FIRST WATCH
Every Record. In Real Time. Automatically.

NAEMT
Serving our nation's EMS practitioners

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Value-Based Finance Models for EMS

Matt Zavadsky
Chief Strategic Integration Officer, MedStar Mobile Healthcare
Chair, AIMHI Education Committee
President, NAEMT

JUNE 12, 2019 | 1:00 PM ET

SPECIAL THANKS TO OUR HOST

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About AIMHI

AIMHI
ACADEMY OF INTERNATIONAL MOBILE HEALTHCARE INTEGRATION

ORGANIZATIONS WITH HIGH PERFORMANCE DESIGN FEATURES

- Sole provider
- Externally accountable
- Full cost accounting
- Control center operations
- Revenue maximization
- Flexible production strategy
- Dynamic Resource Management

VISION

To improve patient health and experience of care by promoting excellence in mobile healthcare system effectiveness and efficiency.

FORMERLY

Coalition of Advanced Emergency Medical Systems (CAEMS)

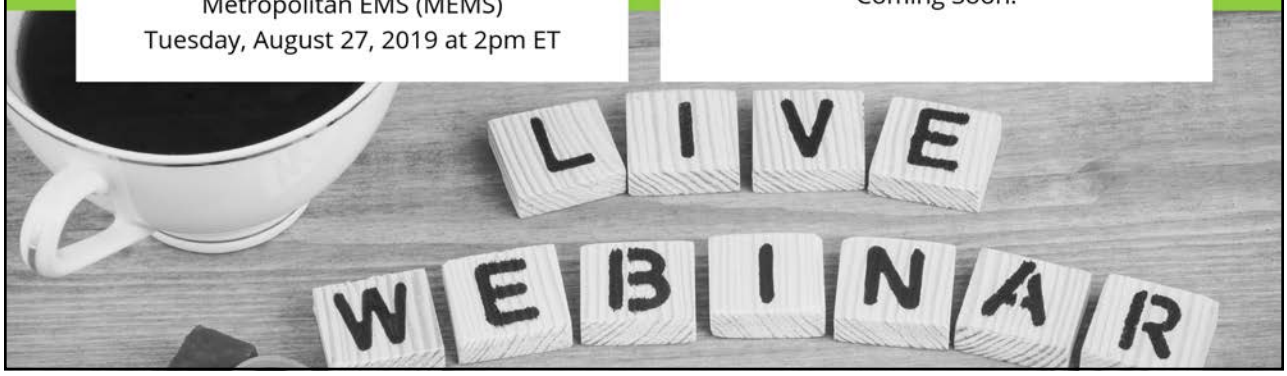
National Association of Public Utility Models

Models for STEMI & Stroke Hospital Activations From the Comm Center

Metropolitan EMS (MEMS)
Tuesday, August 27, 2019 at 2pm ET

AIMHI-NAEMT Webinar Series on the Economics of EMS

Coming Soon!



PINNACLE
INSPIRING EMS LEADERSHIP

ORLANDO
Rosen Shingle Creek
July 22-25

EFFECTIVE STRATEGIES FOR ADDRESSING BEHAVIORAL HEALTH AND SOCIAL ISSUES IN YOUR COMMUNITY
Pinnacle Power Seminar
Monday, July 22, 2019
1:00 pm–4:45 pm ET

EMS INTEGRATION AWARDS
Presentation of awards and recognition of winners.

CURRENT MEMBERS

Emergency Health Service
Halifax, NS (CA)

Emergency Medical Services Authority
Tulsa & Oklahoma City, OK

Mecklenburg EMS Agency
Charlotte, NC

Medic Ambulance
Vallejo, CA

MEDIC Emergency Medical Services
Davenport, IA

MedStar Mobile Healthcare
Fort Worth, TX

Metropolitan Emergency Medical Services
Little Rock, AR

Niagara Emergency Medical Services
Ontario, CA

Northwell Health Center for EMS
Syosset, NY

Pinellas County EMS Authority/Sunstar Paramedics
Largo, FL

Regional EMS Authority
Reno, NV

Richmond Ambulance Authority
Richmond, VA

Three Rivers Ambulance Authority
Fort Wayne, IN

Learn more about membership at www.aimhi.mobi!

You Know You're in EMS When…

You point out all the mistakes on medical TV dramas.

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Pop-Quiz:

Who in the healthcare system is being paid for quality, outcomes & value (at least partly)?

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf

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Progression of Payment Reform

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

Current ambulance reimbursement

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

Source: CMS Innovation Center

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You Know You're in EMS When…

You ask your POV passenger, "Am I clear right?"
Or, if you are a POV passenger, you yell "clear right!"

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$$\text{Success} = \sum_{\text{Insight}}^{\text{Action}} \left[\frac{\text{Value Created}}{\text{Resources Consumed}} \right]_{\text{Perception}}$$

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Alex M. Azar II
HHS Secretary

"The President's budget makes investments and reforms that are vital to making our health and human services programs work for Americans and to sustaining them for future generations. In particular, it supports our four priorities here at HHS: addressing the opioid crisis, bringing down the high price of prescription drugs, increasing the affordability and accessibility of health insurance, and *improving Medicare in ways that push our health system toward paying for value rather than volume.*

HHS Secretary Azar, February 18, 2018

"I don't intend to spend the next several years tinkering with how to build the very best joint-replacement model — ***we want to look at bold measures that will fundamentally reorient how Medicare and Medicaid pay for care, and create a true competitive playing field where value is rewarded handsomely***."

HHS Secretary Azar, March 20, 2018

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Seema Verma
CMS Administrator

"Secretary Azar and I are working for competition and better value by *moving away from a fee-for-service approach, to a system that is value-based – and that rewards value over volume.* This means paying providers on the outcomes they achieve, making people healthier rather than how many procedures they perform."

Remarks by CMS Administrator Seema Verma
HIMSS18 Conference, March 6, 2018

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Revenue Reality… *3 Year Totals*

Metropolitan Area EMS Authority
Payer Mix Analysis
FY 2015 - 2018

	Billed		Cash Collected		
	Amount	% of Total	Amount	% of $ Billed	% of Collected
Medicare	$ 179,199,193	37.3%	$ 48,746,679	27.2%	37.6%
Insurance	$ 65,114,000	13.5%	$ 51,642,936	79.3%	39.8%
Medicaid	$ 77,931,951	16.2%	$ 15,776,388	20.2%	12.2%
Facility	$ 10,272,166	2.1%	$ 8,452,447	82.3%	6.5%
Bill Patient	$ 148,115,165	30.8%	$ 5,053,332	3.4%	3.9%
Total	**$ 480,632,475**	**100.0%**	**$ 129,671,781**	27.0%	**100.0%**

2016-2018 Transports		**319,479**
Average Bill	**$**	**1,504**

Cash Collected	**Billed**	**Rate**
$ 129,671,781	$ 480,632,475	27.0%

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Revenue Reality… *Payers Billed*

Metropolitan Area EMS Authority
Payer Mix Analysis - Annual Trend
October 2015 - September 2018

Billed

	2016	%	2017	%	2018	%
Insurance	$ 21,874,078	14.1%	$ 21,917,831	13.7%	$ 21,322,092	12.9%
Medicare	$ 57,184,014	36.9%	$ 59,834,107	37.3%	$ 62,181,072	37.6%
Medicaid	$ 24,867,161	16.0%	$ 26,237,111	16.3%	$ 26,827,680	16.2%
Facility	$ 4,115,025	2.7%	$ 3,749,830	2.3%	$ 2,407,310	1.5%
Bill Patient	$ 46,919,977	30.3%	$ 48,758,240	30.4%	$ 52,436,948	31.7%
Total	**$ 154,960,254**	**100%**	**$ 160,497,119**	**100%**	**$ 165,175,101**	**100%**

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Revenue Reality… *Dollars Collected*

Metropolitan Area EMS Authority
Payer Mix Analysis - Annual Trend
October 2015 - September 2018

Collected

	2016	% of Cash	% of Payer	2017	% of Cash	% of Payer	2018	% of Cash	% of Payer
Insurance	$ 17,418,794	40.7%	79.6%	$ 17,887,771	40.4%	81.6%	$ 16,336,370	38.4%	76.6%
Medicare	$ 15,289,704	35.7%	26.7%	$ 16,337,301	36.9%	27.3%	$ 17,119,673	40.2%	27.5%
Medicaid	$ 5,337,322	12.5%	21.5%	$ 5,424,489	12.3%	20.7%	$ 5,014,576	11.8%	18.7%
Facility	$ 3,111,247	7.3%	75.6%	$ 2,902,047	6.6%	77.4%	$ 2,439,153	5.7%	101.3%
Bill Patient	$ 1,684,791	3.9%	3.6%	$ 1,723,086	3.9%	3.5%	$ 1,645,455	3.9%	3.1%
Total	**$ 42,841,858**	100.0%	27.6%	**$ 44,274,695**	**100%**	27.6%	**$ 42,555,227**	100.0%	25.8%

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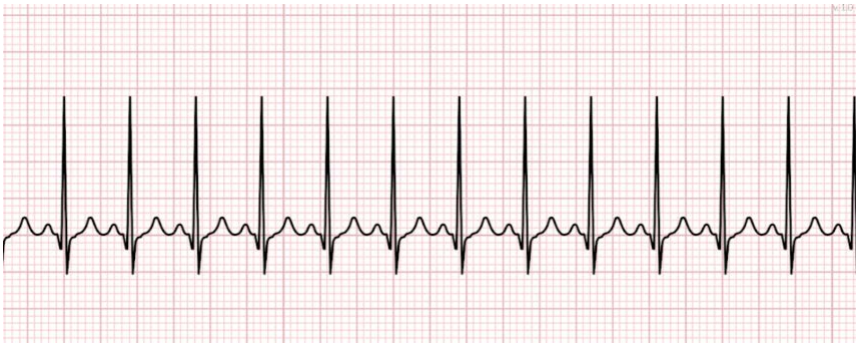
You Know You're in EMS When…



Saying "ooooh she's tacky...." actually refers to her heart rate.

Value?

- Utilization
  - Patient Navigation vs. Transport to the ED
  - Prevention vs. response
- Cost
  - Episodic costs of acute care utilization
  - Tied to ED visits
- Patient Experience
- Quality & Patient Safety
  - Sentinel medical error rate
  - Ambulance crashes, patient drops

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EMS3.0

Explaining the Value to Payers

This document has been created to provide talking points for EMS agencies to explain to payers the value of EMS 3.0 services.

Please review and download as needed the following talking points:

PAYER

→ EMS 3.0 INFOGRAPHIC

NAEMT
Advancing the EMS profession

http://www.naemt.org/initiatives/ems-transformation

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EMS3.0 City Council/Tax Payers

Cost Savings

- Achieves more efficient use of city/tax payer resources by decreasing the cost of EMS and law enforcement resources required for non-emergent medical calls.
  - Helps coordinate and streamline system responses and resources during a 911 call by facilitating alignment between patients' needs and appropriate community and health system resources, thereby reducing emergent responses for preventable 911 calls.
- Leads to additional downstream savings by reducing tax-payer expenditures for tax-funded indigent care.

Care Coordination and Population Health

- Identifies patterns and trends in utilization of social, mental health, and community resources.
- Provides a unique perspective working with residents in crisis, often identifying potential crises before they occur.
- Generates and shares data that significantly impacts population health initiatives.
- Proactively works with identified high utilizers of these services, assisting them in learning how to navigate the local health system and established community resources.

Revenue Generation

- Increases revenue for the community.
  - Payers are increasingly willing to pay for enhanced services provided by EMS, such as programs that improve patient outcomes and reduce expenditures for preventable ED visits and hospital admissions.
- Diversifies the revenue stream from solely ambulance transportation to revenues from other value-added services.
  - Ambulance Transport Alternatives
  - Community Paramedicine
  - 911 Nurse Triage

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EMS3.0 Commercial Insurers

Cost Savings

- Reduces expenditures for preventable ED visits.
  - Identification and proactive management of super utilizers.
  - Effective navigation of patients accessing 911 with low-acuity medical condition through the in-network healthcare resources.
- Reduces expenditures of preventable hospital readmissions through safe transitions.
  - Improves understanding of discharge instructions by having EMS providers review instructions in the home with patient and their family.
  - Enhanced access to 24-hour episodic care through the EMS provider.
- Enhances Health Effectiveness Data and Information Set (HEDIS) measures.
  - Improves proper Emergency Department Utilization by allowing non-emergent patients to be scheduled and taken to proper in network treatment centers, such as primary care offices or urgent care centers.
  - Decreases rate of readmission through post-discharge follow-up visits by EMS.

Revenue Generation

- Enhances promotion of insurer's health plan by partnering with a trusted community provider.
  - Utilizes enhanced 24-7 medical services available through the local EMS agency.

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State Medicaid Offices

Enhances Care Experience for the Patient

- Aligns Incentives.
  - Many patients who call 9-1-1 can have their medical need met at an alternate destination, allowing for patient-centered care and follow-up.
  - Safely navigating patients to the most appropriate medical resource, including 9-1-1 Nurse Triage at call intake or transport to alternate destinations, can enhance the patient's experience of care and improve outcomes through effective care coordination.

Cost Savings

- Reduces Acute Care Expense.
  - EMS agencies are paid by Medicaid to transport patients to an ED.
  - An ambulance trip to the ED often results in significant additional expense to Medicaid.
  - Medicaid payment for things like 9-1-1 Nurse Triage, or transport locations other than ambulance transport to an ED could reduce expenditures of preventable, high cost ED visits.
  - Medicaid coverage for preventive services provided by EMS agencies could reduce the expenditures for both ambulance and high-cost ED visits.

Care Coordination

- Enhances Care Across the Continuum.
  - An EMS agency can provide timely post-acute care transition safety by conducting a post-discharge in-home safety, risk and medical assessment for sharing with the patient's medical care team.
  - On a 9-1-1 call, an EMS agency can assess a patient, and if a low-acuity medical event, contact the patient's PCMH for assistance with determining the most appropriate care transition for the episode.

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Hospitals

Cost Savings

- Reduces the impact of readmission and value-based purchasing penalties.
- Reduces the consequences of un/under reimbursed care.
  - Appropriately navigating patients through the healthcare system based on medical need and payer source.
- Reduces readmissions and repeat ED visits from patients covered under a bundled payment.

Revenue Generation

- Reduces the length of stay for inpatient admissions.
  - Reduces length of stay for Diagnosis Related Groups (DRG) payment to maximize bed utilization.
- Reduces cost of care to Accountable Care Organization (ACO) or other shared-risk populations.
- Promotes additional payer network contracts based on perceived value of effective care coordination for members.

Patient Satisfaction and HCAPHS

- Enhances patient experience scores for value-based purchasing measures.
  - Enhances the patient's perception of the hospital's concern for their wellbeing through post-acute care follow-up on behalf of the hospital.
  - Improves HCAPHS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores for understanding of discharge instructions by having EMS providers review instructions in the home with patient and their family.

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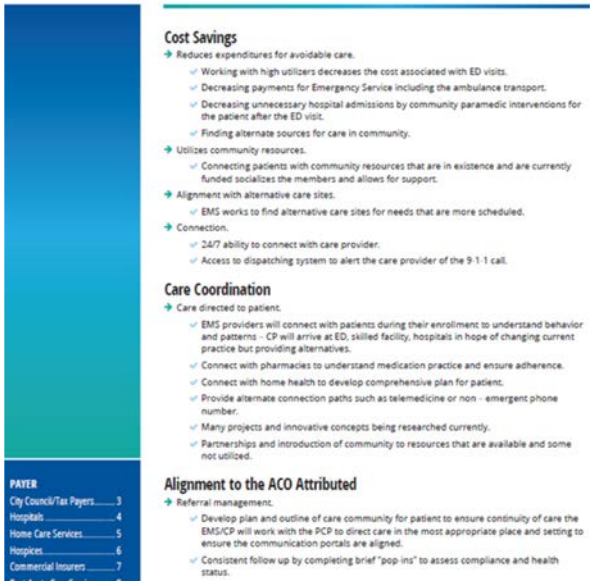
EMS3.0 Accountable Care Organizations (ACOs)



Cost Savings

- Reduces expenditures for avoidable care.
  - Working with high utilizers decreases the cost associated with ED visits.
  - Decreasing payments for Emergency Service including the ambulance transport.
  - Decreasing unnecessary hospital admissions by community paramedic interventions for the patient after the ED visit.
  - Finding alternate sources for care in community.
- Utilizes community resources.
  - Connecting patients with community resources that are in existence and are currently funded socializes the members and allows for support.
- Alignment with alternative care sites.
  - EMS works to find alternative care sites for needs that are more scheduled.
- Connection.
  - 24/7 ability to connect with care provider.
  - Access to dispatching system to alert the care provider of the 9-1-1 call.

Care Coordination

- Care directed to patient.
  - EMS providers will connect with patients during their enrollment to understand behavior and patterns - CP will arrive at ED, skilled facility, hospitals in hope of changing current practice but providing alternatives.
  - Connect with pharmacies to understand medication practice and ensure adherence.
  - Connect with home health to develop comprehensive plan for patient.
  - Provide alternate connection paths such as telemedicine or non - emergent phone number.
  - Many projects and innovative concepts being researched currently.
  - Partnerships and introduction of community to resources that are available and some not utilized.

Alignment to the ACO Attributed

- Referral management.
  - Develop plan and outline of care community for patient to ensure continuity of care the EMS/CP will work with the PCP to direct care in the most appropriate place and setting to ensure the communication portals are aligned.
  - Consistent follow up by completing brief "pop-ins" to assess compliance and health status.

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Value-Based Payment Models: *Leveraging the ET3 Initiative*

- Expand offerings based on gaps in your community

BlueCross BlueShield · Humana · Amerigroup RealSolutions in healthcare · UnitedHealthcare · Aetna · WELLMED

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Value-Based Payment Models: *Leveraging the ET3 Initiative*

- CMS Goal of "Multi-Payer Adoption"
- Contact you payers to propose same 'basic' model to them

Amerigroup Managed Medicaid Enhanced Services Options

Mirror Recently Announced CMS Emergency Triage, Treatment and Transport (ET3) payment model

- 9-1-1 emergency encounters for Amerigroup members are assessed, treated and navigated to the clinically appropriate follow-up care
  - Treat in Place with on-line telehealth with a Qualified Healthcare Provider (QHP)
    - Billed FFS using HCPCS code A0998
    - Reimbursed at $_____ per encounter
    - QHP telehealth also eligible for FFS payment within existing guidelines/rules
  - Transport to alternate destinations such as Urgent Care, or other care settings
    - Billed FFS for the intervention and navigation using appropriate transport HCPCS code + miles
      - A0427 Ambulance Transport, ALS, Emergency $_____
      - A0429 Ambulance Transport, BLS, Emergency $_____
      - A0425 Ambulance Mileage $_____

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Value-Based Payment Models: *Leveraging the ET3 Initiative*

- Expand offerings based on gaps in your community

Enrollment of Amerigroup High Utilizer Group (HUG) Members

- Identified and referred by the Amerigroup Case Management team
- Located by MedStar and member consents to enrollment
- Members enrolled for 90 days, mirroring MedStar's existing High Utilizer Group model
- Paid on per enrollment fee of $_____/enrolled member

Safe Transitions

- Initial home visit for recently discharged in-patients referred by Amerigroup Case Managers
  - Assure safety in the home
  - Review discharge instructions
  - Medication inventory
  - Assure follow-up appointment(s) scheduled with PCP, etc.
- Billed FFS for the encounter using CPT Code **99349** or **99341**:
  *Home visit for the evaluation and management of **a new or established patient**, which requires at least 2 of these 3 key components:*
  - *A detailed interval history;*
  - *A detailed examination;*
  - *Medical decision making of moderate complexity.*

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Value-Based Payment Models: *Leveraging the ET3 Initiative*

- Expand offerings based on gaps in your community

MedStar On-Demand Services

- For any Amerigroup *member* through Amerigroup Nurse Advice, or other referral source
- As Amerigroup *member* benefit for Amerigroup members in the MedStar service area
- For Amerigroup *Case Management Staff* who would like a home visit assessment for an 'at-risk' member
  - Including member education, connection with PCP, other services
  - Billed FFS for the encounter using CPT Code **99349** or **99341**:
    - *Home visit for the evaluation and management of **a new or established patient**, which requires these 3 key components:*
      - *A detailed history;*
      - *A detailed examination; and*
      - *Medical decision making of moderate complexity.*

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You Know You're in EMS When…

You complement a stranger on their great veins.

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ET3 Update(s) & Reminders

- Must apply for Alternate Destinations at a minimum
  - Treat in place is optional
- ***Must*** be in a state that had at least 15,000 Medicare (FFS) emergency transports took place in 2017
  - *Preference* for Counties with > 7,500 Medicare transports in 2017
- Written MOU required for "Non-Participating Partners"
  - And 'vetting' by CMS
- ALS or BLS payment eligibility
  - Based on care provided
- Transport to Alternate Destinations will need to meet medical necessity
  - If not, may need to be treat in place

ET3 Update(s) & Reminders

- "Payment for Treat in Place will be under as a *telehealth originating site facility fee*
  - *A Participant that facilitates in-person or telehealth treatment in place must separately bill Medicare"*
- Paid under HCPCS A0429 or A0427
- May answer the question: "*Is the Telehealth relationship between the QHP and the ambulance agency, or between the QHP and the beneficiary?*"

ET3 Update(s) & Reminders

- 24 hour coverage
  - Can be EITHER Alternate Destination, OR telehealth with QHP
- FaceTime and Skype
  - Do NOT qualify for telemedicine (HIPAA)
- Licensed clinical social worker who bills under their NPI
  - Qualifies as a QHP

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Citation to Current Requirement	Summary of Current Requirement	Model Impact/Justification
§1834(m)(2)(B) of the Act, Payment for Telehealth Services	Establishes the telehealth originating site facility fee (approximately $26 in 2018)	To allow for a payment to Participants of a modified originating site facility fee equal to either the BLS-E or ALS1-E rate, determined by the level of service rendered by the Participant, in order to test whether treatment in place via telehealth is a feasible alternative to transport to the ED.

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Citation to Current Requirement	Summary of Current Requirement	Model Impact/Justification
1834(m)(2)(B) and (m)(4)(C) of the Act; 42 C.F.R. §410.78(b)(3) and (b)(4): Telehealth originating site and geographic reuirements	Limits telehealth services to those furnished in specific types of originating sites located in certain (mostly rural) areas	To allow beneficiaries to receive telehealth services in originating sites other than those listed in the regulations and in non-rural areas, in order to test whether treatment in place via telehealth originating at the scene of an ambulance response is a feasible alternative to transport to the ED

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Considerations now for ET3 Application

- Local Protocols (State or Local)
  - May not allow for AD or treat and refer
  - Some state EMS Directors trying to fix this
- Medical Direction
  - Supportive?
- Alternate Destination sites
  - Do you have any?
  - Key to success!

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Considerations now for ET3 Application

- Payer alignment
  - Key to success!
- Economic Modeling

Treat in Place Model

MedStar Payer Mix (Billed)	Transport Payer Mix	AMA Potential	ALS @ 20%	Billed Reimbursement	BLS @ 80%	Billed Reimbursement	Total Billed Reimbursement	Collection %	Possible Net Reimbursement
Medicare	37.6%	5,510	1,102	$486,181	4,408	$1,637,675	$2,123,856	28%	$594,680
Medicaid	16.2%	2,374	475	$135,444	1,899	$456,222	$591,667	28%	$165,667
Commercial	12.9%	1,890	378	$418,298	1,512	$1,487,281	$1,905,579	28%	$533,562
Private Pay	31.7%	4,645	929	$52,500	3,716	$210,000	$262,500	28%	$73,500
Total		**14,419**	**2,884**	**$1,092,423**	**11,535**	**$3,791,178**	**$4,883,601**		**$1,367,408**

(Does not total to AMA # due to impact of 2.1% 'Facility' billing on payer mix)

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How Many Patients May Qualify?

- Important to know –
  - Telehealth vs. mobile QHP
  - Financial Impact
  - Training for field staff

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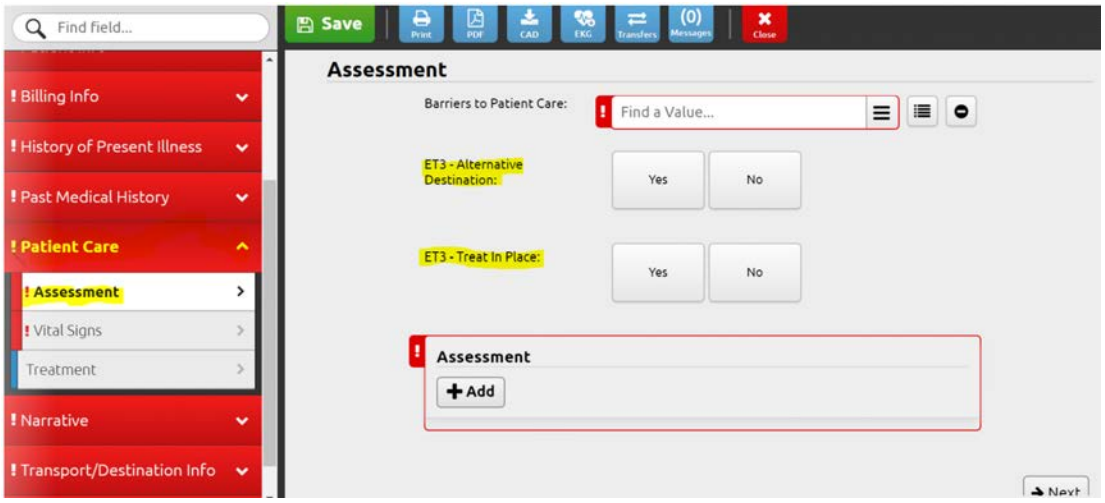
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Save
Print
PDF
CAD
EKG
Transfers
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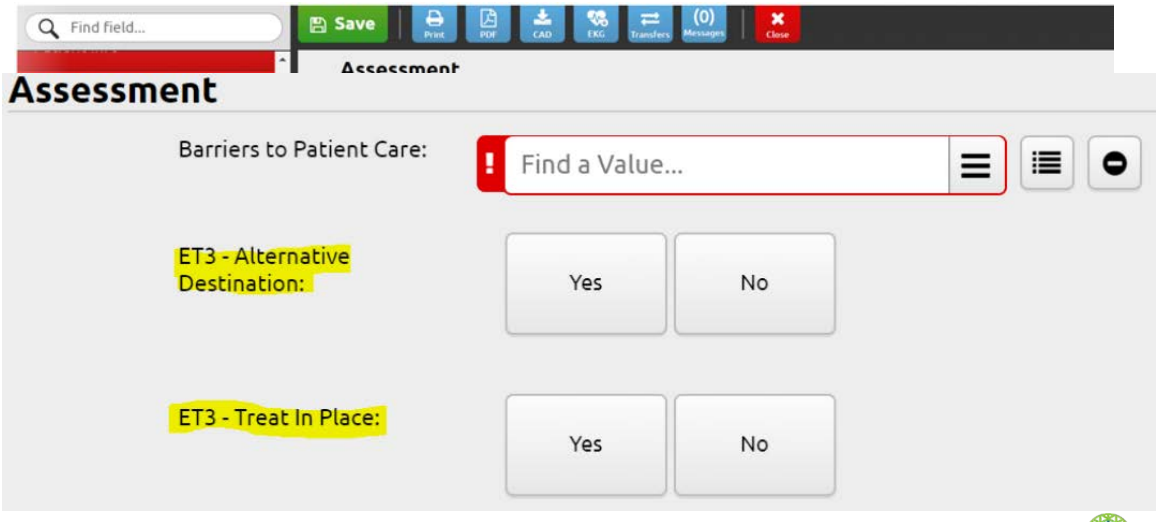
Messages
Close
Billing Info
History of Present Illness
Past Medical History
Patient Care
Assessment
Vital Signs
Treatment
Narrative
Transport/Destination Info
Assessment
Barriers to Patient Care:
Find a Value...
ET3 - Alternative Destination:
Yes
No
ET3 - Treat In Place:
Yes
No
Assessment
Add
Next


Find field...
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(0)
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Assessment
Barriers to Patient Care:
Find a Value...
ET3 - Alternative Destination:
Yes
No
ET3 - Treat In Place:
Yes
No

You Know You're in EMS When…

You pull up to a red light, clear the intersection, drive through the red light... Then realize you're not in the ambulance.

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Thank You

NAEMT
Serving our nation's EMS practitioners

Matt Zavadsky
Chief Strategic Integration Officer
MedStar Mobile Healthcare
Chair, AIMHI Education Committee
President, NAEMT

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mzavadsky@medstar911.org

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