Frequent Flyers: Reducing 911 Abuse

BY: LEANN D. GUZMAN
Senior Assistant City Attorney, Fort Worth, Texas



Many municipalities who provide their own ambulance service are faced with the "frequent flyer"- someone who calls 911 repeatedly and inappropriately for a claimed medical emergency, but who does not actually need emergency medical intervention. This problem is particularly serious as first responders, at the heart of the Covid-19 crisis, answer unprecedented numbers of pandemic-related calls.

These frequent flyers are a small number of people who are responsible for a high volume of ambulance transports. For example, the ambulance authority in Fort Worth, Texas, found in 2009 that 21 patients had been transported to local emergency rooms a total of 800 times over a 12-month period, which created almost $1 million in ambulance charges.[1] The Tucscon Fire Department similarly found that 50 patients were responsible for more than 300 nonemergency 911 calls over a 12-month period.[2] One woman in Washington, DC made 226 calls to 911 in one year and went to the hospital 117 times.[3] The San Francisco Fire Department has over 200 frequent fliers, which they define as using the ambulance service more than four times per year, and about 10% of these frequent fliers have been transported between 30 and 120 times.[4]

When the frequent flyer calls come in, important and finite resources are tied up, from the ambulances to the emergency rooms. However, although the callers may not have an emergency, they are sick or suffering in some way and need help. Their issues are deeper than those presented, often stemming from chronic pain, addiction, mental health issues, lack of insurance, or homelessness.[5] As a result, many communities have explored and are still exploring ways to help the frequent flyer while conserving valuable public resources.

One answer may be through expanding the role of the paramedics at the ambulance service to perform more than emergency response. This increased role is being put into practice through a nationwide movement to provide Mobile Integrated Healthcare-Community Paramedicine (MIH-CP). MIH-CP is "the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment."[6] MIH-CP is an umbrella term that can refer to any number of out-of-hospital services, including 911 nurse triage, chronic disease management, post-hospital discharge follow-up, and case management for frequent 911 users.

MIH-CP has been used for decades in rural areas where the only access to medical care was from EMTs or paramedics. And now urban areas are looking to MIH-CP as a solution for their frequent flyers, who also have resource gaps and challenges to access to the kind of medical care they need, albeit for very different reasons.[7]

Today, over 200 EMS agencies in 33 states plus Washington, DC are operating MIH-CP, with more providing MIH-CP-style services but who do not want to use that label, and still more planning to begin those services soon.[8]

And, MIH-CP is working. In Fort Worth, the MIH-CP program was shown to reduce frequency of transports, reduce hospital admissions, and save millions.[9] In Ontario, Canada, seniors in low-income housing were treated through an MIH-CP program, resulting in reduced emer-

gency calls, lowered blood pressure, and lowered diabetes risk after one year.[10] In Milwaukee, after instituting community paramedicine by the Milwaukee Fire Department, 911 calls across all demographics dropped by more than half.[1]

With the success of these programs, municipal lawyers whose cities provide ambulance services and who do not yet provide MIH-CP may very well encounter questions from their clients about starting the provision of these services soon. This article is intended to provide municipal law practitioners with a broad overview of legal issues of which to be aware as a starting point for vetting the legalities of the provision of MIH-CP services by their client.

1. Legality of MIH-CP Services by City Paramedics

Emergency medical services are regulated by state law, and these laws vary across the country. Traditionally, EMS action has been provided in the context of an emergency, and the trigger for deployment is a call for help. Some states still follow this very narrow definition of what EMS personnel may do. But in order to provide MIH-CP services, the traditional definition of the services that EMS personnel may provide must be expanded in some way, generally by the state legislatures.

Some states have delegated the authority of the scope of EMS to medical directors for the EMS organization, which will not require a change in state law, but will require a change in protocols by the medical director, as the established protocols related to services and dispatch of EMS personnel are usually based on the traditional model of provision of emergency services. Most protocols may remain the same, but others will need to be included, such as, for example, specific procedures for 911 triage and home visits.

In other states, changes to allow for the legality of MIH-CP services will require modifications at the legislature, and collaboration and agreement among multiple entities, including state or local health departments, boards of emergency health services, hospitals, ambulance providers, and supervising physicians.[1]

With the rise in popularity and the proven efficacy of MIH-CP programs, other states are working to change their laws to allow for these services. A list of states' laws related to MIH-CP from March 2018 was put together by the National Association of State EMS Officials, and is a good starting point to find out your state's or US territory's laws, although verification and updates will be needed.[13]

2. Anti-Kickback Statute

If your city wishes to provide MIH-CP services without implicating the federal Anti-Kickback Statute, the city must have a cost analysis and retain that documentation in its files, and then price the services so that the services are not provided below cost.

The Anti-kickback statute ("AKS")[14] is a federal law that prohibits knowing and willful solicitation or receipt of any remuneration, either directly or indirectly, in cash or in kind, to induce referrals of items or services reimbursable by the Federal health care programs, including Medicaid and Medicare. Violations of the AKS subject the violator to The Civil Monetary Penalties Law[15] which authorizes the Office of Inspector General to seek penalties for offenders.

The purpose of the AKS is to protect federal dollars from people and organizations gaming the federal system to get more business and more federal money. Both sides of a transaction are subject to the AKS, so that in the situation of an ambulance service and a facility to which the ambulance takes the patient, the law would be applicable to both the service and the facility.

In the context of MIH-CP, the program must be carefully crafted with AKS compliance in mind, especially if the MIH-CP services are provided through a facility that also refers patients to the ambulance service.

The Office of Inspector General issued a groundbreaking opinion regarding a form of MIH-CP services, stating that the arrangement was allowed to stand even though it could be construed as a technical violation of the AKS.[15] In the situation opined on in OIG Advisory Opinion 13-10 (OIG Opinion), a hospital provided a program with certain post-discharge services, including community paramedic services, free to patients who had congestive heart failure in order to prevent hospital readmissions and improve the patient health. This -type of arrangement may trigger concerns under the AKS if a patient is provided free or discounted services that could potentially incentivize a patient to go to the provider of those services for Medicare or Medicaid-covered care.

The OIG Opinion found that the benefits of the program outweighed the risk of influencing the patient to select that hospital for future services. The opinion rested on several program-specific factors, including that the patient had to have already selected the hospital for follow-up care, no employees would be compensated based on the number of patients in the program, the services were narrowly tailored in time and services, the hospital did not advertise the program, and neither Medicaid nor Medicare would pay directly for the program services.

The OIG Opinion is obviously a case-specific opinion, and should be read as such, but it is also an indication that the federal government is seeing the benefits of MIH-CP services and is willing to work with programs that meet the spirit of the law.[17]

Continued on page 14

Frequent Flyer *cont'd from page 13*

3. Liability Issues
With the City embarking on a new program, particularly one involving the medical care of patients, the possibility for additional liability should be thoroughly vetted and addressed. Patients or potential patients may bring a variety of claims.

Constitutional claims might include a violation of due process through a deprivation of life or liberty interests if a patient is not provided services.[18] However, the U.S. Supreme Court decided in *DeShaney v. Winnebago County Department of Social Services* that a government's failure to assist or respond to someone in need is not a constitutional violation in and of itself, and the government is not generally required to provide people with assistance.[19]

The level, if any, of duty of care for the paramedics that would arise in your state for a program dedicated to providing care for individuals and whether a claim for breach of that duty would survive the immunity statutes in your state is something that should be considered.

4. Other Legalities to Consider
Although not an exhaustive list, here are some additional things to consider in order to perform MIH-CP with city employees:

a. Compliance with state home health licensing and regulation, if applicable
b. Job descriptions of employees providing MIH-CP
c. Credential checks for applicants and existing employees
d. Proper pay and overtime issues
e. Forms for evaluations and assessments necessary to fulfill the services with the clients
f. Consents, waivers, and forms for patients to sign
g. HIPAA-compliant records and record-keeping
h. Training for employees, including skills for the services and for HIPAA compliance
i. Contract with funding or cost-sharing organization(s) or entity, if available, to help assure financial viability of the MIH-CP program
j. Contract with MIH-CP services provider, if different from city
k. Supply contracts
l. Necessary council approvals

5. Implementation
It is important to know Best practices for implementation of an MIH-CP program as you guide your decision-makers.

(1) Identify the need. Rural and urban programs have very different needs, and not every rural area or urban area has the same gap in existing medical services. If the city needs to reduce 911 callers, what is the need by the patient that drives the calls to 911? Stakeholder groups should use reliable and available data to explore the needs in a patient-centered way. The stakeholder groups should be as inclusive as possible (e.g., include people working in homeless services, pre-hospital care, hospital systems, geriatrics, pediatrics, psychiatric and mental health, hospice, and chronic disease management.) If needed data isn't available, conduct community surveys and assessments, or begin to collect necessary data.
(2) Identify the model. How will the MIH-CP program be run using City resources? Some options:

a. Medical Provider-controlled and City-operated. A hospital or other medical services provider is the "owner" of the project and then contracts with the city to provide the service. (Beware of the AKS issues mentioned above.)
b. City-controlled and Operated. The city owns the program and the EMTs in the Fire Department perform the services.
c. City-controlled and Contractor-operated. The city owns the program and outsources the work by contracting with a provider of the services.

No matter the model used, collaboration with other medical providers in the area is critical and will strengthen the program, and the program will need medical oversight by physicians and other community practitioners.
(3) Identify the metrics. How will staff determine that the program has been successful? What data will they want and need to track to ensure the metrics have been met? How often should metrics be evaluated? The answers will depend on the services provided. A list of resources with sample metrics can be found in the MIH-CP Program Toolkit provided by National Association of Emergency Medical Technicians.[20]
(4) Identify the money. Establishing a budget is a relatively easy part of starting a new program, provided staff can identify all overhead and expenses. The difficulty is in finding sustainable funding for the program.

Medicaid and Medicare traditionally have not been funding sources. Medicare, for example, has primarily paid only for an ambulance transport when the patient is taken to a hospital emergency department, which actually creates an incentive to transport people who do not need it. (This problem is not limited to Medicare patients; under most fee-based payment structures historically used in ambulance services, there is no fee charged or paid unless there is a transport somewhere.)

However, this status of the federal government as a non-payer is changing. On February 14, 2019, the United States Department of Health and Human Services (HHS), Center for Medicare and Medicaid Innovation (Innovation Center), announced a new payment model that allows ambulance service providers to partner with qualified health care practitioners to deliver treatment in place (such as through

telemedicine or on-site care) and to provide transportation to alternative destination sites other than emergency rooms (such as urgent-care clinics or primary care physician offices). The model "will encourage development of medical triage lines for low-acuity 911 calls in regions where participating ambulance suppliers and providers operate."[21]

In some states, specifically Nevada, Arizona, New Mexico and Minnesota, Medicaid is paying for parts of the program.[22] Funding could also be obtained through federal grants, cooperative agreements, and contracts.[23]

In conclusion, MIH-CP, if legally allowed in your state, is an important tool in the toolbox when exploring ways to reduce frequent flyers and conserve valuable and finite taxpayer resources from being monopolized by a few people whose true needs could be met in other ways. ML

Notes

1. The Agency for Healthcare Research and Quality, *Case study: How an EMS agency tackled "frequent fliers"*, EMS1.COM (February 7, 2012) https://www.ems1.com/research-reviews/articles/1233831-Case-study-How-an-EMS-agency-tackled-frequent-fliers/.
2. *Id.*
3. Amy Brittain, *D.C. woman's number of 911 calls prompt city to request that she be given a guardian*, WASH. POST (November 8, 2013), https://www.washingtonpost.com/local/dc-womans-number-of-911-calls-prompt-city-to-request-that-she-be-given-a-guardian/2013/11/08/85f9d428-4897-11e3-bf0c-cebf37c6f484_story.html?utm_term=.22622e900f57
4. ABC7, *Ambulance frequent fliers costing cities millions* (May 18, 2012), https://abc7news.com/archive/8666579/.
5. National Association of Emergency Medical Technicians, *Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey*, http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2.
6. National Association of Emergency Medical Technicians, *Mobile Integrated Healthcare-Community Paramedicine*, https://www.naemt.org/initiatives/mih-cp (Last Visited June 25, 2019).
7. National Association of Emergency Medical Technicians, *Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey*, http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2
8. *Id.*
9. National Center for Biotechnology Information, *A pilot mobile integrated healthcare program for frequent utilizers of emergency department services,* https://www.ncbi.nlm.nih.gov/pubmed/28495031 (Last visited June 25, 2019).
10. MedStar Mobile Healthcare, *Mobile Healthcare Programs* – Overview, National Association of Emergency Medical Technicians, http://www.medstar911.org/mobile-healthcare-programs (Last visited June 26, 2019).
11. Laura Otto, *Paramedic training helps improve health, reduce 911 calls*, UMW Report (April 24, 2018) https://uwm.edu/news/uwm-helps-improve-health-reduce-911-calls/
12. www.astho.org/Preparedness/ASTHO-EMS-and-Law-Report.
13. National Association of State EMS Officials, *State by State Community Paramedicine – Mobile Integrated Healthcare (CP-MIH) Status Board,* (March 2018) https://nasemso.org/wp-content/uploads/CP_State_Status_Board_CURRENT.pdf.
14. 42 U.S.C. Section 1320a-7b.
15. 42 U.S.C. Section 1320a-7a.
16. Office of Inspector General, U.S. Department of Health and Human Services, *OIG Advisory Opinion 13-10*, (August 9, 2013) https://www.oig.hhs.gov/fraud/docs/advisoryopinions/2013/AdvOpn13-10.pdf.
17. James G. Hodge, Jr., Daniel G. Orenstein, Kim Weidenaar, *Expanding the Role of Emergency Medical Services Providers: A Legal Analysis*, Association of State and Territorial Health Officials (2014).
18. 489 U.S. 189 (1989).
National Association of Emergency Medical Technicians, *MIH-CP Program Toolkit*, http://naemt.org/initiatives/mih-cp/mih-cp-program-toolkit (Last visited June 25, 2019).
19. U.S. Department of Health & Human Services, *HHC launches innovative payment model with new treatment and transport options to more appropriately and effectively meet beneficiaries' emergency needs* (February 14, 2019), https://www.hhs.gov/about/news/2019/02/14/hhs-launches-innovative-payment-model-new-treatment-transport-options.html.
20. National Association of Emergency Medical Technicians, *New Money Makeover: What new EMS payment models mean to Medical Directors and their agencies* (January 3, 2019), www.naemt.org/docs/default-source/community-paramedicine/toolkit/new-money-makeover-what-new-ems-payment-models-mean-to-medical-directors-and-their-agencies.pdf.
21. International Roundtable on Community Paramedicine, *Potential Funding for Community Paramedicine Projects in the United States*, http://ircp.info/Portals/11/Downloads/Funding/Funding_Streams_in_US.pdf?ver=2013-10-24-113402-000 (Last visited June 25, 2019).

Leann Guzman was licensed to practice law in Texas in 2001, joined the City of Fort Worth City Attorney's Office in 2004, and is currently the Section Chief of the Real Estate and City Facilities practice group in the Transactional Division of the City Attorney's Office. She received her law degree from University of Texas School of Law and her bachelor's degree in political science from the University of Texas at Arlington.