMS will always be focused on providing optimal care to acutely ill or injured patients. CARES programs are an enhancement that allows performance of activities designed to reduce unnecessary medical care. CARES-related activities include preventative, social health, and primary care activities that exceed the current scope of practice established for certified EMS providers. For the proponents of the CARES practice model, the goal is to apply and expand the skills learned by paramedics into the domain of community health and prevention. CARES programs are an opportunity to offer the EMS profession a new level of training and a new way to contribute their skills.

While there are several CARES programs in operation, there is little guidance for the programs on what constitutes best practice or an evidence based model. A standardized approach would allow the department and program participants to better assess the impact of the programs on communities, as well as identify areas for improvement.

### **Recommendation:**

The department recommends, resource dependent, that it work with the EMS and Trauma Steering Committee to establish a workgroup to develop a CARES Program pilot project. The project would be based on an evidence-based practice model that includes standards for care, training, and protocol.

#### Rationale:

- Further study is needed on the impact of CARES programs on health care processes and outcomes in terms of effectiveness, value, safety, and access;
- CARES programs address important community needs, but their effectiveness may be enhanced if there was a standardized set of activities or scope of practice.
- Training requirements should be developed for the EMS personnel who work in CARES programs to assure standardization and quality in the care delivered. These may include flexible training models like the [Community Health Worker program](#), and education in primary care, public health, disease management, prevention, wellness and behavioral and mental health.

