Community Paramedicine Program Legislation and Reimbursement: Environmental Scan

Community Paramedicine Monitoring, Evaluation & Policy Research

November 2022

Submitted to:

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Overview

Understanding the legislative and policy landscape of states with community paramedicine programs is an important foundation for the Office of MaineCare Services in their determination for regulating and reimbursing community paramedicine services. To that end, Cutler staff reviewed other states with CP programs and the legislation surrounding them. Cutler staff developed a matrix that outlines legislation and, where available and applicable, state statutes, and Medicaid coverage policies and state plan amendments for states with community paramedicine programs.

Methodology

Our review was based on a 2019 study by the California Health Care Foundation which described state legislation addressing the authorization, regulation, and reimbursement efforts of community paramedicine.[1] Our primary purpose was to identify Medicaid reimbursement, and so those states where CP services were covered by commercial insurance but not Medicaid were not included in our examination.[2] Cutler staff undertook a further investigation into the legislation of seven states highlighted in the California study to examine their Medicaid coverage policies. The states included: Arizona, Indiana, Georgia, Minnesota, North Dakota, Nevada, and Wyoming.

Of note, although Georgia was listed in the study by Coffman and Kwong as having legislatively authorized CP pilot projects, Medicaid reimbursement for CP services as well as treat without transport for 911 calls, and commercial insurance reimbursement for CP services, we were unable to verify this in our review. Because Colorado was an early adopter of community paramedicine and was a model for other states, we decided to include the state in our examination of legislative efforts for Medicaid reimbursement.

In addition to reviewing state legislative websites and documents, we also searched the EMS professional organization websites of the National Association of EMS Officials (NASEMSO) and the National Association of Emergency Medical Technicians (NAEMT). In some cases, we reached out to contacts at the appropriate State Offices of Rural Health and the National Association of Mobile Integrated Health Providers for additional information.

Where available, Medicaid state plan amendment (SPA) information was also reviewed. As noted on the federal Medicaid website (https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/), *when a state is planning to make a change to its program policies or operational approach, states send state plan amendments (SPAs) to the Centers for Medicare & Medicaid Services (CMS) for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information.* Since a SPA is a likely mechanism for Maine

[1] Coffman JM, Kwong C. *Left behind in California: Comparing community paramedicine policies across states*. California Health Care Foundation;2019 November. Accessed January 19, 2022. https://www.chcf.org/wp-content/uploads/2019/11/LeftBehindCaliforniaComparingCommunityParamedicine.pdf

[2] Those states included: Connecticut, Idaho, Kentucky, Maine, Michigan, Missouri, New Hampshire, New York, Ohio, Texas, Virginia, and Wisconsin.

OMS to make changes that will enable CP to be reimbursed through its Medicaid program, a scan was completed on each state with a Medicaid-reimbursable CP program. State plan amendments that were found were catalogued and are attached to this report (Attachments A, B).

State Summaries

In our review of the legislative efforts and policies surrounding CP and Medicaid reimbursement for the target states, our aim was to focus on four to five main aspects: authorizing legislation for CP, authorizing legislation for specifically authorizing Medicaid reimbursement for CP services, revised or amended legislation, requirements for licensure levels and training, and whether specific CP services were either listed or excluded within the legislative documents. In some cases, these categories are laid out very clearly and in detail via state resources available online. For other states the legislation authorizes the appropriate regulatory agency to determine licensure levels, training and specific services to be offered within the scope of CP. The following states were included as part of the review: Arizona, Colorado, Indiana, Minnesota, North Dakota, Nevada and Wyoming.

The following state summaries include embedded active links (accessed: Oct 2022) to several primary sources that provide more details on the domains listed above. Two state plan amendments (AZ, NV) that were available online and may serve as a template for Maine OMS are attached to this report.

Arizona

Summary and Medicaid Reimbursement

The Arizona State office of Emergency Medical Services and Trauma System are a division of the Arizona Department of Health Services and are governed by the EMS Council and the Medical Direction Commission. Arizona did not purse legislative authorization Community Paramedicine (CP). Instead, the EMS Council and the Medical Direction Commission pursued a Treat and Refer program. There was no legislation involved in establishing Medicaid reimbursement for community paramedicine services in Arizona. According to the AHCCCS "The Arizona Department of Health Services, Bureau of EMS and Trauma System, recently launched the Arizona Treat and Refer Recognition Program by publishing the manual and application on its website." The Arizona Treat and Refer Program appears to have been codified in 2016. This Treat and Refer Program is similar to standard practice of many EMS systems across the nation and does not resemble any other CP model.

Reimbursement for the Treat and Refer program was established by a Medicaid State Plan Amendment which was approved by Medicaid on October 24, 2016 according to the Arizona Health Care Cost Containment System (AHCCCS). The AHCCCS also provides the following Treat and Refer FFS Fee Schedule:

Proc	Mod	Procedure Description	FFS Rate
A0998	UA	Treat at home, refer to PCP/specialist	$227.13
A0998	UB	Treat at home, refer to Crisis Response	$227.13
A0998	UC	Treat at home, refer to BH Provider	$227.13
A0998	UD	Treat at home, refer to Urgent Care	$227.13

Licensure/Certification and Training

The Treat and Refer Program manuals do specify that Emergency Medical Care Technicians (EMCTs) are qualified to provide the Treat and Refer program scope of services after 12 hours of initial education. The EMCT must complete 4 hours of additional training each year.

Covered Services

Medicaid reimbursement is limited to the above four categories regardless of the services provided. This program does not expand the scope of practice or the services that may be offered by EMS systems.

Colorado

Authorizing Legislation

SB 16-069 amends the Colorado Revised Statutes pertaining to EMS Education and Certification and EMS Practice and Medical Director Oversight. The revisions include endorsement of community paramedicine certification levels and authorization for the Department to create Rules for Community Integrated Health Care Service (CIHCS) Agencies under which community paramedics must practice and a scope of practice for community paramedics, including protocols and allowable out-of-hospital services they can deliver.

Revised Legislation and Rules

CIHCS licensure allows agencies to offer out-of-hospital medical services. As permitted by SB 16-069, the Department developed rules for CIHCS agencies as well as a scope of practice for CP providers within these agencies.

Medicaid Reimbursement

No evidence was found of Legislation that describes if or how community paramedicine services are reimbursed in Colorado. Medicaid does not reimburse for community paramedicine services in Colorado.

Licensure Level + Training Requirements

The EMS endorsement of community paramedicine appears to be limited to paramedics and acknowledges the education and credentialing requirements for paramedics to become CP providers must be through certification or credentialling from an accredited college or university, or a nationally offered CP exam. The endorsement allows paramedics who meet these requirements to have an expanded scope of care under a CIHCS Agency. A certified community paramedic is considered a C-PC when they meet these credentialing requirements.

Covered Services

Providers with a C-PC certification in CIHCS agencies can carry out tasks in addition to those of the paramedic scope of work. The C-PC scope of work is described in Section 18 of 6 CCR 1015-3. Their EMS CERTIFICATION OR LICENSURE document is extremely thorough and describes the scope of all EMS activities and all licensure levels including Critical Care Paramedics and Community Paramedics (C-PCs). Specifically, the expanded scope of practice for C-PCs includes care coordination and resource navigation as well as:

- Accessing central lines, indwelling venous ports, peritoneal dialysis catheters, or percutaneous tubes
- Assisting with home mechanical ventilators

Ostomy care
Simple wound closure and simple wound care
Ability to assist with Ultrasound procedures

C-PCs are expressly prohibited from performing complex wound closures (sutures, staples or even steri-strips) and Ultrasound diagnosis under 6 CCR 1015-3.

Indiana

Authorizing Legislation

Indiana authorized Mobile Integrated Health (MIH) in April 2019 per SB048. Note that here Indiana is using the term MIH as other use CP. This bill does provide "that the office of the secretary of family and social services may reimburse certain emergency medical services provider agencies for covered services provided to a Medicaid recipient as part of a mobile integration healthcare program." https://legiscan.com/IN/bill/SB0498/2019

It is unclear if the Indiana EMS Commission or the Secretary took any action regarding Medicaid at that time. It appears that it was discussed but no further action was taken until 2021.

Revised Legislation and Rules

In April 2016 MIH programs were officially approved. Then In May 2021 the EMS Commission's Mobile Integrated Health Advisory Committee issued a report that updated the legislative efforts since 2019. Importantly, they authorize MIH to engage in community mental health with a medical provider's guidance. They mention Medicaid reimbursement and specify that EMS agencies must work through a private third-party billing company in order to obtain Medicaid reimbursement. This company also appears to be a provider of ambulance services in Indiana. Because of the third-party involvement, no public information is available on the exact rates for reimbursement. It is also unclear what services EMS agencies might be submitting for reimbursement.

Medicaid Billing and Reimbursement

In Indiana, there currently appear to be eleven (11) EMS systems that are approved for CP programs. See the above Revised Legislation section for a discussion of the current state of Medicaid billing in Indiana. Overall, the information available on the scope of MIH, the licensure level, training and current actual practice is difficult to parse out. While they have clearly authorized MIH and have provided a mechanism for reimbursement, the functional state of MIH in Indiana is unknown. Notably, as recently as June 2022 the Indiana Department of Health was grant-funding Community Paramedicine programs using COVID relief funds.[3] This appears to be allowed according to the Indiana Department of Health.

Licensure Level

The Indiana statues mention that an EMS Agency must be operating at the Advanced Life Support level in order to be eligible for Medicaid reimbursement. While the EMS Commission discusses potential scope of MIH practice in their Program Approval document, they do not seem to address licensure level.

[3] https://www.washtimesherald.com/news/local_news/dch-receives-grant-for-community-paramedic-program/article_00fd71fa-fd2c-11ec-91fa-4337cee4d39f.html

There is an implication that the statutes might exempt EMT Basics from participation, but this is not clear.

Training Requirements

The Indiana EMS Commission reviews and approves Mobile Integrated Health programs, pursuant to Indiana Code 16-31-12-3. No clear training requirements to participate in MIH could be found.

Covered Services

As in the case of Training Requirements, while the Indian EMS Commission oversees MIH, specific services do not appear to be outlined. Similarly, there is no mention of specific services being excluded. The implication is that providers can not operate outside of their scope-of practice.

Minnesota

Authorizing Legislation

Minnesota first authorized the creation of Community Paramedicine by establishing an Emergency medical technician-community paramedic (EMT-CP) licensure level in the regular session of the 2011 legislature. This legislation was signed by the governor on April 6, 2011. Under CHAPTER 12--S.F.No. 119 the actual position became effective on July 1, 2011.

This legislation is notable as it not only created the EMT-CP licensure level but authorized payment for those services by the Minnesota Medical Assistance Program (Minnesota's Medicaid) under Section 3 and further provided oversite and evaluation by the Commissioner of Human Services Section 4. Section 4 went further by authorizing the Commissioner to "evaluate the effect of medical assistance and MinnesotaCare (state program for those without affordable health coverage and distinct from their Medical Assistance Program) coverage of community paramedic services on the cost and quality of care under those programs and the coordination of these services with the health care home services " (CHAPTER 12--S.F.No. 119). Here Minnesota contemplated both MinnesotaCare and Minnesota Medical Assistance Program in covering the costs of CP. A final requirement of this authorizing legislation under Section 4 was to require cost and quality performance data to be provided to the Commissioner for evaluation.

Revised Legislation

Minnesota made a few revisions to the original CP legislation in 2012. The first was Minnesota Statute 256B.0625, Subdivision 60. This reinforced Medicaid reimbursement but specified that payment for CP services was predicated on the care being authorized by a primary care provider. It further specified that the CP agency be registered as a Medicaid provider. A final step of this legislation was to specify that CP services to a given patient could not duplicate those being actively provided by a home health entity.

Medicaid Billing and Reimbursement

Minnesota has been proactive in including Medicaid Billing and Reimbursement from the inception of CP efforts in the state. These are therefore included in the two above legislative sections. Medicaid reimbursement is further reiterated on the Minnesota Department of Health website.

Licensure Level

As with Medicaid reimbursement, Minnesota was proactive in licensure level, and this was provided for in the both the authorizing and revised legislations. In Minnesota only a currently licensed paramedic may apply to become a community paramedic. EMTBs and AEMTs are prohibited from participation.

Training Requirements and Covered Services

The second revision to the original CP legislation in 2012 included specifics about training. Language states that a paramedic licensed in Minnesota must have served for two years before completing an approved and nationally accredited CP specific education program. That program must include supervised advance practice clinical experience. This legislation also reiterated the above noted restrictions of PCP orders and nonduplication of home health services to any given patient.

Minnesota Statute 144E.28, Subdivision 9 as amended in 2012 is still current as of 2021.

The Minnesota Department of Health has updated their website specific to community paramedics and has further clarified curriculum requirements and the two schools with authorized curriculums. This page also lists services as including, but not limited to:

Health assessments
Chronic disease monitoring and education
Medication compliance
Immunizations and vaccinations
Laboratory specimen collection
Hospital discharge follow–up care
Minor medical procedures approved by the Ambulance Medical Director

North Dakota

Authorizing Legislation, Revised Legislation and Rules

It appears that pilot CP programs were authorized in 2013 with a small update in 2015. Despite many Senate and House Bills, no update has been made since. The 2015 legislation did authorize the Department of Human Services to "adopt rules governing payments to licensed community paramedics, advanced emergency medical technicians, and emergency medical technicians for health related services provided to recipients of medical assistance, subject to necessary limitations and exclusions."

Legislation in 2015 did specify that CP activities must be supervised by a physician or an advanced practice RN. A 2016 Public Notice stated that as a result of 2015 Senate Bill 2043, effective on or after 1/1/2017, ND Medicaid would be putting in a SPA "and enrolling community paramedics." These services were to be limited to vaccinations and immunizations. (Note, no SPA was located online.)

In 2021 the North Dakota Legislative committee meeting heard testimony on Medicaid reimbursement and expanding role for community paramedics and AEMTs. No evidence can be found that those rules were ever drafted or adopted.

Medicaid Billing

As noted above, no evidence can be found that North Dakota ever moved forward with Medicaid reimbursement.

Licensure Level

Initial legislation allowed emergency medical technicians (EMT), advanced emergency medical technicians (AEMT) or paramedics to be eligible. There is a severe shortage of prehospital providers in North Dakota, and they rely primarily on volunteers. The state has entered into a multistate agreement to honor licenses from neighboring states. As such North Dakota allows providers licensed in those states to practice in ND. While ND authorized CP programs there is no specific requirement to be licensed at a higher level as a provider.

Training Requirements

State EMS has a CP web page that states "Coming Soon!" There is no information about CP nor any relevant to this scan. No information is available within the statutes.

Covered Services

No evidence found that North Dakota specifies what services may be offered either as a CP program or as a provider within such a program.

Nevada

Authorizing Legislation

Nevada legislature initially authorized CP on May 25th 2015. This was pursuant to Assembly Bill number 305, Chapter 154. It required quarterly updates by agencies engaged in CP and yearly summary of those updates by the Department of Health. Restrictions were established to allow only communities smaller than 700,000 people to engage in CP. The legislation also required endorsement by the Board of Health (Board). EMS agencies are required to apply to the Board for CP endorsement for that agency. It further specified that an individual with CP authorization could only provide those services for the agency where they work/volunteer and where that authorization was granted. In effect, an individual working for multiple agencies in any EMS capacity would have seek authorization to perform CP services for each agency.

Revised Legislation and Rules

Nevada Division of Health Care Financing and Policy (DHCFP) Rules as of March 2022 note that Nevada is divided into two administrative districts for EMS oversight: the Nevada Division of Public and Behavioral Health, Office of Emergency Medical Services and the Southern Nevada Health District's Board of Health. As such, Nevada has two separate authorities that regulate the EMS profession based on geographical location within the state.

The Medicaid Services Manual, Chapter 600, Section 604 states that CP providers, to be reimbursed by Nevada Medicaid, must be enrolled as Nevada Medicaid providers and have to work under a licensed EMS agency. The manual also specifies that "the Medical Director of the EMS agency providing community paramedicine services must be enrolled as a Nevada Medicaid Provider." (sec. 604.1)

As of 2022 and under Medicaid Services Manual, Chapter 600, Section 604, CP "services are delivered according to a recipient-specific plan of care under the supervision of a Nevada-licensed EMS agency medical director and coordinated with a primary care provider (PCP). The plan of care is to be developed after an appropriate assessment and does not have to be in place before community paramedicine services are started but must be developed while the recipient is receiving community paramedicine services. If a recipient does not have a PCP, the plan of care must include establishing a medical home with a PCP. It is expected that all health care providers delivering care to community paramedicine recipients coordinate the patient's care to avoid duplication of services to the recipient" (sec. 604.2)

Medicaid Billing

Of all the states reviewed for this summary, Nevada has the most transparent and readily available information on their Medicaid billing and reimbursement. Nevada Medicaid Billing Information is up to date and includes covered procedures and covered diagnosis codes. As noted above, CP providers must be registered as Medicaid providers, thus Community Paramedicine has its own Provider Type listed and

can be found under the PT 32, specialty 249 billing guide. Nevada's Medicaid Search Fee Schedule provides specific reimbursement rates.

The current Medicaid Services Manual, Chapter 600, Section 604 reiterates CP licensure level, CP program requirements for Medicaid reimbursement, and specifies covered and exempted services (noted below). The manual refers to the above PT 32 for up-to-date reimbursement amounts. In Nevada, CP services do not require prior approval.

Licensure Level

The initial authorizing legislation allowed emergency medical technicians (EMT), advanced emergency medical technician (AEMT) or paramedics to be eligible. This notably excluded medical responders (MR) which is the basic national standard EMS qualification for most fire-fighters. Note this would eliminate participation of smaller fire based (especially volunteer) EMS from participation as those agencies members are generally certified at the MR level. This was the only state in our review to clarify this distinction.

Training Requirements

The initial authorizing legislation did specify that eligible EMS personnel would be required to obtain additional training and maintain proficiency through continuing education. The legislature left it to the Board to specify that training.

Covered Services

In 2022, the state solidified the covered services when Medicaid began reimbursements for CP services. This reaffirmed the above 3 licensure levels. It reaffirmed the requirement The following services can be provided within a community paramedicine provider's scope of practice as part of a community paramedicine visit when requested in plan of care: (per Medicaid Services Manual, Chapter 600, Section 604):

Health evaluation
Chronic disease prevention, monitoring and education (how is not specified)
Medication reconciliation
Administer vaccinations
Point of care lab tests
Follow up from hospital discharge
Preapproved 'minor' medical procedures and treatments within their scope of practice (as approved by the EMS agency's medical director)
by the EMS agency's medical director
Assess home safety
Telehealth

That same authorization specifically prohibited reimbursement for:

travel time or mileage;
servicing hospital-acquired conditions;

Emergency (911) response or EMS transport;
duplicated services (implication is that CP would not be reimbursed if the services was already being provided by Home Health);
personal care and mental or behavioral crisis intervention.

Wyoming

Authorizing Legislation

Legislature initially authorized Community Paramedicine (CP) on 7/25/2016: 48-14 Wyo. Code R. § 14-3.

Revised Legislation and Rules

It appears that Wyoming has made several attempts since 2016 to revise the initial legislation and to authorize Medicaid billing. There are citations on the state legislative site that includes testimony on several bills, but few, if any, seem to have been enacted. There is little available on actual legislation over the last few years. Wyoming did update rules specifically related to Medicaid reimbursement in 2018. This was all directed to covering 'ambulance service.'

Medicaid Billing

Section 10 of the above mentioned rules that did specify that Medicaid was authorized and allowable as payment. These revised rules also specified that CP visits must not involve transport in order to qualify for Medicaid reimbursement. Wyoming Medicaid fee schedule can be found here: https://www.wyomingmedicaid.com/portal/fee-schedules.

Licensure Level

A currently licensed EMT, AEMT, IEMT (Intermediate EMT which predated AEMT certification) or Paramedic, may apply for endorsement as a Community EMS Technician or Community EMS Clinician.

Training Requirements

It is unclear if any specific or additional training is required to obtain the above mentioned 'endorsement.' No CP related training documents or reference were found during the course of this review.

Covered Services

Section 7 of the revised rules deals with Covered Services. Oddly the first item in this Subsection specifically states that "Emergency ground ambulance transportation is a covered service" (Ch. 15, Sub. 7). This would seem to be a contradiction to the opening statement of these same rules (see Medicaid Billing section above).

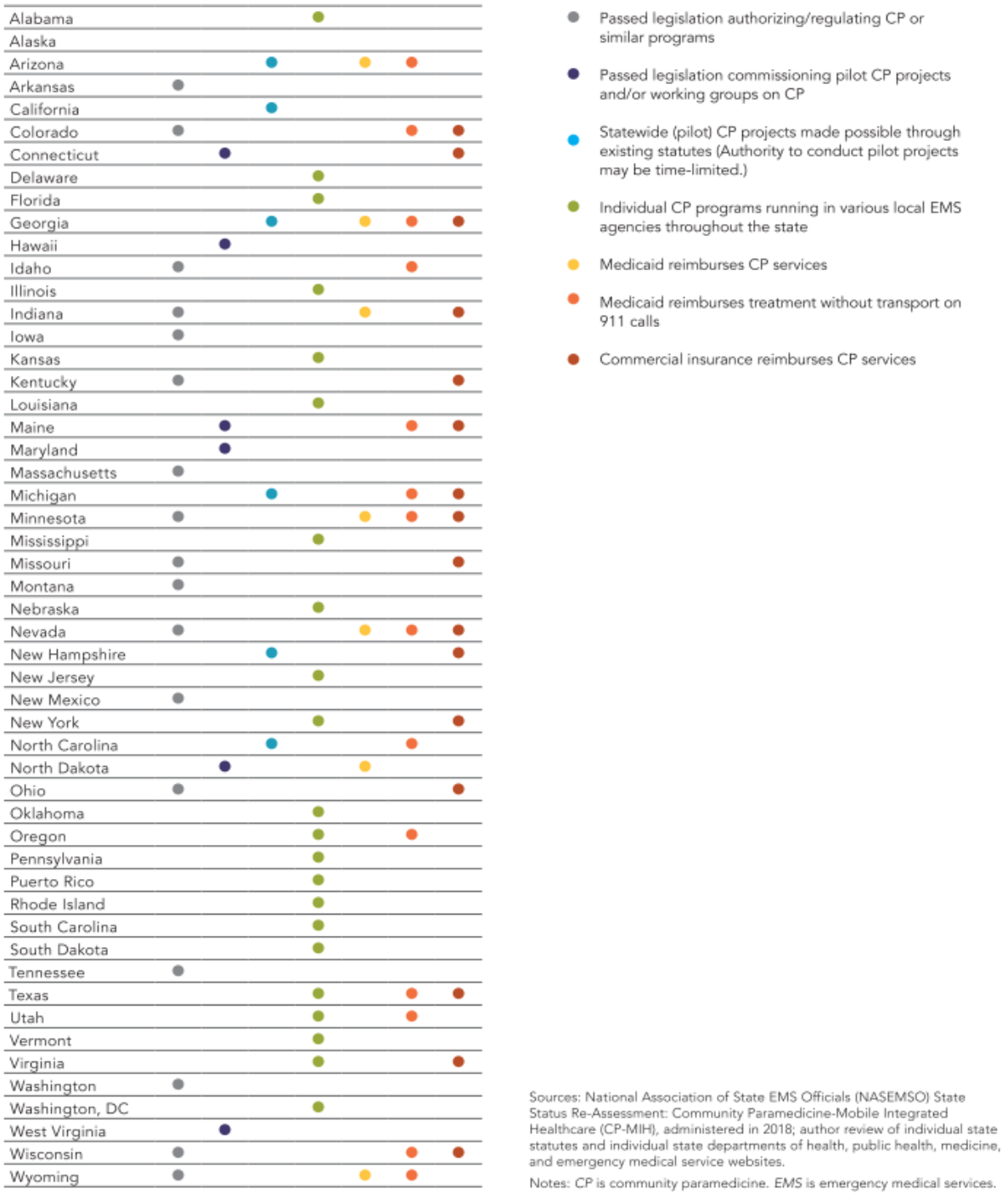
The rules state the following services may qualify for Medicaid reimbursement as long as a "written, well documented plan of care" is available: health assessments; chronic disease monitoring and education; medication compliance; immunizations and vaccinations; laboratory specimen collection; hospital discharge follow-up care; and minor medical procedures" (Ch. 15, sub. 7). The rules do require that all CP services be under orders of a physician.

The same authorization specifically prohibits Medicaid reimbursement for:

> (a) Transportation to receive services that are not covered services; (b) No-load trips and unloaded mileage (when no patient is aboard the ambulance), including transportation of life-support equipment in response to an emergency call; (c) Transportation of a client who is pronounced dead before an ambulance is called or after the ambulance is called but before transport; (d) Transportation of a family member or friend to visit a client or consult with the client's physician or other provider of medical services; (e) Transportation to pick up pharmaceuticals; (f) A client's return home when ambulance transportation is not medically necessary, including a client's return back to a nursing facility; (g) Transportation of a resident of a nursing facility to receive services that are available at the nursing facility; (h) Air ambulance services to transport a client from a hospital capable of treating the client to another hospital at the request of the client or family; (i) Transportation of a client in response to detention ordered by a court or law enforcement agency; (j) Transportation based on a physician's standing orders; (k) Stand-by time; (l) Special attendants; (m) Specialty Care Transport (SCT); (n) Paramedic Intercept (PI); (o) When a client can be transported by a mode other than ambulance without endangering the client's health, regardless of whether other transportation is available; and (p) Any other service not included in Section 7 of this Chapter.

Baseline source for our national scan: Coffman JM, Kwong C. *Left behind in California: Comparing community paramedicine policies across states*. California Health Care Foundation;2019 November. Accessed January 19, 2022. https://www.chcf.org/wp-content/uploads/2019/11/LeftBehindCaliforniaComparingCommunityParamedicine.pdf

Table 2. Legislative Environment for Community Paramedicine, by State (including DC and Puerto Rico), 2019



Sources: National Association of State EMS Officials (NASEMSO) State Status Re-Assessment: Community Paramedicine-Mobile Integrated Healthcare (CP-MIH), administered in 2018; author review of individual state statutes and individual state departments of health, public health, medicine, and emergency medical service websites.

Notes: CP is community paramedicine. *EMS* is emergency medical services.

State Plan Amendments and Authorizing Modalities

The table below briefly summarizes efforts to locate state plan amendments for the states included in this review, and notes where they can be found online (accessed October 12, 2022). For states that did not institute SPAs, the table briefly summarizes the mechanisms for reimbursement for CP services and provides links underneath by state (all accessed October 12, 2022).

Table. Details of SPAs in States with Community Paramedicine Programs

State	SPA Approval Date	Notes on Authorization
Arizona	Oct 2016	EMCTs may provide Treat and Refer services; are able to perform medical treatments, procedures, techniques when certified by the statewide EMS & Trauma Systems. https://www.azahcccs.gov/Resources/Downloads/MedicaidStatePlan/Amendments/2016/ApprovedSPA16-006.pdf
Colorado	n/a	SPA not found.
Indiana	n/a	SPA not found.
Minnesota	n/a	SPA not used; law passed in 2012 that set payment for community paramedics at 90% of rate paid to physician assistants for same or similar service; recent updates to community paramedics as providers in 2021. https://www.revisor.mn.gov/laws/2012/0/Session+Law/Chapter/169/
North Dakota	n/a	SPA not found, although Public Notice stating that as a result of 2015 Senate Bill 2043, effective on or after January 1, 2017, North Dakota Medicaid was to begin reimbursing community paramedic services. At that time, community paramedic services were limited to vaccinations and immunizations. https://www.nd.gov/dhs/info/publicnotice/2016/9-13-public-notice-medicaid-covered-outpatient-drug-upcoming-reimbursement-changes.pdf
Nevada	July 2016	Coverage provided for medically necessary CP services to the "medically underserved;" services must be ordered by PCP. SPA lists serviced covered (included in NV state summary of this report). https://dhcfp.nv.gov/Pgms/CPT/CP/CP/
Wyoming	n/a	SPA not found, but rule making was conducted for reimbursement of CP services. https://wyoleg.gov/arules/2012/rules/ARR18-001.pdf

Attached are the approved State Plan Amendments for Arizona and Nevada.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

October 24, 2016

Tom Betlach, Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

Dear Mr. Betlach:

We have reviewed the proposed State Plan Amendment (SPA) 16-006, which was submitted to the Centers for Medicare & Medicaid Services (CMS) San Francisco Regional Office on August 26, 2016. This SPA adds treat and refer services under the other licensed practitioner benefit.

Based on the information provided, we are approving SPA 16-006 with an effective date of October 1, 2016 as requested. We are enclosing the approved Form CMS-179 and the following Medicaid State Plan pages:

- Attachment 3.1-A Limitations, Pages 6 and 7
- Attachment 4.19-B, Page 5b

If you have any additional questions or need further assistance, please contact Brian Zolynas at (415) 744-3601 or Brian.Zolynas@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Jessica Woodard

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: Centers for Medicare and Medicaid Services**	1. TRANSMITTAL NUMBER: 16-006	2. STATE Arizona
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2016	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

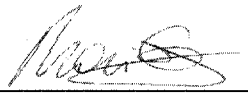
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.60	7. FEDERAL BUDGET IMPACT: None
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A Limitations, Page 6 and 7 Attachment 4.19-B, Page 5(b)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

10. SUBJECT OF AMENDMENT:

Updates the State Plan to describe community paramedicine, otherwise referred to as Treat and Refer.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Monica Coury 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034
13. TYPED NAME: Monica Coury	
14. TITLE: Assistant Director	
15. DATE SUBMITTED: August 26, 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: August 26, 2016	18. DATE APPROVED: 10/24/2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL: Henrietta C. Sam-louie -S
21. TYPED NAME: Henrietta Sam-Louie	22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Services covered by a dentist must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw and include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain
.medication and antibiotics.

6. Medical care and any other types of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

6b. Optometrists' services.

Optometrists' services when they are provided by a licensed optometrist. See section l2d for limitations on eyeglasses and contact lenses.

6d. Other practitioners' services.

Other practitioners' services provided by:

i. Respiratory Therapists

ii. Certified Nurse Practitioners

iii. Certified Registered Nurse Anesthetists

iv. Non-physician First Surgical Assistants and Physician Assistants

v. Licensed midwives within the limitations provided in the AHCCCS policy and Procedures

vi. Licensed affiliated practice dental hygienists practicing within the scope of Arizona's state practice act.

vii. Licensed Pharmacists employed by an AHCCCS-registered pharmacy and acting within the scope of their practice may administer AHCCCS covered vaccines and anaphylaxis agents to adults.

viii. Non-physician behavioral health professionals, as defined in rule, when the services are provided by the following state-licensed practitioners: social workers, physician assistants, psychologists, counselors, registered nurses, psychiatric nurse practitioners, marriage and family therapists, and substance abuse counselors.

ix. Emergency Medical Care Technicians (EMCT) providing Treat and Refer services through an AHCCCS-registered Treat and Refer entity, in accordance with locally adopted Treat and Refer standards of care, education and certification requirements, and demonstration of competence pursuant to A.R.S. 36-2204.

EMCT personnel are able to perform medical treatments, procedures, or techniques within their scope of practice when certified by the statewide Emergency Medical Services and Trauma System.

A Treat and Refer interaction is a healthcare event with an individual that accessed 9-1-1 or a similar emergency number, but whose illness or injury does not require ambulance transport to an emergency department, or other such facility.

The interaction must include (1) documentation of an appropriate clinical and social evaluation, (2) a treatment/referral plan for accessing social, behavioral and/or healthcare services that address the patient's immediate needs, (3) evidence of efforts to follow-up with the patient to ascertain adherence with the treatment plan, and (4) documentation of efforts to assess customer satisfaction with the treat and refer visit.

7. Home health services.

Home health services and supplies are provided by licensed home health agencies that coordinate in-home services, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances and require prior authorization. Home health services meet the requirements of 42 CFR 440.70.

7c. Medical supplies, equipment and applicances suitable for use in the home.

Personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition.

7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

The State offers physical therapy, occupational therapy, and speech pathology and audiology services under the home health benefit (item 7d). The limits for these therapies are the same as those described for items 11, 11b, 11c ofthis section of the State plan.

8. Private duty nursing services.

Private duty nursing services are provided for members who reside in their own home and must be ordered by a physician and provided by an RN or an LPN if provided under the supervision and direction of the recipient's physician. This service is limited to members enrolled in the Arizona Long Term Care System program who receive services provided under the 1115 Waiver and members under the age of 21.

9. Clinic services.

Medical services provided in an ambulatory clinic including physician services, dental services, dialysis, laboratory, x-ray and imaging services, health assessment services, immunizations, medications and medical supplies, therapies, family planning services and EPSDT services.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

- **Other Licensed Practitioner Services**
  - OLP-Pharmacist: AHCCCS-registered pharmacies will be reimbursed for all AHCCCS covered immunizations and anaphylaxis agents administered by licensed pharmacists within the scope of their practice. AHCCCS will provide an administration fee for pharmacies administering the vaccine. The administration fee can be found on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/pharmacy.html
  - OLP-Emergency Medical Care Technician: EMCT personnel providing Treat and Refer services through an AHCCCS-registered Treat and Refer entity whereby the entity will be reimbursed for Treat and Refer services subject to the available rates located at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
- **Dental Services**
- **Vision Services** (including eye examinations, eyeglasses and contact lenses)
- **Diagnostic, Screening and Preventive Services**
- **Respiratory Care Services**
- **Transportation Services (see page 5h for information about ambulance rates)**
- **Private Duty Nurse Services**
- **Other practitioner's services**
- **Physical therapy**
- **Occupational therapy**
- **Services for individuals with speech, hearing and language disorders**
- **Prosthetic devices**
- **Screening services**
- **Preventative services**
- **Rehabilitation services**
- **EPSDT services**
- **Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women: The rates for these services are included in the fee schedules listed under this Attachment associated with the relevant provider services.**

Table of Contents

State/Territory Name: Nevada

State Plan Amendment (SPA) #: 16-012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 12, 2016

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 16-012. The SPA updates the coverage and reimbursement sections of the State Plan to include community paramedicine services. It was submitted to my office on June 14, 2016.

The approval is effective July 1, 2016. Attached are copies of the following pages to be incorporated into your State Plan:

- Attachment 3.1-A, pgs. 3a and 3a continued
- Attachment 4.19-B, pg. 1e

If you have any questions, please contact Peter Banks by phone at (415) 744-3782 or by email at Peter.Banks@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Marta Jensen: Acting Administrator, DHCFP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **16-012**

2. STATE: **NEVADA**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
State Plan Under Title XIX of the Social Security Act: 42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $0
b. FFY 2017 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 1e
Attachment 3.1-A, Page 3a and Page 3a Continued

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 1 e
Attachment 3.1-A, Page 3a

10. SUBJECT OF AMENDMENT:
Reimbursement methodology will be added under section 6.e. for services billed for community paramedicine services. The amendment will add language to include medicine codes and evaluation and management codes. Community Paramedicine Services will be added to the State Plan Amendment Alternative Benefits Plan.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. [redacted] CY OFFICIAL:

13. TYPED NAME:
Richard Whitley

14. TITLE:
Director, Department of Health and Human Services

15. DATE SUBMITTED:
June 8, 2016

16. RETURN TO:
Lynne Foster, Chief of Division Compliance
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
6/14/16

18. DATE APPROVED:
8/12/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Henrietta Sam Louie

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

6.b. Optometrist services require prior authorization from the Nevada Medicaid Office. Refractions are limited to one in 24 months except for those required as a result of an EPSDT examination.

6.c. Chiropractor services are limited to individuals under the age of 21 and referred as a result of a Healthy Kids (EPSDT) screening.

6.d. Other practitioner services

Physician Assistants' services are limited to the same extent as are physicians' services.

Advanced Practice Registered Nurses' services are limited to the same extent as are physicians' services.

Psychologists' Services must be prior authorized by the Medicaid Office on Form NMO-3 and normally are limited to 24 one-hour individual therapy visits per year. Any limitation of services for children under age 21 will be exceeded based on medical necessity for EPSDT services.

Community Paramedicine services:

1. The Division of Health Care Financing and Policy (DHCFP) provides coverage for medically necessary community paramedicine services which are designed to provide health care services to the medically underserved. Community Paramedicine services (Emergency Medical Technician, Advanced Emergency Medical Technician, Paramedic, or Community Paramedic) fill patient care gaps in a local health care system and prevent duplication of services while improving the healthcare experience for the recipient. Prevention of unnecessary ambulance responses, emergency room visits, and hospital admissions and readmissions can result in cost reductions for the DHCFP.

2. Services must be part of the care plan ordered by the recipient's primary care provider. The primary care provider consults with the ambulance service's Medical Director to ensure there is no duplication of services.

   A) The following services are covered under the supervision of the Medical Director:

      a. Evaluation/health assessment.
      b. Chronic disease prevention, monitoring and education.
      c. Medication compliance.
      d. Immunizations and vaccinations.
      e. Laboratory specimen collection and point of care lab tests.
      f. Hospital discharge follow-up care.
      g. Minor medical procedures and treatments within their scope of practice as approved by the Community Paramedicine agency's Medical Director.
      h. A home safety assessment.
      i. Telehealth originating site.

B) The following are non-covered services:

a. Travel time.
b. Mileage.
c. Services related to hospital-acquired conditions or complications resulting from treatment provided in a hospital.
d. Emergency response; for recipients requiring emergency response, the EMS transport will be billed under the ambulance medical emergency code.
e. Duplication of services.
f. Personal care services.

7. Home health care services

Services: As regulated under 42 CFR 484, 42 CFR 440.70 and other applicable state and federal law or regulation.

Home health services are provided to a recipient at his place of residence, certified by a physician and provided under a physician approved Plan of Care. The provider must be enrolled as a Medicare Certified Home Health Agency licensed and authorized by state and federal laws to provide health care services in the home. Home health services include the following services and items:

a. Physical therapy.
(Reference section 11 "a" of Attachment 3.1-A)

b. Occupational therapy.
(Reference section 11 "b" of Attachment 3.1-A)

c. Speech therapy.
(Reference section 11 "c" of Attachment 3.1-A)

d. Family planning education.

Home health agencies employ registered nurses to provide post partum home visiting services to Medicaid eligible women.

Provider Qualifications:

(Reference section 7 "e" of Attachment 3.1-A)

e. Skilled nursing services (RN/LPN visits)

e. Payment for community paramedicine services will be the lower of billed charges or the amount specified below:

1. The following Medicine codes and Evaluation and Management codes will be reimbursed at 63% of the Medicare non-facility rate: 90460, 90471-90474, 99341-99345, 99347-99350. The Medicare non-facility rate will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule factor.

f. Payment for services billed by a Nurse Anesthetist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Medicine codes 90000 - 99199 and Evaluation and Management codes 99201 – 99499 will be reimbursed at 74% of the Medicare non-facility rate. Vaccine Products 90476 – 90749 will be reimbursed at 85% of the Medicare non-facility rate.
2. Anesthesia codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia codes 01967 – 01969 are occurrence based codes that are paid a flat rate. Anesthesia codes 99100 – 99140 are not covered.
3. When codes 90465-90468, 90471-90474, 99381-99385 and 99391-99395 are used for EPSDT services, the reimbursement will be 85% of the Medicare non-facility rate.

g. Payment for services billed by a Psychologist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or 85% of the Medicare non- facility based rate.

h. Medicine codes 90281-90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B with the exception of the pharmacy dispensing fee component of the algorithm.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.