Emergency Triage, Treat and Transport: An Ambulance Alternative Payment Model

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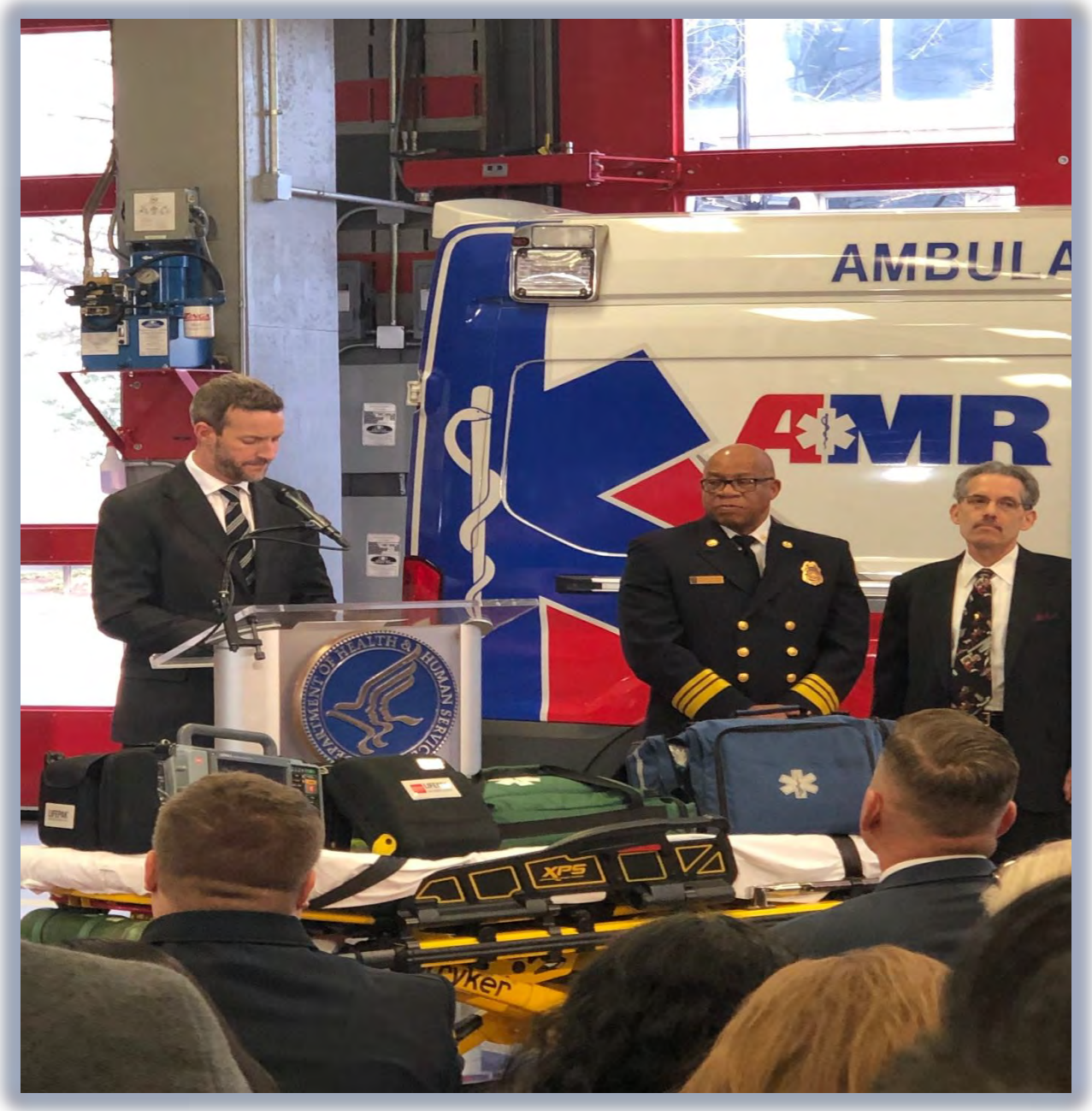
Agenda

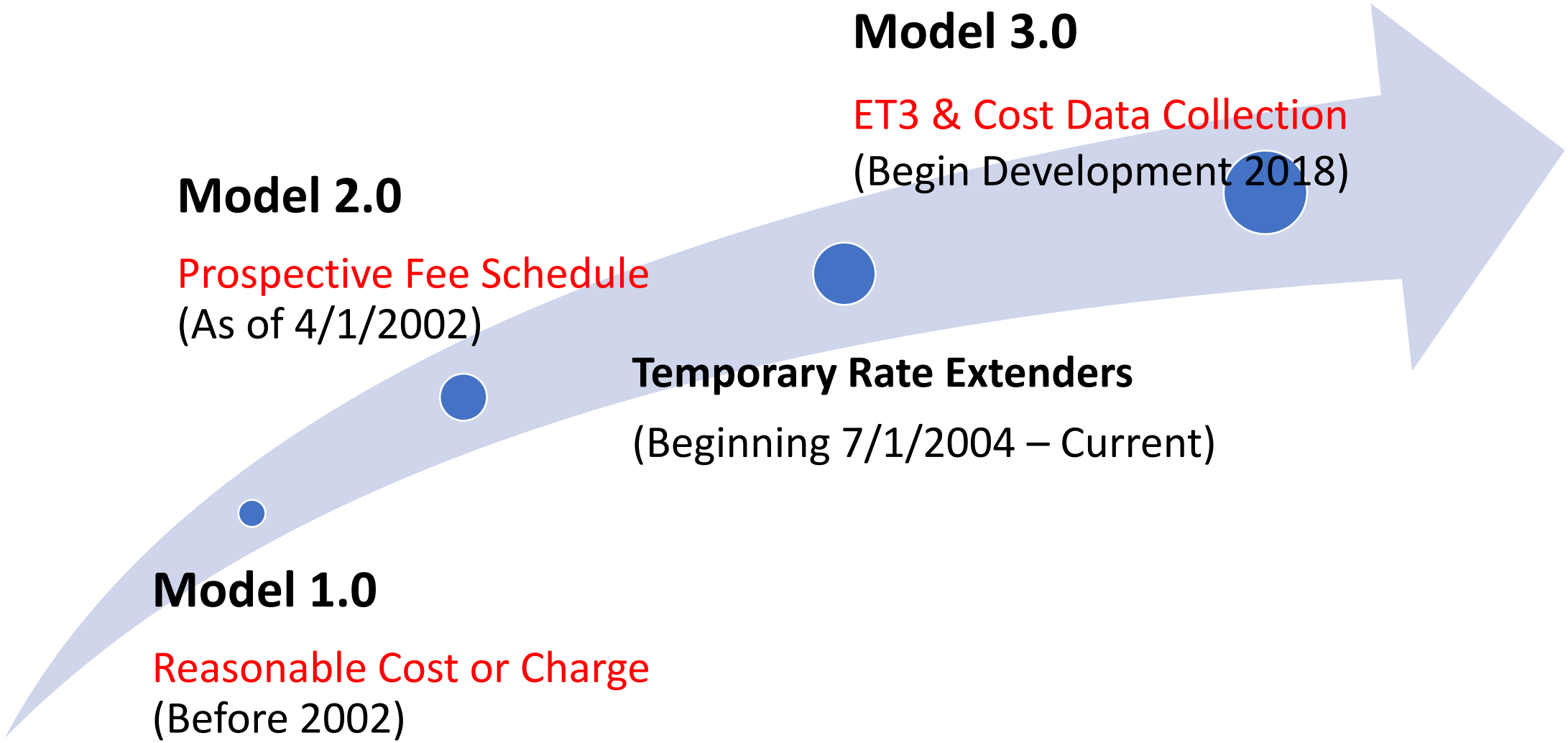
1. What are we trying to solve?
    - Background
    - Drivers/Barriers to change
2. ET3 Model
3. Where do we go from here?
    - Quality
    - Future APM



- 1 -
Background

What problem are we trying to solve?

Ambulance Payment Evolution



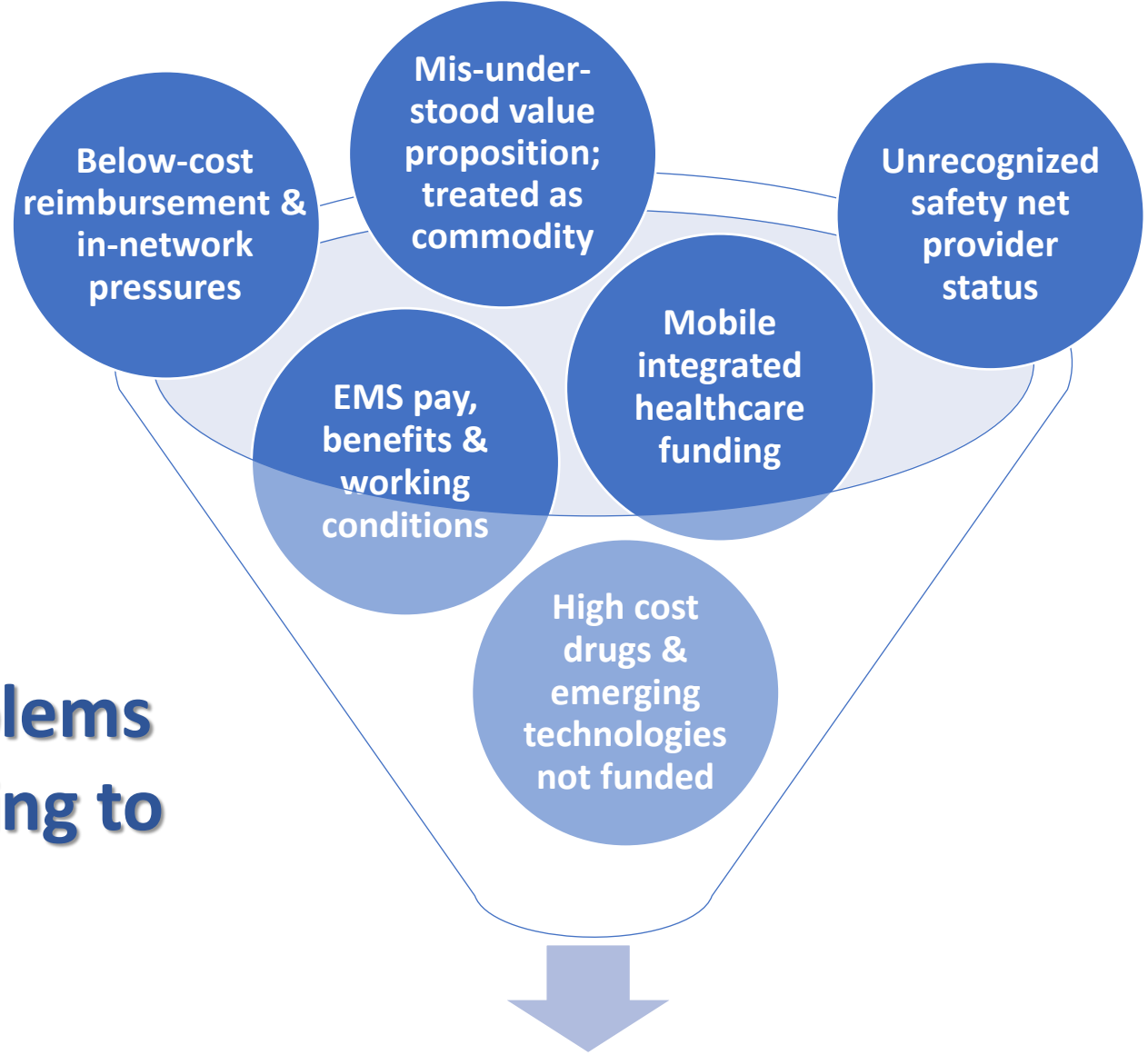
BBA 97 Authorizes Medicare Ambulance Fee Schedule

- Chapter 3, Section 4531: Payments for Ambulance Services
- Interim Reductions: 1 %
- Establish Prospective Fee Schedule for Ambulance Services through a **negotiated rulemaking process**
- **Considerations. In establishing the fee schedule, the Secretary shall**
  - establish mechanisms to control increases in expenditures for ambulance services
  - establish definitions for ambulance services which link payments to the type of services provided
  - consider appropriate regional and operational differences
  - consider adjustments to payment rates to account for inflation and other relevant factors
  - phase in the application of the payment rates under the fee schedule in an efficient and fair manner
- Savings
  - **Global budget**
  - **Annual updates based upon CPI-Urban**
- Consultation
- Limitation on Review
- Restraint on Billing
- Uniform Coding System
- Effective Date
- Payment for Paramedic Intercept Service to Providers in Rural Communities

Federal Reports Focus on Ambulance

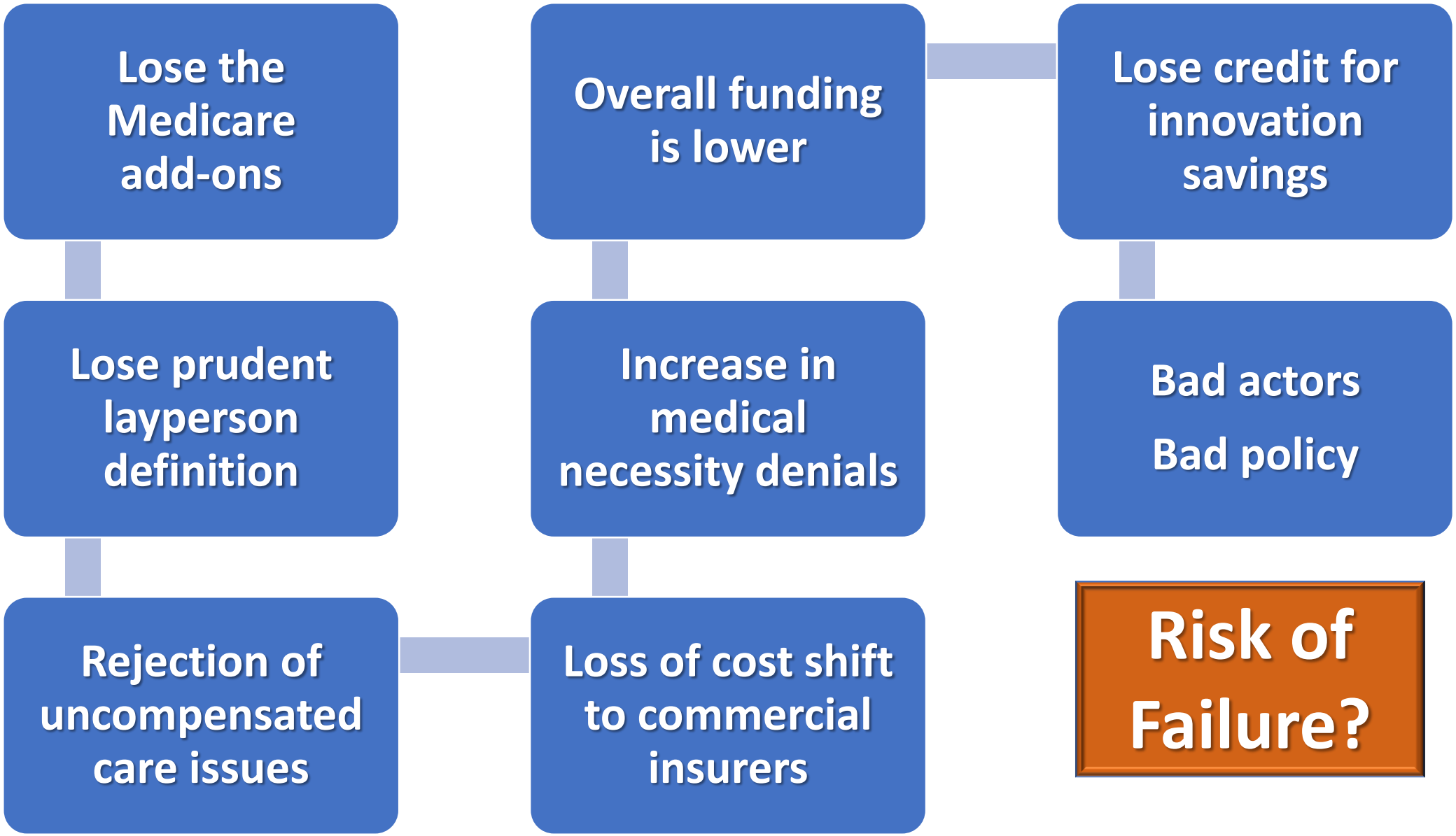
US GAO 2003	• Medicare Payments Can be Better Targeted to Trips in Less Densely Populated Areas (GAO-03-986)
OIG/HHS 2006	• Medicare Payments for Ambulance Transports
US GAO 2007	• Costs & Expected Medicare Margins Vary Greatly (GAO-07-383)
OIG/HHS 2011	• Semiannual Report to Congress
US GAO 2012	• Costs & Expected Medicare Margins Vary Widely; Transports of Beneficiaries Have Increased (GAO-13-6)
MedPac 2013	• Mandated Report: Medicare Payment for Amb Service (June 2013)
MedPac 2018	• Assessing Payment Adequacy & Updating Payments in Fee-for-Service Medicare (March 2018)

What problems are we trying to solve?



Better reimbursement

Unintended consequences?



Joint Statement on Ambulance Reform

Policymakers Should Examine Short- and Intermediate-Term Policies to Promote Innovation in the Delivery of Emergency and Non-Emergency Care Provided by Ambulance Services

Joint Statement of the
American Ambulance Association;
National Association of EMS Physicians;
National Association of EMTs; and
National Association of State EMS Officials

EMS AGENDA 2050

A PEOPLE-CENTERED VISION FOR THE FUTURE OF EMERGENCY MEDICAL SERVICES

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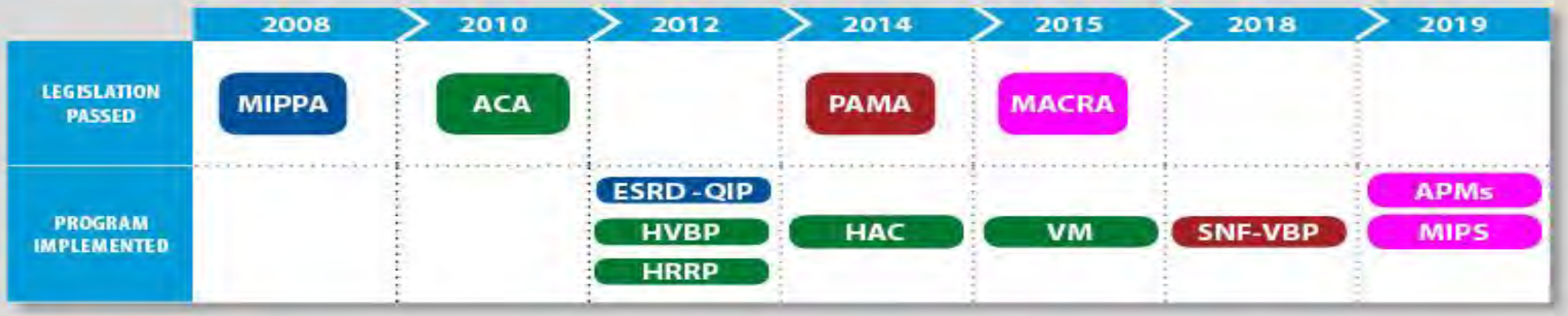
Background

What are the drivers/barriers to change?

VALUE-BASED PROGRAMS



LEGISLATION

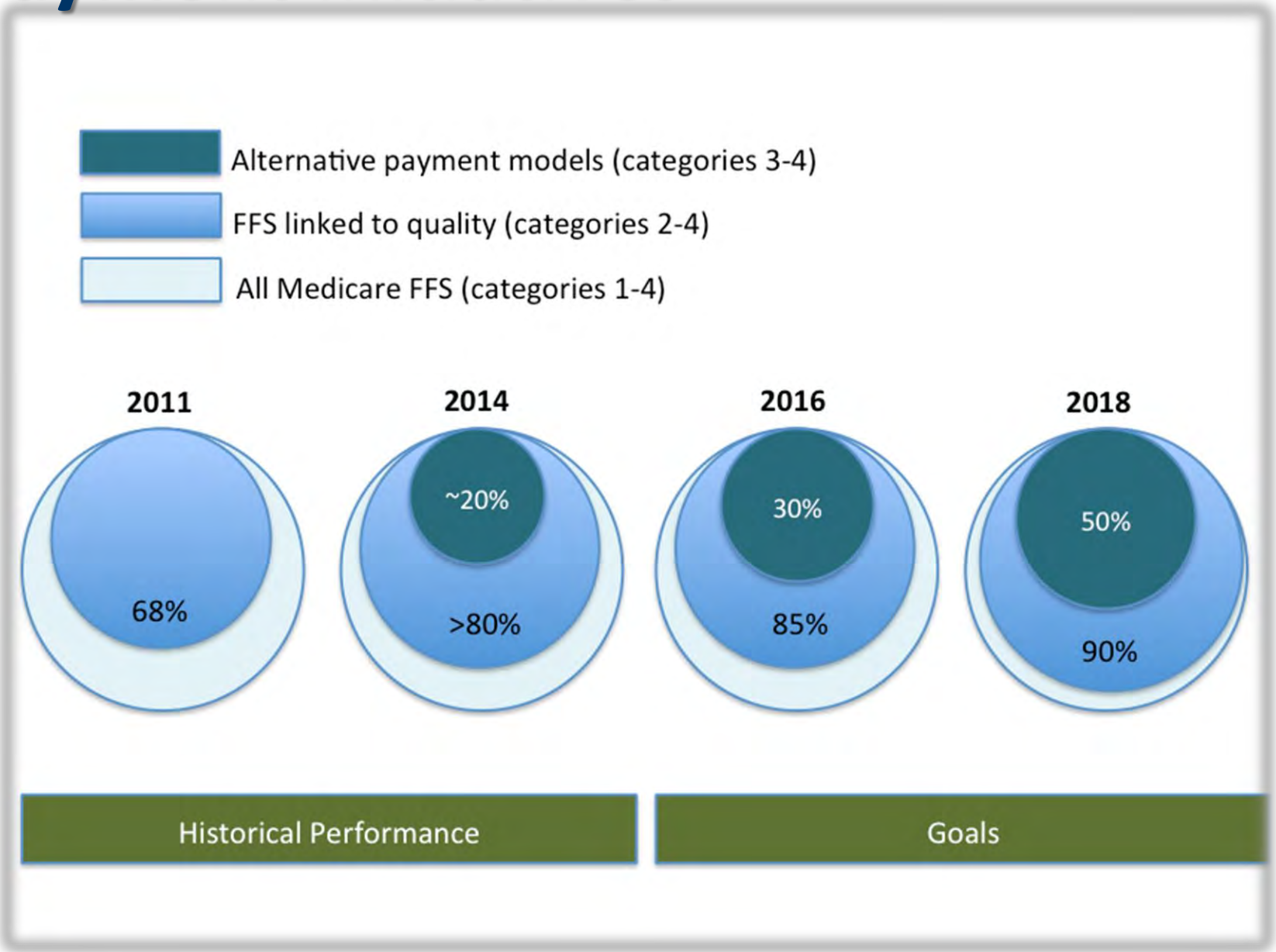
ACA: Affordable Care Act
MACRA: the Medicare Access & CHIP Reauthorization Act of 2015
MIPPA: Medicare Improvements for Patients & Providers Act
PAMA: Protecting Access to Medicare Act

PROGRAM

APMs: Alternative Payment Models
ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
HACRP: Hospital-Acquired Condition Reduction Program
HRRP: Hospital Readmissions Reduction Program
HVBP: Hospital Value-Based Purchasing Program
MIPS: Merit-Based Incentive Payment System
VM: Value Modifier or Physician Value-Based Modifier (PVBM)
SNFVBP: Skilled Nursing Facility Value-Based Purchasing Program

Centers for Medicare and Medicaid Services

CMS Payment Initiatives



Replication of Successful Innovations/Pilots

Sustain

- Lock in the progress & assure funding

← Pilot Tests: HCIA (6) + Medicaid + Comm Insurance + MIH Programs

Spread

- A system to accelerate improvement by spreading change ideas within and between organizations

← ET3 Voluntary Payment Model (CMMI Demonstration)

At Scale

- A large improvement initiative across a health care system, region, state or nation

Source: Institute for Healthcare Improvement

Progression of Payment Reform

CMS is increasingly linking fee-for-service payment to value

Category 1	• Fee for Service – No link to quality	Current Medicare Ambulance Fee Schedule
Category 2	• Fee for Service – Linked to quality	ET3 Payment Model
Category 3	• Alternative Payment Models on fee for service architecture	
Category 4	• Population-based Payment	

Source: CMS Innovation Center

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Category 3	• Alternative Payment Models on fee for service architecture	**ET3 Savings Validation**
Category 4	• Population-based Payment	

Source: CMS Innovation Center

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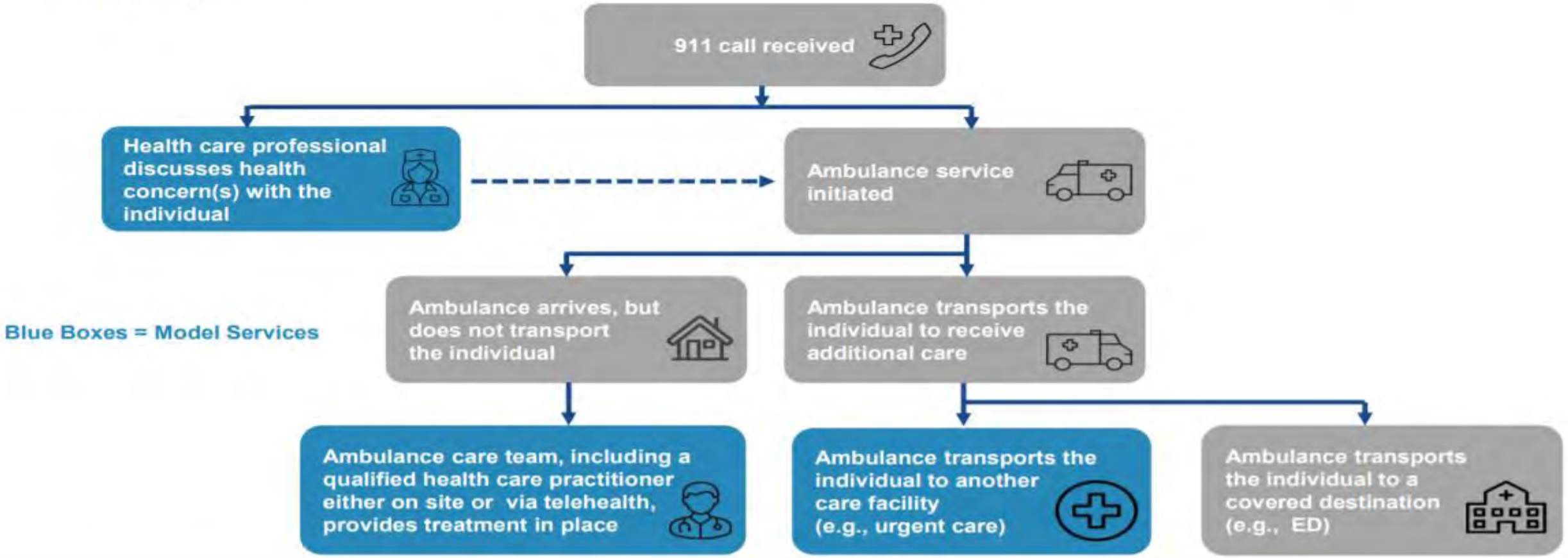
Emergency Triage, Treat, Transport (ET3)

Re-aligning Incentives for Future State

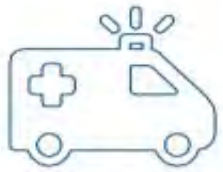
New options help individuals get the care they need and enable ambulances to work more efficiently.



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

ET3 Model Participants and Awardees

Together, ambulance suppliers and providers will focus on direct services, while local governments, its designees, or other entities that operate or have authority over one or more 911 dispatches that receive cooperative agreements will create a supportive structure to ensure successful and sustainable delivery of those services.



Medicare-Enrolled Ambulance Suppliers & Providers will support EMS innovation by transporting Medicare FFS beneficiaries to covered destinations (e.g., ED) or alternative destinations, and by providing treatment in place with a qualified health care practitioner (on site or via telehealth).

Local Governments, its designees, or other entities that operate or have authority over one or more 911 dispatches will promote successful model implementation by establishing a medical triage line for low-acuity calls received via their 911 dispatch system.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Model Overview

A.D.

- Transport the beneficiary to an alternative destination

T.I.P.

- Initiate and facilitate treatment in place by a qualified healthcare practitioner either in-person on the scene of a 911 emergency response or via telehealth

PARTICIPANT

Medicare-enrolled ambulance suppliers or hospital-based ambulance providers

NON-PARTICIPANT PARTNERS

Alternative destination sites and Medicare-enrolled qualified healthcare practitioners

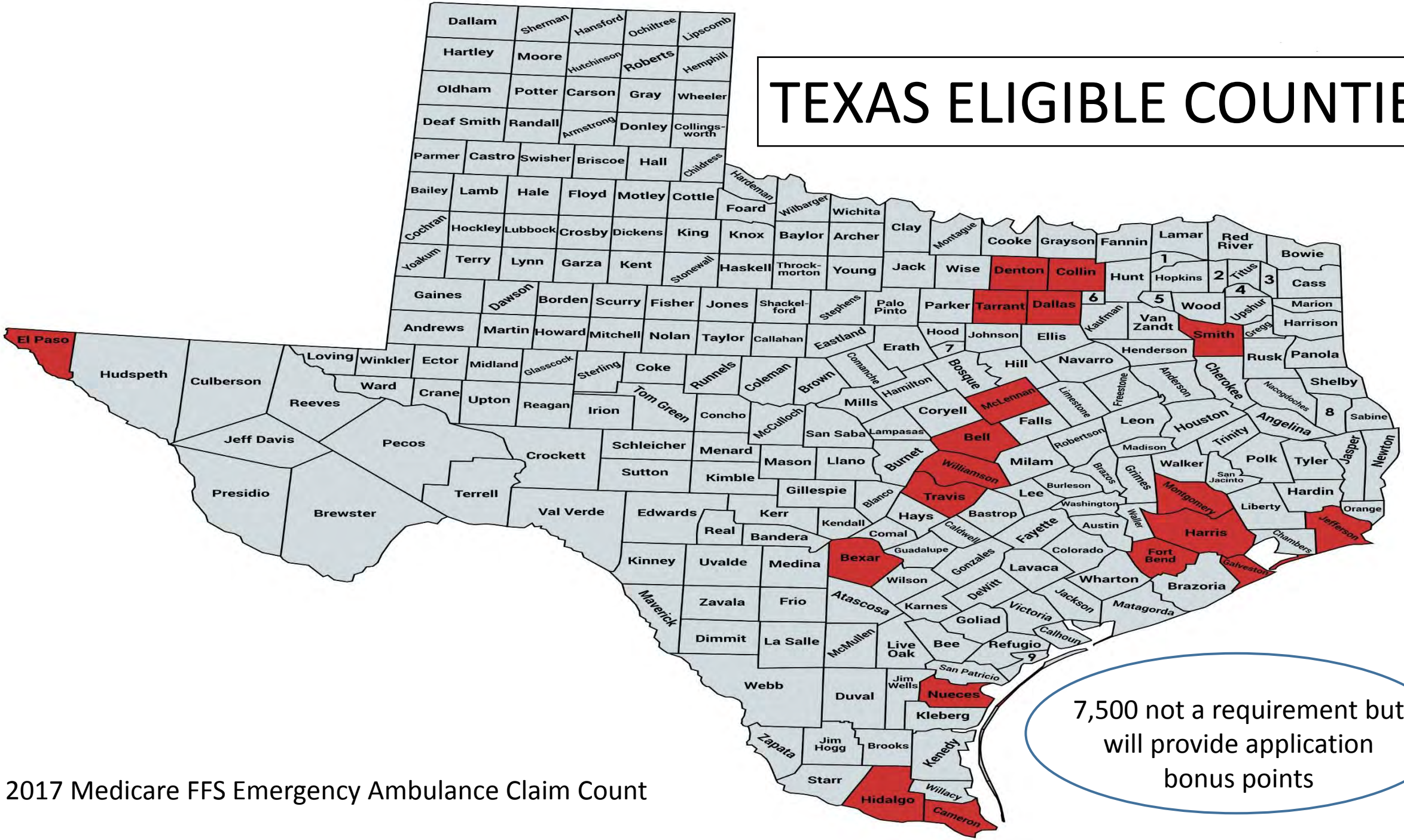
Model Region

State = 15,000 Medicare FFS Emergency Ambulance Transports

County = 7,500 Medicare FFS Emergency Ambulance Transports

States w/ no counties with 7,500 transports	States w/ 3 or less counties with 7,500 transports
Alaska	Alabama
Guam	Arkansas
Montana	Delaware
North Dakota	District of Columbia
North Marianas	Hawaii
Puerto Rico	Idaho
South Dakota	Iowa
Vermont	Kansas
Virgin Islands	Kentucky
Wyoming	Minnesota
	Mississippi
	Nebraska
	Nevada
	New Hampshire
	New Mexico
	Oklahoma
	Rhode Island
	Utah
	West Virginia
	Wisconsin

TEXAS ELIGIBLE COUNTIES



7,500 not a requirement but will provide application bonus points

2017 Medicare FFS Emergency Ambulance Claim Count

ET3 Eligibility Requirements

- Ambulance supplier or provider prior to final determination by CMS of the Applicant's selection status; and
- Identify a single entity that seeks to participate and bear financial responsibility to Medicare in the ET3 model; and
- Continue to provider current ambulance services under the Medicare program; and
- Obtain approval from CMS prior to finalizing partnerships with Non-participant Partners, as well as notifying CMS of any material changes, including termination during Model Performance Period.

An entity may concurrently participate in ET3 and other CMS initiatives, including shared savings, total cost of care, and medical home initiatives. However, CMS does reserve the right to modify additional requirements and other factors to avoid duplicative savings analysis.

Neither Participants or Non-Participant Partners may receive payment for services that are not medically necessary!

Alternative Destination Site

- An entity that serves as a destination to which model Participants may transport a beneficiary who meets medical necessity requirements; and
- Has sufficient Medicare-enrolled physicians or other practitioners to meet the needs of the beneficiary; and
- Is an alternative to a hospital emergency department or other covered Medicare destination.

Alternative Destination (A.D.) Reimbursement Model

Payment will equal Medicare rate equivalent to current ambulance fee schedule base rate:

- A0427 (ALS Emergency)*
- A0429 (BLS Emergency)
- A0425 (Mileage)

**42 C.F.R. 414.605, Fee Schedule for Ambulance Services, Definitions.*

Treatment In Place

A non-transport intervention, facilitated by model Participants, which may include:

1. Telehealth services rendered by a qualified health care practitioner located at a distant site; or
2. In-person services rendered by a qualified health care practitioner at the scene of the 911 emergency response.

Telehealth service is a covered health care service included on the telehealth list furnished by an approved qualified health care practitioner using video/audio equipment between the patient and distant site physician or practitioner.

Treatment In Place (T.I.P.) Reimbursement Model

Participant will be paid a telehealth originating site facility fee equivalent to:

- A0427 (ALS Emergency Base Rate)
- A0429 (BLS Emergency Base Rate)

New model-specific code TBD

Paid for the facilitation of telehealth in-person or T.I.P.

Payment Adjustment

Qualified Health Care Practitioner

- Non-participant
- Provides treatment to a model ET3 beneficiary via T.I.P.
- Eligible for a 15% increase in rate during non-business hours, 8p – 8a

Model Participant

- Not a guarantee
- Conditioned on CMS's ability to validate potential measures
- Up to 5% increase at Year 3 for A.D.T. and T.I.P. services
- Based upon prior year performance

Other Considerations

- Interoperability Plan
- Compliance Analysis and Plan
- Payer Strategy
- Patient-Centered Design

Applicant Vetting

Participant

- Program Integrity Screening
- Sanction Disclosure
- Disclosure of investigations, including Qui Tam, CAP, etc…
- Financial Arrangement Disclosures between participant and non-participant

Non-participant

- Subject to approval by CMS
- Program Integrity Screening
- Proposed A.D. sites that are not enrolled in Medicare will be required to provide more information than Medicare-enrolled A.D. sites.
- Financial Arrangement Disclosures between participant and non-participant

i. Table 4. Application Review Component Value

Component	Value
Applicant Organizational Information	0
Proposed Model Region	10
Applicant Governance Structure and Capacity to Implement the ET3 Model	10
Intervention Design: Alternative Destination Intervention	35
Intervention Design: Treatment in Place Intervention (Optional)	*Up to 10 bonus points*
Interoperability Plan	10
Compliance Analysis and Plan	15
Payer Strategy	20
Patient-Centered Design	10

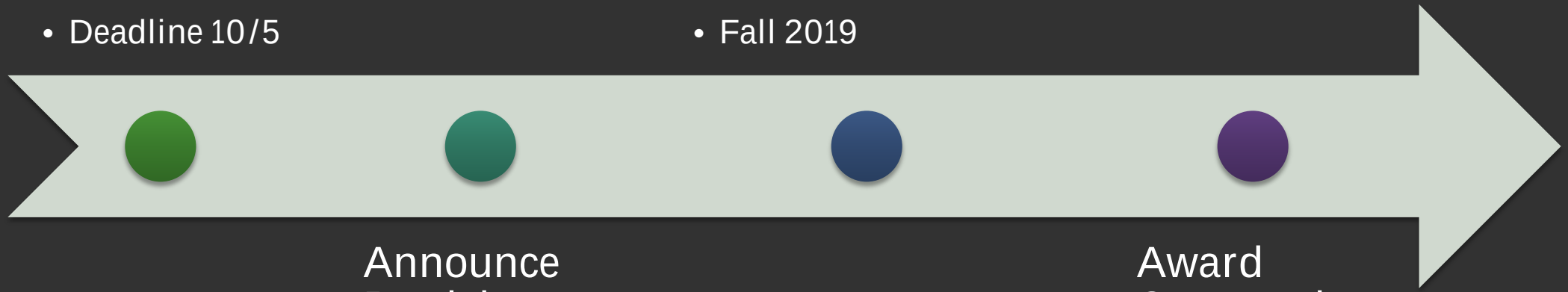
Program Implementation

Request for Application (RFA)

- Deadline 10/5

Notice of Funding Opportunity (NOFO)

- Fall 2019



Announce Participants

- Fall 2019

Award Cooperative Agreements

- Early 2020

Emergency Triage, Treat, and Transport (ET3) Model

Share

Have questions about the ET3 Model? Visit our FAQ page for answers.

Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare beneficiaries following a 911 call. Under the ET3 model, the Centers for Medicare & Medicaid Services (CMS) will pay participating ambulance suppliers and providers to 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations, 2) transport to an alternative destination (such as a primary care doctor's office or an urgent care clinic), or 3) provide treatment in place with a qualified health care practitioner, either on the scene or connected using telehealth. The model will allow beneficiaries to access the most appropriate emergency services at the right time and place. The model will also encourage local governments, their designees, or other entities that operate or have authority over one or more 911 dispatches to promote successful model implementation by establishing a medical triage line for low-acuity 911 calls. As a result, the ET3 model aims to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports.

Stay up to date on the latest ET3 Model news and updates by subscribing to the ET3 Model listserv.

Model Summary

Stage: Announced
Number of Participants: N/A
Category: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
Authority: Section 1115A of the Social Security Act

Milestones & Updates

Jun 03, 2019
Announced: Request for Applications (RFA) overview webinar June 11, 2019

May 22, 2019
Announced: Request for Applications (RFA) preview and frequently asked questions (FAQs) posted

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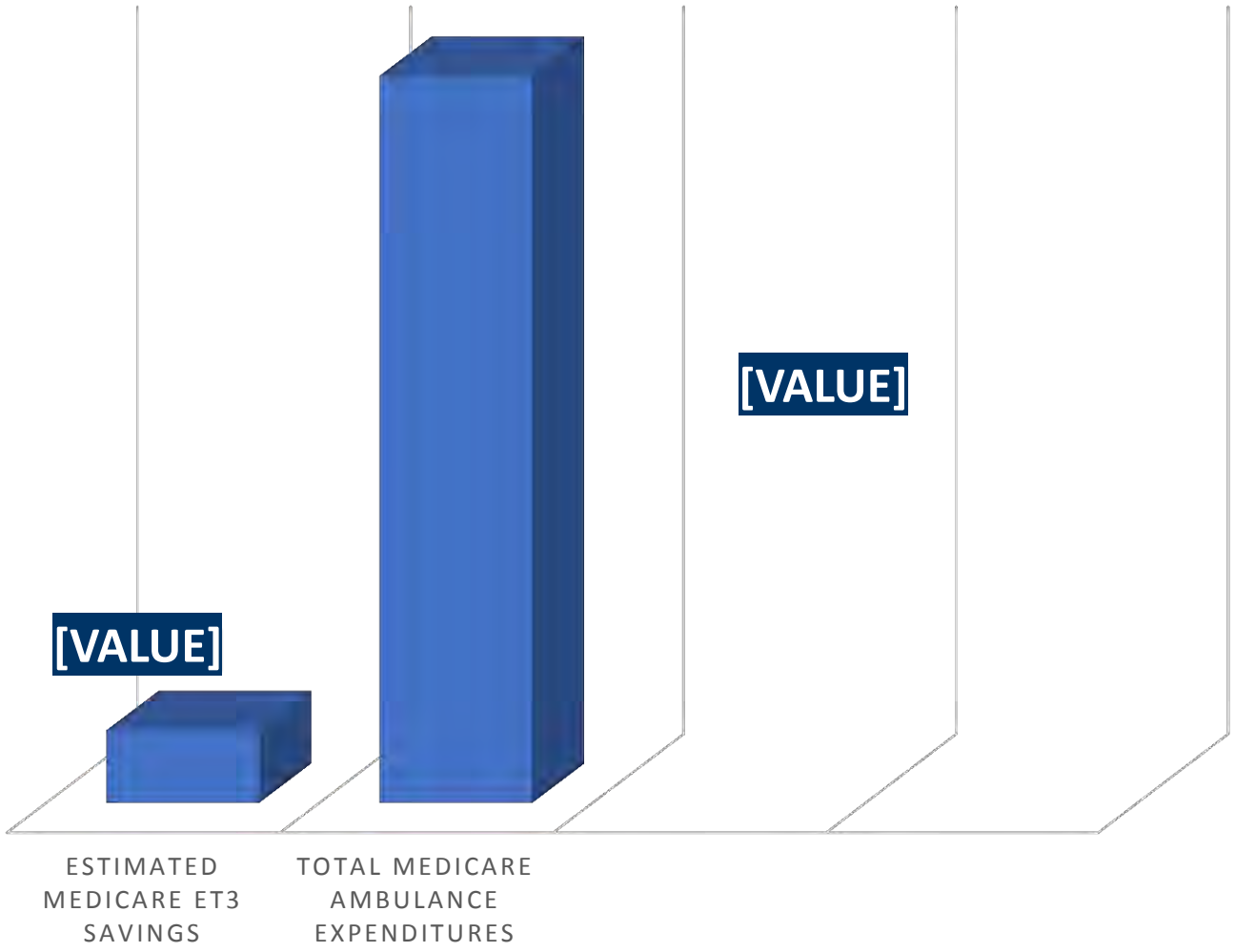
Fee Schedule Linked to Quality

What will future Ambulance reimbursement be?

Recognizing EMS' Gate Keeper Role



"Giving EMS Flexibility in Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings," Health Affairs, Dec 2013

EXHIBIT 1

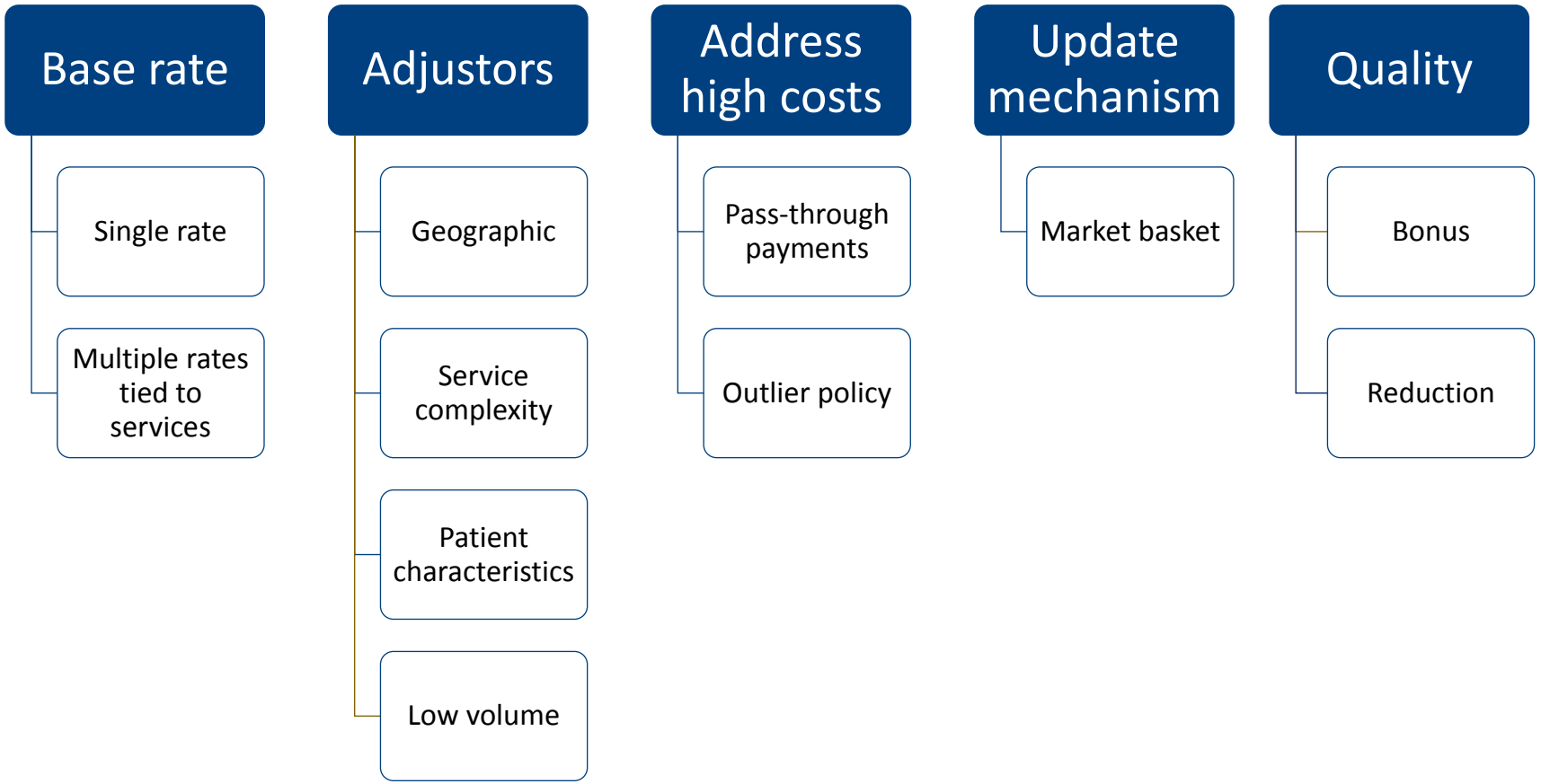
Numbers And Costs Of Emergency Medical Services (EMS) Transports Of Medicare Beneficiaries, By Level Of Severity Of Emergency Department (ED) Discharge Diagnosis

	Level of severity[a]							
	Primary care treatable		Emergent, ED care needed		ED visits related to:[b]			
	Nonemergent	Emergent	Preventable or avoidable	Not preventable or avoidable	Injury	Mental health	Alcohol use	Drug use
Transports not admitted to hospital[c]	14.1%	20.4%	10.3%	32.5%	16.0%	2.1%	0.7%	0.1%
5% MEDICARE SAMPLE, 2005–09								
Transports	114,028	165,196	83,382	263,392	129,724	16,694	5,662	698
Out-of-pocket costs (millions)								
Ambulance	$10.06	$15.11	$7.77	$24.94	$11.38	$1.46	$0.52	$0.06
ED	18.32	30.70	15.59	61.63	23.19	1.73	0.59	0.08
Medicare costs (millions)								
Ambulance	$38.01	$57.25	$29.46	$ 94.51	$42.65	$5.44	$1.91	$0.24
ED	55.90	99.81	52.95	200.49	64.72	6.07	2.10	0.29
EXTRAPOLATED TO NATIONAL MEDICARE POPULATION, PER YEAR								
Transports	456,112	660,782	333,528	1,053,566	518,896	66,776	22,648	2,792
Out-of-pocket costs (millions)								
Ambulance	$40.24	$60.46	$31.09	$ 99.77	$45.51	$5.85	$2.08	$0.25
ED	73.29	122.79	62.36	246.52	92.76	6.93	2.37	0.33
Medicare costs (millions)								
Ambulance	$152.06	$229.00	$117.85	$ 378.04	$170.61	$21.77	$ 7.63	$0.96
ED	223.59	399.24	211.81	801.97	258.89	24.27	8.41	1.16
Total Medicare costs	375.65	628.23	329.66	1,180.01	429.51	46.04	16.04	2.12

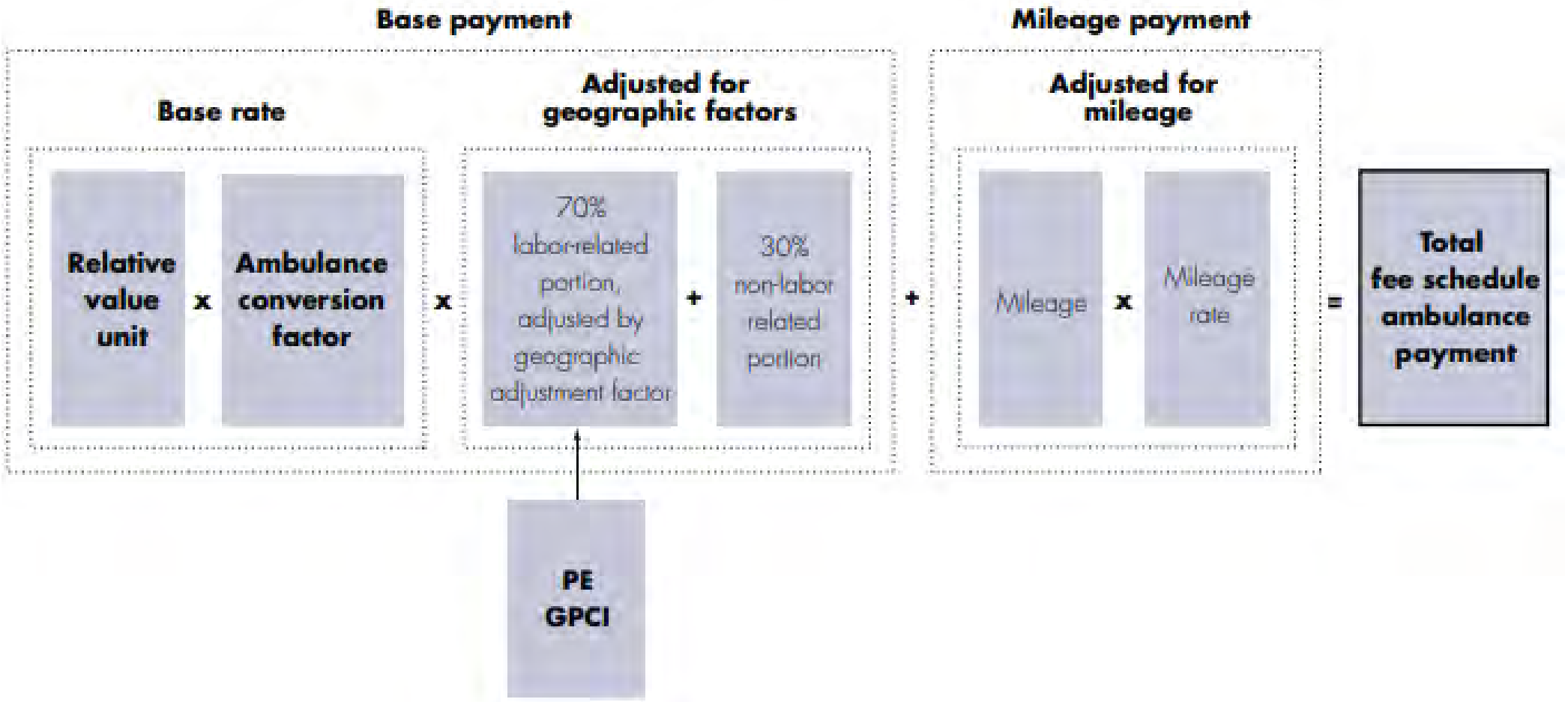
SOURCE Authors' analysis. **NOTE** All costs are in 2011 dollars, adjusted for inflation by the medical Consumer Price Index. [a]See Billings J, et al., Emergency department use (Note 10 in text). [b]ED visits not assigned a level of severity by Billings J, et al., Emergency department use (Note 10 in text). [c]$N = 811,306$. Percentages do not sum to 100 because 4 percent of transports not admitted to the hospital had an unclassified severity level.

"Medicare alone could save nearly $600 million."

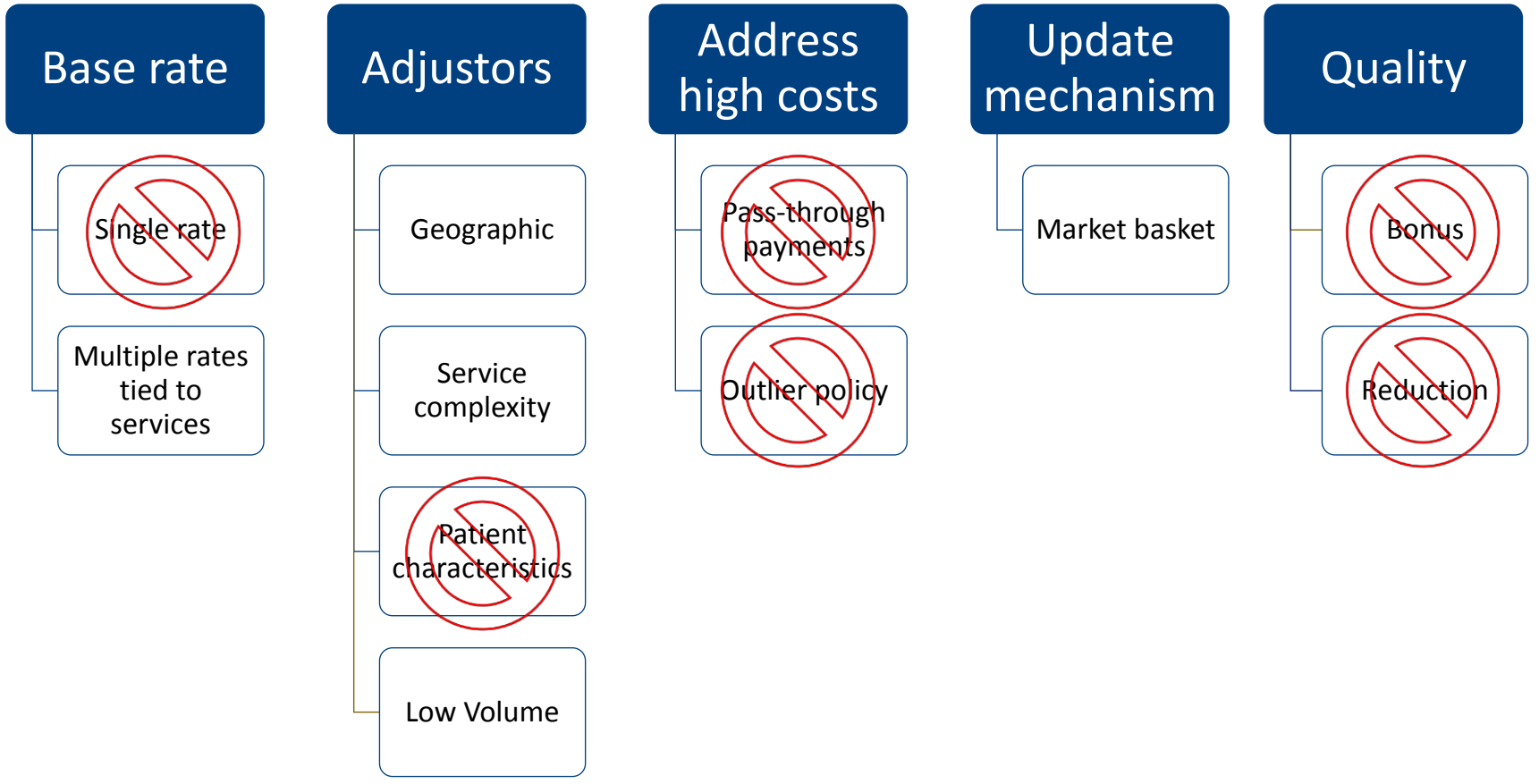
Other Medicare Prospective Payment Systems



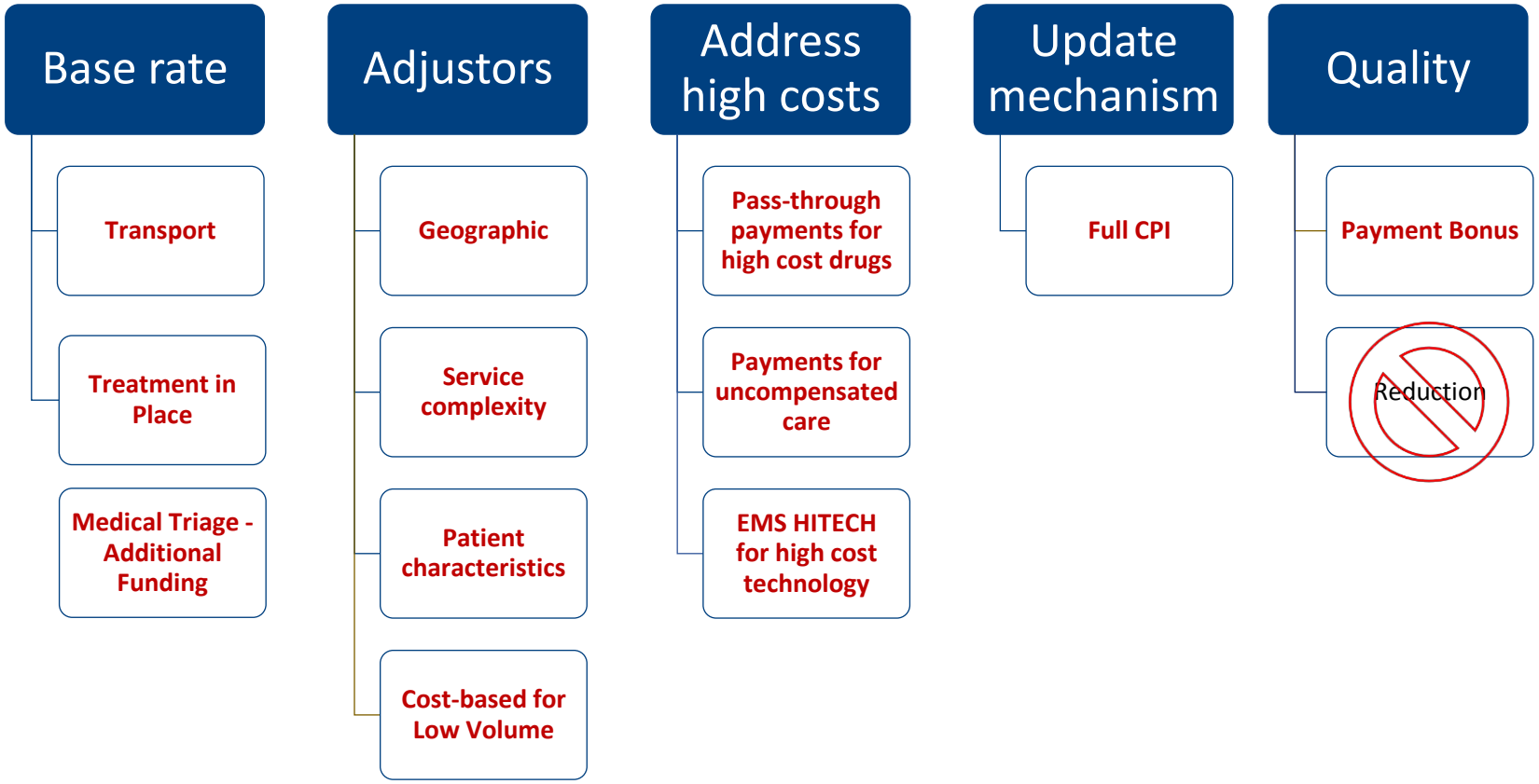
Current Medicare Ambulance Fee Schedule



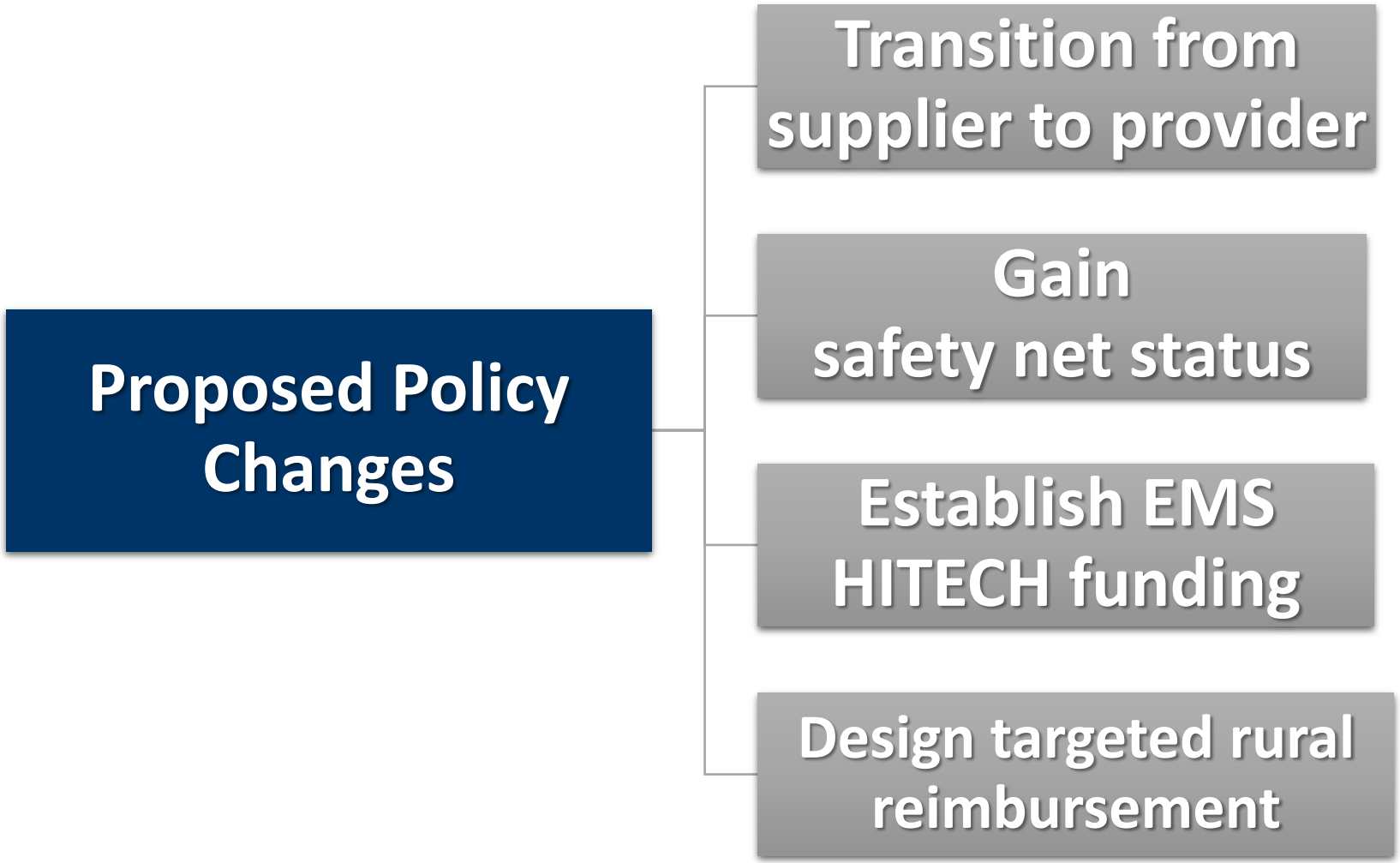
Medicare Ambulance Fee Schedule - Current



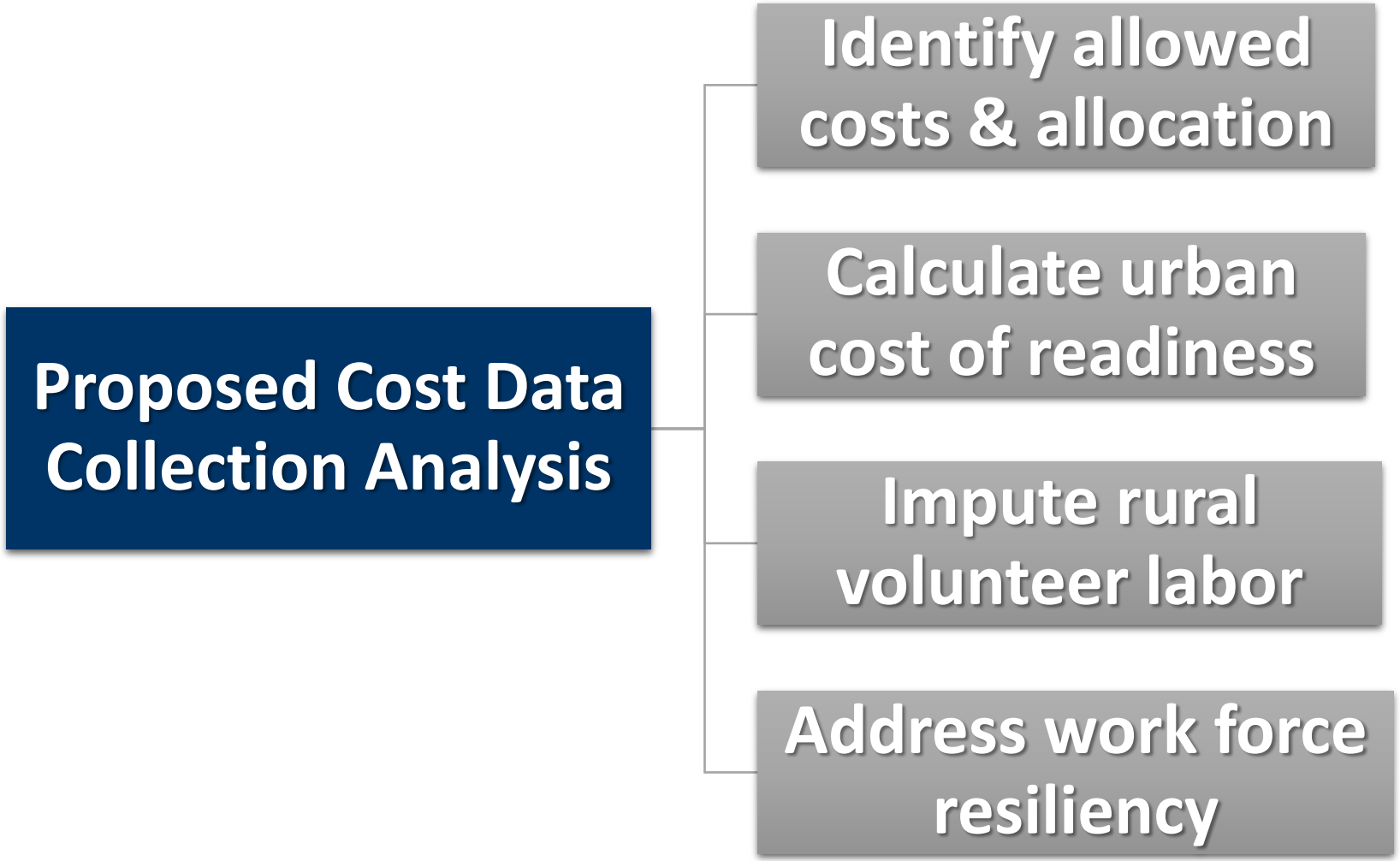
Medicare Ambulance Fee Schedule - Update Options



Proposed Payment Reform - Policy Changes



Proposed Payment Reform – Cost Data Analysis



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