PREPARING FOR THE 2017 TEXAS LEGISLATURE
June 20, 2016 | Dudley Wait, Butch Oberhoff, Joe Schmider, Doug Hooten, Matt Zavadsky & Dinah Welsh
THE STORY
Of the Texas EMS Alliance

Our vision
Members of the industry came together after the 2013 Texas Legislature to serve as an effective and unified voice of the Texas EMS industry.

Our philosophy
Incorporate all voices in the Texas EMS industry. Each segment of the industry has a board seat. As a result, each segment has equal representation.

Our mission
Ensure that all Texans have access to outstanding EMS services.
CURRENT MEMBERSHIP
68 MEMBERS
WASHINGTON, DC 2015 WAS A BUSY YEAR

MEDICARE PHYSICIAN PAYMENT OVERHAUL – Spring 2015

CONGRESSIONAL BUDGET CEILING DEAL – Fall 2015
WASHINGTON, DC EMS ISSUES
Two Major Bills Passed: Spring SGR Reform and Fall Medicare Budget Ceiling Deal

- Payment Reform
- Medicare Access, Fraud Prevention & Reform Act (S. 377 & H.R. 745)
- CMS’s Designation of Zip Codes
- Public Safety Officer Death Benefits
- Federal Fuel Tax Relief
- CMS Moratorium
- Prior-Authorization
FALL 2015 CONGRESSIONAL BUDGET CEILING DEAL

An offset included site-neutral payments. Under this concept, a payer will reimburse a service that can be provided in multiple levels of settings at the lowest setting rate.

EMS providers are not affected at the moment.
EMS AGENCIES MUST ENGAGE 2017 LEGISLATURE
Laws and regulations touch on every aspect of an EMS operation. Therefore, EMS agencies must engage in the public policy process. Otherwise, our opponents will define EMS issues on their own terms.
THE NEXT SIX MONTHS EMS ADVOCACY WORK
Texas EMS Alliance Goals for the Months Leading up to the 2017 Texas Legislature

• July 13 EMS/Trauma hearing in the Texas House

• Identify key contacts within the EMS industry to educate lawmakers about 2017 issues.

• Engage EMS agencies. TEMSA will educate members about the issues that will affect them.
TEXAS HOUSE PUBLIC HEALTH COMMITTEE

Oversight of EMS licensing issues

Chair Myra Crownover (R-Denton)  
Elliott Naishtat (D-Austin)  
Cesar Blanco (D-El Paso)  
Garnet Coleman (D-Houston)  
Nicole Collier (D-Fort Worth)  
Sarah Davis (R-Houston)  
Bobby Guerra (D-McAllen)  
Rick Miller (R-Sugar Land)  
JD Sheffield (R-Gatesville)  
Bill Zedler (R-Arlington)  
John Zerwas (R-Simonton)
TEXAS SENATE HEALTH & HUMAN SERVICES
Oversight of EMS licensing issues

Chair Charles Schwertner (R-Georgetown)
Lois Kolkhorst (R-Brenham)
Donna Campbell (R-New Braunfels)
Craig Estes (R-Wichita Falls)
Charles Perry (R-Lubbock)

Jose Rodriguez (D-El Paso)
Van Taylor (R-Plano)
Carlos Uresti (D-San Antonio)
Judith Zaffirini (D-Laredo)
TEXAS HOUSE INSURANCE COMMITTEE
Oversight of commercial insurance issues

Chair John Frullo (R-Lubbock)  Dennis Paul (R-Houston)
Sergio Munoz (D-Mission)    Kenneth Sheets (R-Dallas)
Greg Bonnen (R-Friendswood)  Hubert Vo (D-Houston)
Bobby Guerra (D-McAllen)    Paul Workman (R-Austin)
Morgan Meyer (R-Dallas)
TEXAS SENATE BUSINESS & COMMERCE

Oversight of commercial insurance issues

Chair Kelly Hancock (R-DFW Mid Cities)  
Brandon Creighton (R-The Woodlands)  
Don Huffines (R-Dallas)  
Charles Schwertner (R-Georgetown)  
Kel Seliger (R-Amarillo)  
Larry Taylor (R-Friendswood)  
Kirk Watson (D-Austin)  
John Whitmire (D-Houston)
EDUCATING OUR INDUSTRY

HOW TO ADVOCATE

Health care is one of the most regulated industries in the nation. Laws and regulations touch on every aspect of an EMS operation.

Therefore, EMS agencies have no choice but to engage in the public policy process by educating lawmakers about EMS issues.

House Appropriations
- Amanda B. Fehlhaber
- Leticia Shalley
- Juanita Stiles (Speaker)
- Derby Buzbee (San Antonio)
- Mark Brandon (Houston)
- Cheryl Kight (Houston)
- Arleen Lennie (Galveston)

House Public Health
- Laura Bias (Brownsville)
- Sarah Bertie (Houston)
- Marilyn Arrington (Houston)
- Ruben Caballero (Laredo)
- John Faso (Tyler)
- John Zerwas (CyFair)

Senate Health
- Charles Huggins (Lubbock)
- Steve Stenslie (Brownsville)
- Glenn Hegar (Austin)
- Dan Huberty (Houston)
- Larry Taylor (Houston)
- Don Huffines (Dallas)

Senate Appropriations
- Jane Nelson (Dallas)
- Clay Puceo (San Antonio)
- Paul Bettencourt (Houston)
- Mike Collier (Dallas)
- Judson Hammons (Brownsville)
- Larry Hall (Houston)
- Morgan Meyer (Dallas)
- Kevin Eltchinger (Surfside Beach)

It is critical for EMS agencies to engage all of these committees.

Texas EMS Alliance
THE TEXAS EMERGENCY MEDICAL SERVICES ALLIANCE
www.txemsa.com

Does Your Lawmaker Know Who You Are?
How to Be an Advocate & Make a Difference in 2017

Health care is one of the most regulated industries in the nation. Laws and regulations touch on every aspect of an EMS operation. Therefore, EMS agencies have no choice but to engage in the public policy process by educating lawmakers about EMS issues.

Preparations for the 2017 Legislature Begin Today
The 85th Legislature is likely to be active for EMS agencies. It's critical for Texas EMS agencies to begin preparing now for the first day of the Legislature: January 10, 2017.

Does Your Lawmaker Know You?
When a state lawmaker is preparing to make a decision on an EMS issue, it is critical for the lawmaker to turn to you for your expertise on EMS issues. TEMSA wants lawmakers to know the EMS agencies and officials in their district.

Host a Lawmaker at Your Headquarters
While the Texas Legislature is out of session, ask your state representatives and senators to visit your headquarters. Educate them about the basics of EMS—how EMS agencies are paid for their services, personnel issues, and EMS and ambulance capabilities.

TEXMAs can help you prepare for the lawmaker visit with materials and other items. In addition, TEXMAs can share its 2017 legislative priorities handbook.

Engage Local Officials
Local officials—including mayors, city council members, and county executives—will play a critical role in the 2017 Texas Legislature. These lawmakers place a great emphasis on meeting with their local officials and listening to their concerns.

Enlisting the support of local officials to help with EMS issues during the 2017 Texas Legislature will be critical to EMS agencies. It is important to start working with local officials now to educate them on EMS issues.

Local officials understand how important EMS is to their communities. These officials can be some of your biggest advocates.

Key Legislative Committees
Four health care committees have jurisdiction over EMS issues—Public Health and Human Services (Article II) in the House and Health and Human Services and Finance in the Senate. The members of these committees can be found on the right.

In addition, balance billing issues that will have a direct impact on EMS agencies will begin their journey through the House Insurance Committee and the Senate Business & Commerce Committee.

It is critical for EMS agencies to engage all of these committees.
Texas EMS Agencies: A Vital Part of Every Texas Community

Emergency Medical Services (EMS) agencies are a vital part of every community and serve a unique role in the state’s health care delivery system. EMS providers are the only segment of the health care delivery system designed to respond to the location of a patient suffering from an acute onset of illness or a traumatic injury, provide patients with initial care on scene, and provide timely access to a specialized segment of the health care system, such as a trauma hospital or stroke center.

Recent EMS advances in the field of trauma, STEMI, and stroke/brain events have resulted in countless saved lives. For many of these issues, every minute matters, and paramedics are prepared to provide valuable response during initial contact and transfer to a hospital.

When symptoms of a heart attack begin to present, cardiologists recommend that a patient call 9-1-1 instead of driving to a hospital. Within many EMS agencies, paramedics have the ability to begin treatment within the field. Paramedics can access the patient’s vital signs and heart activity and trigger the cardiac catheterization lab at the hospital. Research shows that patients who have access to an angioplasty within 90 minutes of first medical contact typically have the best outcomes.

Each EMS Agency is Different

Over 800 entities are licensed by Texas DSHS to provide EMS service to Texas communities. Texas is such a large and diverse state that each community utilizes a different model for delivering 9-1-1 services to its citizens.

Fire Department Model. Some communities have its EMS operations associated with the community’s fire department. The cities of San Antonio, Dallas, Houston, San Antonio, and Houston are examples.

Government-Owned and Operated EMS Model (Ems, 911 Service). Some EMS agencies within communities operate as an independent agency with the local government (city, county, Emergency Services District, Hospital District, etc.) and are separate from the fire department. This is called a “911 Service EMS Agency” in which the hospital has three services: policy, fire, and EMS. Austin/Texas County is an example.

Contracted EMS. Some citizens or counties may contractually outsource their 9-1-1 ambulance service to a private company. Bexar County is an example.

Chartered or Private EMS Agencies. Some counties or cities may work with an EMS agency, which is a non-profit or locally funded as a volunteer organization, to provide 9-1-1 services. Harris County Emergency Corps, which was Texas’ first EMS agency in 1937, is an example.

Texas EMS Agencies: A Vital Part of Every Community

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MESSAGING
COST OF READINESS

EMS agencies that provide emergency medical care via a 911-system are subject to rigid contractual guidelines that are established by a local governing authority such as a city, county, or Emergency Services District (EDS). The local authorities determine response time parameters, staffing ratios, maintenance schedules for emergency vehicles, and the rate structure for the community.

As a result of the rate regulation by the local governing authority, EMS agencies cannot raise their reimbursement rates without approval from the local governing authority.

It is a common misconception that ambulance transportation is a free and essential public service whose cost is completely covered by local taxes like police and fire.

EMT (Emergency Medical Technician) - Emergency personnel who are trained in providing medical care to patients in emergencies.

EMR (Emergency Medical Responder) - Emergency personnel who provide basic life support and medical care in emergency situations.

EMS (Emergency Medical Services) - A system for providing emergency medical care to people in need.

EMS agencies face rigid contractual guidelines:

- EMS agencies that provide emergency medical care via a 911-system are subject to rigid contractual guidelines that are established by a local governing authority such as a city, county, or Emergency Services District (EDS).

Two choices for EMS Operating Revenue:

- Either the Patient Requires Transport Pays or Taxpayers Pay

Dilling the Patient: When transported to a hospital, the EMS agency bills the patient for the service. However, since the local government often regulates the rate, patient bills are rarely enough to cover the entire EMS agency’s operations. EMS agencies cannot charge the patient more than the rate set by the local government authority. This funding model puts more of the cost of providing EMS on the actual user, instead of all taxpayers in the community. If a patient has not met his or her insurance deductible, the ambulance transport is often applied to the deductible because it is faster to generate than the hospital bill, which may be more complicated to calculate and take more time to generate.

Local Taxpayer Subsidies: EMS agencies are expected to be ready at all times and respond to every emergency, even if a patient is not transported to a hospital. They are not able to bill an insurance company or the patient unless the patient is transported. EMS agencies refer to these non-revenue generating calls as “the cost of readiness.” EMS agencies must rely on subsidies in the form of local taxpayer dollars to cover its shortfall due to not enough patient fees being collected. If the Texas Legislature places limitations on EMTs agencies to bill patients, then the local taxpayer will be forced to pay more.

Government Grants Are Extremely Limited: The state and federal government funding of EMS operations is extremely limited. In Texas, the Tobacco Fund, which is almost exhausted, provides a minimal level of grants to EMS agencies.

The Cost of Readiness:

The Unique Financial Challenges for EMS Agencies

An EMS (Emergency Medical Services) agency is a unique health care provider group – its clinical and reimbursement characteristics cannot be found in any other segment of the health care industry. From a clinical standpoint, an EMS agency is the only type of provider that is licensed to respond to the location of a patient suffering from an acute onset of illness or traumatic injury, provide patients with initial care en route, and provide timely access to a hospital. From a reimbursement standpoint, an EMS agency faces rigid contractual guidelines established by a local governing authority.

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DSHS IN 2016 EMS RULE UPDATE
SUNSET DSHS & EMS PROVISIONS
SB 1899 served as a sunset vehicle

- EMS jurisprudence exam.
- Physical location that is a permanent location (owned or leased by the licensee) must remain in the location for the period of the license.
- Must keep patient care records at the location and only one licensee may operate out of a single location.
- Licensee must be able to show that they own or lease all major equipment.
- DSHS will have the ability to report possible violations of other regulatory agencies discovered during investigations.
2017 LEGISLATURE EMS & TRAUMA ISSUES
JULY 13 EMS/TRAUMA HEARING IN THE HOUSE

Key concepts that TEMSA will present at the hearing with the Public Health and Appropriations Committees

- Overview of EMS. Few lawmakers have a strong understanding of the EMS delivery system in Texas.
- Potential fuel tax relief legislation for agencies that provide 911 services.
- The importance of protecting balance billing for EMS.
- Overview of how the tobacco fund and other state revenue streams have provided grants to EMS agencies.
Study the trauma system in the State of Texas, including financing, service delivery, planning, and coordination among Emergency Medical Services providers, Trauma Services Area Regional Advisory Councils, The Emergency Medical Task Force, and hospitals.

Determine strengths and weaknesses, including challenges for rural areas of the state. Make recommendations to reduce any duplicated services, improve the coordination of services, and advance the delivery of trauma services in Texas.
MEDICAID & THE BUDGET LIMITED INCREASES
2015 Texas Legislature

- Only rural hospitals received a Medicaid increase (limited to outpatient services).
- Primary care physicians witnessed an increase in the House budget. But it was ultimately removed in the conference committee.
- Therapy services associated with home health care received the largest cut.
- The continued emphasis revolves around the future of the Medicaid 1115 waiver.
- The state’s Medicaid regions are developing creative plans to draw down additional federal funds.
“EBOLA” & EMTF FUNDING SUCCESSFUL
2015 Texas Legislature

• The Texas Emergency Medical Task Force (EMTF) will be funded when the state receives more than a defined amount of “federal ebola funding.” The provision allocates $6.65 million each fiscal year for the purpose of epidemiology surveillance and response.

• If DSHS receives federal funds of $20,270,483 or more during the 2016-17 biennium related to ebola, the state funds can be utilized to fund EMTF.

• The original budget would have tied the funding to SB 538. However, that contingency was removed.

• SB 538 would have created new capabilities for the state government to address infectious disease emergencies. However, the bill died after several groups opposed it due to concerns over vaccinations.
CARDIOLOGY & STROKE FUNDING $6.5 M
2015 Texas Legislature

• $6.5 million was directed to fund the state’s cardiovascular and stroke project.
• $2 million of that fund is earmarked for the state’s Council.
• The balance will go to the University of Texas’ Stroke System of Care Coordination (Lone Star Stroke).
• The Council is currently talking to RACs regarding the funding.
TELEMEDICINE PROJECT WEST TEXAS

HB 2004 was amended to HB 479

- HB 2004, which was amended to HB 479, creates an EMS telemedicine project in West Texas through Texas Tech.
- HB 2008 was a larger bill that would have had a more dramatic impact.
- The original concept would have directed RAC 9-1-1 pass-through dollars from RACs and EMS for use in the telemedicine pilot project.
DRIVER RESPONSIBILITY PROGRAM LATE SURGE
2015 Texas Legislature

• HB 1437 and SB 93 attempted to alter the DRP by removing the provision to take away a driver’s license if an individual fails to pay the surcharge.

• Both sides of the aisle expressed strong interest at the end of the Legislature to remove the driver’s license penalty.
AIR MEDICAL IN TEXAS TWO KEY ISSUES

2015 Legislature
• HB 3077 would have allowed air ambulance providers to draw down additional federal funds.
• The bill was eventually offered as an amendment to a tax bill. It was ultimately stripped.

Fall 2015 SOAH & Workers’ Comp
• Will the State Office of Administrative Hearing decision lead to a Workers’ Comp fee schedule for EMS?
“In conclusion, the ALJ finds that neither the Carriers’ proposed reimbursement of Medicare nor PHI’s proposed reimbursement of billed charges satisfy the applicable statutory standards. However, the reimbursement rate of 149% of Medicare does satisfy the statutory standards, and that is the amount the ALJ orders be reimbursed by Carriers for the air ambulance services in issue.

For each of the 33 cases involved in this joined docket, the parties have submitted a chart reflecting the amounts already paid, the total amount required at the rate of 149% of Medicare, and the remaining balance owed based upon this total amount due. Consistent with that chart, the ALJ finds that PHI is entitled to the amounts shown on the chart, and Carriers shall make payment for the “amount owed” for each case.
MANAGED CARE ISSUES AUSTIN & WASHINGTON
Will Balance Billing Be the Top Issues in the 2017 Legislature?
MANAGED CARE ISSUES
WHAT THE HEALTH PLANS ARE SAYING
Solving Network Disputes: Key Considerations

- "Usual or Customary Charge" rule mandating health plans pay out-of-network ER providers based on "billed charges" has created an incentive for providers to stay out of network, exacerbated the out-of-network ER problem, and exposed more consumers to balance billing
  - Problem with "billed charges:" Often have very little connection to underlying costs, quality, or market prices
  - Milliman predicted an increase in health care costs and the loss of hospital-based network providers due to the incentive to make more money out of network
  - 12 large ER provider groups terminated their contract with BCBSTX, citing it as a "business decision" after the 2013 rule implementation

- There are still significant surprise billing problems related to emergency care and out-of-network hospital-based providers not included in the mediation statute

- Mediation is working but is limited and needs to be expanded
Surprise Billing Is Still A Problem

- **Additional Hospital-Based Providers**: Not all hospital-based providers are listed in statute - Surprise billing is increasing from other out-of-network providers, ex. “Hospitalists”

- **Emergency Care**: Data shows there is an out-of-network emergency care problem that needs to be addressed

- **Emergency Care Protections Are Inconsistent & Create an Incentive to Stay Out of Network**:
  - Current payment protections across product types are complex, confusing, and create an incentive for emergency care providers to stay out of network
  - Balance billing protections vary across product types, creating confusion

- **Transparency**: System is still too confusing for consumers; more transparency is needed on network status and prices (billed charges)
Emergency Services Are The Top Surprise Billing Problem: 2015

Percent of Claims & Dollars Out of Network:
Hospital Based Physicians—2015

Emergency Room Facility Claims:
Network vs. Out of Network

Source: TAHP Out-of-Network Claims Survey and Analysis of Three Large Texas Health Plans: 2015 Claims; May 2016
Out-Of-Network ER Concerns

• Emergency care payment protections are inconsistent & create an incentive to stay out of network

• TDI requires health plans to pay out-of-network providers based on billed charges, the “usual or customary charge” for emergency care
  • Based on billed charges, not what is usually accepted & negotiated in the market
  • Creates a financial incentive for providers to stay out of network
  • Many ER providers have left health plan networks since U&C was adopted
  • Freestanding ERs tend to be out of network
  • 21% to 56% of hospitals have no in-network ER doc at in-network hospitals for the three largest health plans in TX

• Providers can still balance bill patients in excess of the “usual or customary charge” payment
Mediation Is Working When Available

Total Number of Mediation Requests Received by TDI

Note: The mediation request threshold changed from $1,000 to $500 on 9/1/2015. During the last 3 months of 2015, 46 out of the 1,062 requests were for bills between $500 - $1,000.

Mediation Savings Impact to Consumers: 2015

Source: TDI Data On Out Of Network Mediation Requests, April 2016
Recommendations

- TAHP believes in a balanced approach that accomplishes three goals:
  - Protect patients from bills they are not responsible for paying
  - Provide for fair and reasonable payment to out-of-network providers
  - Provide for a dispute process when providers feel they have not been accurately or adequately paid

- Expand mediation and surprise billing protections for consumers for all out-of-network emergency care services – physicians, providers, and facilities
- Expand mediation protection for consumers who receive services from any out-of-network providers working at an in-network hospital
- Expand mediation to bills lower than the current $500 threshold
- Streamline emergency care protections, so they are uniform across all product types
- Set reasonable out-of-network payment standards for emergency care that do not create an incentive for providers to stay out of network – NAIC model recommendation
- Increase transparency of health care prices (billed charges) and network status
BALANCE BILLING KEY CONSIDERATIONS

• The state of Texas does not have jurisdiction over ERISA (self-funded) and government health plans – all of which make up approximately 80 percent of the insureds in Texas.

• The health plans initially expressed an interest in eliminating balance billing. All eyes were on Florida’s recent action.

• The health plans’ position has evolved and seems to have focused more on applying the state’s $500 mediation threshold to all providers and eliminating the state’s PPO network adequacy provision that requires a usual, customary, and reasonable (UCR) payment for out-of-network emergency services.

• The Federal Aviation Administration (FAA) has jurisdiction over air ambulance charges.
• 2009 law (HB 2256) allows patients to enter into an informal teleconference and potential mediation with a facility-based physician for an out-of-network balance bill of $1,000 or more.

• SB 481 (2015) was signed into law and lowers the threshold to $500.

• It applies to anesthesiologists, emergency physicians, radiologists, neonatologists, pathologists, and assisting surgeons.
BALANCE BILLING \textbf{ALL EYES ARE ON FLORIDA}
Florida’s Spring 2016 Law Eliminated the Ability to Balance Bill for Out-of-network Services

\begin{itemize}
  \item The patient is taken out of any balance bills.
  \item Providers (facilities and physicians) may not send a balance bill for out-of-network services to a patient. If the provider wants to recover the balance, the provider must enter into an arbitration with the health insurance plan.
  \item EMS agencies did achieve an exception to the law.
\end{itemize}
Average **out-of-network** billed charges were 118% - 1,382% higher than amounts paid by Medicare, according to a new report from AHIP.
### Balance Billing in Texas Considerations

Both the Texas House and Senate have held committee hearings.

<table>
<thead>
<tr>
<th><strong>$500 Mediation Threshold for All</strong></th>
<th><strong>Pricing Transparency</strong></th>
<th><strong>Eliminate the UCR Provision in Network Adequacy</strong></th>
</tr>
</thead>
</table>
| • Health plans started the discussion with pushing a complete ban like Florida.  
  • The conversation has evolved into a $500 mediation for all. | • Require providers to post prices for their most common services and require plans to post allowables.  
  • HB 3102 (2015) would have required providers to send estimate notices for non-emergency services. Did not move. | • Texas’ PPO network adequacy rule contains a provision that out-of-network emergency services must be paid based on a UCR.  
  • The health plans believe that FSEDs target this. |
Air Ambulances Offer a Lifeline, and Then a Sky-High Bill

An air ambulance crew from Life Star of Kansas delivers a patient to Stormont-Vail Hospital in Topeka. Life Star is a nonprofit, and its fees are not as high as those charged by some services.
• **New York state.** Prevents balance billing for out-of-network ambulance services.

• **Emergency services.** Many of the bans on balance billing apply to emergency services.

• **ERISA.** State insurance laws can only apply to non-ERISA plans. If state policymakers want to affect the entire system, they have to place the burden on providers. States can regulate all providers (but not all insurance plans).
LICENSING ISSUES AUSTIN, TX
DSHS LICENSING ISSUES
Interstate compact and paramedic practice bills passed.

• **Interstate licensing compact for paramedics.** HB 2498 was signed into law and adds Texas to the compact. No DSHS action necessary until 10 states have entered the compact.

• **Waiver of tuition fees.** HB 3273 did not make it out of the House. It would have waived certain tuition fees for EMS education.
PARAMEDIC PRACTICE EXPANSION & SUNSET

HB 2020/SB 1899 Signed into Law

- Allows paramedics to provide ALS in hospitals under a physician’s supervision.
- The legislation faced initial criticism from several different stakeholder groups.
- SB 1899 included DSHS/EMS sunset language.
PERSONNEL ISSUES AUSTIN, TX
2015 Texas Legislature & Potential 2017 Preview
PERSONNEL ISSUES PASSED & FAILED

Infection Control & Disease Disclosure
- SB 1574 – Emergency personnel exposure. Signed into law and requires a designated infection control officer. Recent regulatory action.
- HB 2646 – Communicable disease disclosure. Signed into law and notifies first responders about individuals who are monitored for potential communicable disease.

Other Bills Passed
- HB 1338 – Traumatic brain injury training. TX Commission on Law Enforcement must create a training program by 12.31.15.
- HB 1388 – Appeals related to work. Adds clarifying language regarding how to determine if MI or stroke occurred as a result of work.
- HB 2771 – Workers’ Comp transport to scene. Driving to an emergency is part of the scope.

Failed Bills
- HB 353 – Volunteer EMS concealed weapons. Failed after moving out of a House committee.
- HB 3488 – SOAH and EMS personnel terminations. It would have applied to Travis County.
LODD DEATH BENEFITS
HB 1094 was signed into law

• Allows spousal benefits until death (even in cases of re-marriage).
• The one-time payment will increase from $250,000 to $500,000.
• Sponsored by Rep. Charlie Geren (R-Fort Worth).
MEDICAID MCOS AMBULANCE INDUSTRY INITIATIVES
Austin, Texas efforts

• Standardization of the pre-authorization form.
• Requiring all subcontractors to MCOs to meet the minimum electronic data interchange (EDI) requirements.
• Administrative simplification initiatives for claims processing and appeals.
EMS & TRAUMA ISSUES AUSTIN

2015 Texas Legislature & Regulatory Arena
## Direct Transport: HB 2711
- Did not leave the House.
- Would have permitted EMS personnel to bypass a hospital ED and transport a patient demonstrating mental illness directly to a mental health facility.

## Patient Holds & Detentions: SB 359 & SB 355
- SB 359 was vetoed and would have allowed hospital personnel to hold a patient displaying mental illness for four hours.
- SB 355 was not considered. It would have allowed peace officers to hold patients with certain communicable diseases.

## Opioid Antagonist: HB 1462 & HB 225
- HB 1462 was signed into law and allows providers to give opioid antagonist authority to friends/family of patients.
- HB 225 was vetoed due to its good samaritan provision.
AMBULANCE ISSUES \textbf{AUSTIN}

\textit{84\textsuperscript{th} Texas Legislature}
## FUEL TAXES in TEXAS LEGISLATURE

### 2015 Issues

<table>
<thead>
<tr>
<th>Non-Profit Entities: HB 2731</th>
<th>Sales Tax Relief: HB 3229 &amp; HB 4067</th>
<th>Motor Fuel Tax Relief: HB 3468</th>
</tr>
</thead>
</table>
| • Amended to another bill that passed and provides fuel tax relief for non-profit EMS entities | • The bills ran out of time in the House.  
• They would have provided sales tax relief for emergency vehicles. | • HB 3468 would have provided motor fuel tax relief for emergency vehicles.  
• It ran out of time in the House. |
**AMBULANCES TWO OTHER ISSUES**

<table>
<thead>
<tr>
<th>Emergency Insignias</th>
<th>Competitive Bidding</th>
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<tr>
<td>• HB 2722 ran out of time in the House.</td>
<td>• SB 1377 did not make it out of the Senate committee.</td>
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<td>• It would have required emergency markings to be removed from ambulances before sales to the general public.</td>
<td>• It would have required competitive bidding for ESDs (emergency service districts) for providing ambulance services.</td>
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### OTHER MEDICAID ISSUES Texas Legislature

Limited issues in 2015

<table>
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<tr>
<th>Adequate Networks: SB 760</th>
<th>Medicaid OIG Reform: SB 207</th>
<th>Medicaid Managed Care Payments for Ambulances</th>
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<tr>
<td>• Signed into law.</td>
<td>• Signed into law.</td>
<td>• HB 2773 and SB 702 failed.</td>
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<td>• It will “enhance” Medicaid HMO networks.</td>
<td>• Restricts the OIG’s ability to withhold funds during a Medicaid investigation.</td>
<td>• The bills would have required Medicaid HMOs to reimburse ambulances at 100 percent of the allowable.</td>
</tr>
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<td>• The federal government issued a proposed rule regarding the same subject in the spring of 2015.</td>
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</tr>
</tbody>
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Texas EMS Alliance
OTHER ISSUES TO CONSIDER AUSTIN
2015 and Beyond
ADVANCE DIRECTIVES 2015 LEGISLATURE
Relatively quiet after a heated 2013 debate

• HB 3074 passed.

• It amends the Texas Advance Directives Act to require artificial nutrition and hydration be provided to a patient except for certain circumstances.

• It requires the continued provision of life-sustaining treatment for up to 10 days from the time that a patient is given both the hospital ethics committee’s written decision that the continuance of treatment is not appropriate and the patient’s medical record.
### Three Different Models in Texas

<table>
<thead>
<tr>
<th><strong>Hospital</strong></th>
<th><strong>Satellite HOPD</strong></th>
<th><strong>Independent FEMC</strong></th>
</tr>
</thead>
</table>
| - Some operators acquire a hospital license from DSHS and serve as an “emergency hospital.”  
  - It may take federal patients (Medicare, Medicaid, and TriCare). | - Satellite HOPDs operate under the parent hospital’s license.  
  - Medicare’s 35-mile rule.  
  - Texas does not require additional licensing.  
  - First Choice transitioned their DFW facilities into satellites in early November.  
  - Site neutral payments and the future. | - Texas created the nation’s first and only state license in 2009.  
  - Not recognized by Medicare. |
FREESTANDING ER **KEY ISSUES**

- The health plans realized in 2015 that they would not be able to eliminate them. In 2017, they will focus on a provision in the state’s PPO network.
- It amends the Texas Advance Directives Act to require artificial nutrition and hydration be provided to a patient except for certain circumstances.
- It requires the continued provision of life-sustaining treatment for up to 10 days from the time that a patient is given both the hospital ethics committee’s written decision that the continuance of treatment is not appropriate and the patient’s medical record.
MEDICAID JUNE 17, 2016 RE-ENROLLMENT

All providers must re-enroll by a 2016 deadline

• Begin the re-enrollment process today. It will take time.
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