

Centers for Medicare & Medicaid Services  
Ambulance  
Open Door Forum  
Moderator: Jill Darling  
Thursday, March 28, 2019  
2:47 p.m. EST

Operator: Good afternoon. My name is (Erica) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Ambulance Open Door Forum.

All lines had been place on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you. Ms. Jill Darling, you may begin your conference.

Jill Darling: Great. Thank you, (Erica). Good morning and good afternoon everyone and welcome to the first Ambulance Open Door Forum of 2019. Before we get into today's agenda, I have one brief announcement.

This Open Door Forum is open to everyone, but if you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at [Press@cms.hhs.gov](mailto:Press@cms.hhs.gov). And now I'll hand it off to our Chair, Sarah Shirey-Losso.

Sarah Shirey-Losso: Welcome everyone, to ambulance providers and suppliers and the (regional) offices, some of our (MACs). I want to welcome everyone and thank you for joining us today.

Again, I'm Sarah Shirey-Losso, I'm the Director in the Division of Ambulatory Services which is in CMS's Center for Medicare and specifically

our division works on Medicare fee-for-service payment policy for ambulance services and the ambulance fee schedule.

So, I'm happy to be chairing this call and look forward to hearing your questions. As a quick reminder in the next several months, probably in time for the next call, I wanted to remind everyone that we had the Balanced Budget Act of 2018 is – has directed the Secretary of Health and Human Services to develop a data collection system that will collect cost, revenue, utilization and other information with respect to providers and suppliers of ground ambulance services.

So, we'll have more about that data collection system I think later in the summer, but I wanted to have everyone stay mindful of that provision. And look forward to talking about that more in the near future.

I'm excited for today's agenda which includes a presentation from our colleagues in the CMS Innovation Center, who'll discuss the Emergency Triage, Treat and Transport model. So with that, I'll pass it on to (Juliana).

(Juliana Tiongson ): OK, thank you, Sarah. It's a pleasure for me to be here today to brief you on the Emergency Triage, Treat and Transport – ET3 for short – model.

So at a high level, this model seeks to correct some misaligned incentives that currently exist for ambulance suppliers and providers, where basically Medicare primarily pays for emergency ground ambulance service only when a beneficiary is taken to a limited number of covered destinations. And it's generally to the hospital emergency department.

Therefore, when beneficiaries do call 911 with a medical emergency, they're taken – often taken to a high acuity care setting, even when a lower acuity, less costly destination may be more appropriate.

So, the ET3 model aims to provide greater flexibility to ambulance care teams responding to 911 calls and at the same time reducing expenditures while preserving or enhancing quality of care for beneficiaries.

So, some research has been done that demonstrated that approximately 16 percent of Medicare fee-for-service emergency ambulance transports to an ED could have been treated in lower acuity settings which was the retrospective analysis using Medicare claims.

And that translated into a potential savings of 560 million per year by transporting individuals to a lower acuity setting such as a physician office rather than the hospital ED.

So in this model, in the ET3 model, we are testing two new payments for ambulance suppliers and providers. Those two new payments, one is transport to alternative destinations, and the second one is treatment without transport or treatment in place.

So, the way this would work is a beneficiary calls 911 and an ambulance is initiated. Upon arriving at the scene, the ambulance crew, using clinical protocols that were approved by their medical director would make a determination if the individual would qualify for transport to an alternative destination or treatment in place without transport.

That, if they were deemed eligible based on the acuity of their condition for either of those services, they would be offered those services.

It's important to note that the beneficiary will always be able to say, "No, I want to go to the emergency department." And if that is their wish, they need to be taken to the emergency department.

For the treatment without transport service, that will require in all cases a qualified healthcare practitioner partnering with the EMS crew to either provide treatment on scene or via telehealth.

So that is – those are the two new services that are being tested for ambulance suppliers and providers. This is a voluntary model, it's a five-year model and ambulance suppliers and providers interested will submit applications and enter into participant agreements with CMS to test these two new services.

There is a second part of the model – there is a second opportunity, which is for local governments, their designees or related entities that operate a 911 dispatch center.

This opportunity will come after we've selected model participants for the participant agreements, and this opportunity will be limited to geographic areas where we have ambulance suppliers and providers participating in the model.

But, it will be an opportunity for cooperative agreements, again, for local governments or their designees that operate a 911 dispatch center to create a medical triage line that's fully integrated with the 911 line or to expand upon an existing medical triage line.

The hope is that this will work synergistically with these other two new services that will be offered by ambulance suppliers and providers. However, I will say that we will not – we will likely not have cooperative agreements for medical triage lines in every geography that we have participating ambulance suppliers and providers.

OK. So I just want to talk about the three main goals of the model are to provide person-centered care, such that individuals receive care safely at the right time and place; increased efficiency in the EMS system to allow ambulances to more readily respond to and focus on high acuity cases such as heart attacks and strokes; and encourage the appropriate utilization of emergency medical services to meet healthcare needs effectively.

So again, there's two opportunities, one is model participant agreement with ambulance suppliers and providers; and the second one is cooperative agreement with local governments or their designees to establish or expand upon a medical triage line. And the medical triage line would handle those lower acuity calls and hopefully prevent initiation of an ambulance when it is not actually needed.

Let's see, I believe I said it was a five-year model, it's voluntary. OK. As far as payment goes, so we're trying to neutralize payments to deal with this issue of misaligned incentives.

So for a participating ambulance supplier and provider, whether an individual is transported to a currently covered destination such as a hospital ED, or if they're transported to an alternative destination such as an urgent care center or if they are not transported but received treatment in place, the ambulance supplier or provider will receive the BLS ground ambulance rate – no matter which of those options is provided to the beneficiary.

In the case of treatment in place, the partnering qualified healthcare practitioner will bill Medicare separately for the HCPCS codes. But depending on what services were rendered to the beneficiary, they will bill per usual, or they will bill the telehealth fee per usual.

There is also a 15 percent payment increase available to the qualified healthcare practitioners to incentivize them to partner with ambulances in this endeavor. That 15 percent bump up in payment would be available for after-hours care and we will be defining that in the request for applications that's due out later this summer.

Let's see. So, the timeline for this is we hope to have the request for applications available midsummer and we would like to be able to announce ambulance supplier and provider participants in the fall of this year.

Again once we have selections made, we will release the Notice of Funding Opportunity for the cooperative agreements late this year.

And we hope that the model will be live, that beneficiaries will be receiving these new services in January of 2020. I think that pretty much covers the summary of the program and I'm happy to take questions.

Jill Darling: All right, great, thanks (Juliana). We'll take questions after today's presentation. And then last, we have Glenn McGuirk, who will – who has

announcement on the ambulance inflation factor for calendar year 2019 and productivity adjustment.

Glenn McGuirk: Yes. On November 30, 2018, we published Transmittal 4172, also known as Change Request to 11031, the Ambulance Inflation Factor for Calendar Year 2019 and productivity adjustment.

The AIF, as it's known, is for determining a payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act and updates publication 100-04, the Medicare Claims Processing Manual, Chapter 15, Section 20.4.

The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private, non-foreign business, multifactor productivity, MFP, as projected by the Secretary for the 10-year period ending with the applicable fiscal year cost reporting period or other annual period.

The MFP for calendar year 2019 is 0.6 percent and the CPI-U for 2019 is 2.9 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this results – reduction results in a negative AIF update. Therefore, the AIF for calendar year 2019 is 2.3 percent.

Jill Darling: All right, thank you, Glenn and thank you, (Juliana). (Erica), will you please open the line for Q&A please?

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question at this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Please limit your question to one question and one follow-up to allow other participants time for questions. If you require any further follow-up questions, press star one again to rejoin the queue. Your first question comes from (Michelle Ash). And (Michelle), your line is open. We'll move on to (Jennifer Bump). (Jennifer), your line is open.

(Jennifer Bump): Hi, we just wanted clarification in regards to the ET3 for the treat and release reimbursement rate. Did we hear that – that would be reimbursed as a BLS (fee) rate?

(Juliana Tiongson): For the ambulance suppliers and providers, yes, that is correct, for their part in the treatment in place. And then the partnering healthcare practitioner would bill Medicare separately.

(Jennifer Bump). Perfect, thank you.

(Juliana Tiongson): Sure.

Operator: And your next question is from (Cassandra Helm).

(Cassandra Helm): Hi, I just want to clarify because we are a local government and that we don't put in an application when the applications are during – come out during midsummer, we wait for the fall announcement of the Notice of Funded?

(Juliana Tiongson): Yes for the medical triage line that is correct.

(Cassandra Helm): So – OK, so we don't – if we want to participate we don't need to put in an application at summer, at all?

(Juliana Tiongson): No but you might want to encourage ambulance suppliers and providers in your area to participate, because the medical triage opportunities will be limited to geographies where we have participating ambulance suppliers and providers.

(Cassandra Helm): Oh. Because right now we are one of – only with a few instances, we're the only ones that have the COPC in to operate in (Pinellis County), as of right now.

So, we're kind of it for (Pinellis County), so we were interested in participating but we just want to make sure that we're responding at the right time. And you said local government should not respond when the applications are requested? So there is – there's no others that operate here.

(Juliana Tionson): Do you operate ambulances?

(Cassandra Helm): Yes, we do.

(Juliana Tionson): Oh – well that – yes, so then you could – if you have Medicare-enrolled ambulances, you could apply for that request for applications. So, you could apply to both announcements.

(Cassandra Helm): OK. OK, thank you.

(Juliana Tionson): Sure.

Operator: And your next question is from (Petra Nelopane).

(Petra Nelopane): Yes. My question is, will there be a limit to the ambulance services willing to participate? Is there going to be cap on that?

(Juliana Tionson): We don't have a cap at this time. It's – we're putting out a national solicitation. There will be some selection criteria that will guide us in selection but those details will be provided in the request for applications that is expected to be available this summer.

(Petra Nelopane): Thank you.

Operator: And your next question is from (Ron Marshall).

(Ron Marshall): Yes, thank you for the information. From a previous call, I would like to clarify if an ambulance takes somebody to a lower acuity level such as a physician office, it is a one-way payment and the patient must find another method to return home or to another location, is that correct?

(Juliana Tionson): Yes, that is correct.

(Ron Marshall): Thank you.

Operator: And your next question is from (Hilda Cameron).

(Hilda Cameron): Hello. Could you explain what qualifies as telehealth? Would a call to medical control from the ambulance crew by phone qualify?

(Juliana Tionson): OK, thank you for your question. We received a lot of questions on this. We are bound by the Medicare definition of telehealth and so it cannot be just the call, it needs to be audio and video to...

(Hilda Cameron): Thank you.

(Juliana Tionson): ... meet the telehealth definition.

(Hilda Cameron): Thank you very much for that clarification. There seems to be a lot of confusion about that one.

(Juliana Tionson): (Inaudible.) Yes.

Operator: And your next question is from (Clay Mann).

(Clay Mann): Thank you. My question was just answered, thank you.

Operator: Your next question is from (Cory Alt).

(Cory Alt): Hello. We were wondering if you had any updates on the evaluation of the repetitive schedule, non-emergency ambulance transportation – (the) prior auth demonstrations. But I don't know if you have anybody on the phone that could answer that?

Female: (Inaudible).

Sarah Shirey-Losso: Hi, yes. Unfortunately, you're right. We don't have anyone that you know (inaudible) (that) on this call. I believe they have a mailbox but I don't have it in front of me but feel free to send an e-mail into the Ambulance Open Door Forum mailbox which is [ambulanceodf@cms.hhs.gov](mailto:ambulanceodf@cms.hhs.gov).

(Cory Alt): All right, thank you .

Sarah Shirey-Losso: Sure.

Operator: And your next question is from (David Ornalles).

(David Ornalles): Yes, I was just wondering what you guys foresee happening with like specialty ambulances such as mobile stroke units that have treatment on board?

(Juliana Tiongson): I assume that they would continue operating the way they do today. That sounds like a high acuity condition that would – that would receive ALS and this is more – our model is looking at offering alternatives for emergency but lower acuity conditions. So, I think you would just continue to operate. I don't – I don't think there would be any impact by our model.

(David Ornalles): OK, sounds good. I just was curious because we kind of utilize most of those models including telehealth, as well. So, a lot of those dynamics are involved.

Operator: And your next question is from (Monty Jenkins).

(Monty Jenkins): Yes, good afternoon. My question is for (Juliana) regarding what documentation is going to be looked for relevant to the treatment and release model. Is it going to be strictly to telehealth, a video documentation? Because, now a lot of times if we get a question on a Medicare transport, they're looking for verification of hospital emergency department admission to verify ambulance transportation to that location.

(Juliana Tiongson): Yes, so we're working on a change request with the – with the Medicare Administrative Contractors, so that they will be familiar with the new – the two new payments and services available to participating ambulance suppliers and providers that I have gone over here today – transport to an alternative destination and treatment without transport.

We will also later provide guidance to selecting model participants on what codes to submit on your claims for these to be processed correctly.

(Monty Jenkins): OK, thank you.

(Juliana Tiongson): Yes.

Operator: Your next question is from (William Rogers).

(William Rogers): Hello, thanks for taking my question. I wasn't able to hear who is it that will be able to authorize transport to an alternative destination?

(Juliana Tiongson): Yes, so the ambulance crews following clinical protocols that are approved by their medical directors and in line with their state and local (laws) will be able to make that determination.

(William Rogers): I see. They'll be autonomous on that. Great, thanks.

(Juliana Tiongson): Yes.

Operator: And your next question is from (Christine Cole).

(Christine Cole): Hi, yes, I wonder if you could define for me who is a – let's see it said that it has to be a practitioner, a qualified practitioner. Could you define that for me, in all cases, they have to be evaluated by a qualified practitioner?

(Juliana Tiongson): Yes, so that means the Medicare-enrolled provider, so it would typically be a physician or nurse practitioner. In some states, it could possibly be a physician-assistant. In no case would it be a registered nurse or an advanced paramedic. So hopefully that answers your question.

(Christine Cole): It does, thank you.

Operator: And your next question is from (Maria Timberand).

(Maria Timberand): Hi, thank you for taking my question. I think you may have answered it in the previous question, but to clarify, there are some state regulations that require transport to an ED.

And I was just curious if CMS was aware of those because – and if that would – how would we, you know, how would we handle that if we – if just large pockets I guess of geographics that maybe controlled by state law where we

can't take advantage of these, transporting to alternative location. Has that been discussed or brought up?

(Juliana Tionson): It – yes, we've heard this raised by a few others. Unfortunately, our waiver authority to test models does not allow us to waive state and local laws, so ...

(Maria Timberand): Sure.

(Juliana Tionson): ... you would have to be operating within those constraints.

(Maria Timberand): Thank you. I appreciate the feedback.

(Juliana Tionson): Sure.

Operator: And your next question is from the line of (Max Shipley).

(Max Shipley): Hi, I'm calling – I've previously spoken to my (MAC) about this and I've kind of gotten some inconsistent responses.

And I was wondering if this is an answer that could be answered on – a question that could be answered on this call, it's related to joint responses. Is that something that you guys – a question you can take on this call or should I send an e-mail?

Sarah Shirey-Losso: Yes, I mean sure. Please send us your question and certainly if we can't answer on the fly you can happily send that to us in our mailbox.

(Max Shipley): OK.

Sarah Shirey-Losso: But I think for the benefit of others on the call, it might be helpful to hear your question.

(Max Shipley): OK. OK, so for – like under 10.5 joint responses part A and part B, my question is related to ground service transporting a – an air ambulance crew and a patient in situation where there is no contract between the two, like that already exists.

And the ground service doesn't provide any care to the patient, it's all provided by the air ambulance crew. I was wondering is that – is that claim billable by the ground service as a BLS level service, even though they didn't provide any care or is that not billable at all?

Sarah Shirey-Losso: Yes, so that is – yes, I think we'd like to see that question in the mailbox if you don't mind and we'll happily respond to you and we'll bring it back on a future call.

(Max Shipley): Great, thank you.

Operator: Your next question is from (Todd Valarie).

(Todd Valarie): Hi, thank you for taking my question. Under ET3, do you anticipate a relaxing of the medical necessity standards for transports to an alternative destination?

There seems to be a catch-22 situation, and that is if a patient is of such low acuity that they can be cared for in the clinic setting, then they probably don't meet the medical necessity standard for transport in the first place.

Currently, in these low acuity cases that are being transported to an emergency department, they're being billed with the GY modifier due to a lack of medical necessity. How is that gap going to be bridged?

(Juliana Tiongson): So, I'm not familiar with the G1 or GY modifier that you mentioned. This would be a good question to put into our mailbox. I think our resource mailbox was put out as part of the agenda, the [ET3model@cms.hhs.gov](mailto:ET3model@cms.hhs.gov).

I will say that we're not waiving the current standards for medical necessity or the contraindications for transporting by any other means than an ambulance. So I can look more into – do some research into what this code is that you're talking about, but that's basically my answer for right now.

(Todd Valarie): Sure. I will submit that question in writing and thank you very much. It seems to be a fundamental challenge with alternative destination and reimbursement.

Operator: And your next question is from (Nancy Crenshaw).

(Nancy Crenshaw): Yes, mine's a kind of a two-part question. Can you clarify for me the covered destinations or alternative covered destinations? I heard a (caller) earlier mentioned M.D. office. Is that in addition to urgent care, so an M.D. office would be considered an alternate destination?

(Juliana Tiongson): So, we're leaving that up to the applicants to tell us because we expect the alternative destinations to vary by community in terms of community needs, what is available in your community. We believe that you, the applicants, are more familiar obviously with your community than we are.

So, we're leaving that up to you to identify suitable alternative destinations, approach those entities and form partnerships or agreements with them to ensure that they are willing to accept individuals arriving via ambulance for a lower acuity like – the purpose of the program (if) they need treatment then and now but it doesn't need to be in an ED.

So, we're not – I mentioned a few that have come to mind like urgent care centers, perhaps FQHCs, community mental health centers.

It could be physician office, but any of these places would have to be equipped to provide service to an individual arriving via ambulance. So we leave that up to you to tell us who you – who your alternative destinations will be as part of your applications.

(Nancy Crenshaw): OK. And if you do travel to one of these alternative destinations, I'm assuming the BLS – HCPCS that you mentioned would still be the BLS emergent code and you would still be allowed to bill for mileage – on loaded miles?

(Juliana Tiongson): Yes, that's correct.

(Nancy Crenshaw): Thank you.

Operator: And your next question is from (George Vital). OK, I'm sorry, it looks (George) dropped from the queue. Your next question will be from (Tracy Raddy).

(Tracy Raddy): Hi, my one question was answered through the mileage question. The other one is just to piggyback on to the electronics that will be used, you said video and audio. Is it going to be certified, you know, this is what is recommended, this is what is specifically designated to be used –this type of equipment? Or is it just to be yet determined?

(Juliana Tiongson): Yes, I don't anticipate that we're going to provide that level of specificity just that it needs to conform with the Medicare definition of telehealth, so it has to be both ...

(Tracy Raddy): OK.

(Juliana Tiongson): ... audio and video but in terms of ...

(Tracy Raddy): Sure.

(Juliana Tiongson): ... specifying like exact types of equipment, I don't think that we're – I mean as of right now we're not planning to do that.

(Tracy Raddy): OK, thank you. And can I have one more like question? But it seems like that, if it's going to be allowed (to the) BLS call, you know most patients can get taken to a hospital setting and be paid without some of this other, I don't know, maybe for lack of better term, maybe a cumbersomeness for the crew.

And so do you feel it's going to be more of an incentive to just do this type of – to apply for this type of telemedicine instead of just doing straight BLS calls and – from the ambulance transport side, not so much for the physician? I see it's more of an incentive than it is for the ambulance crew.

(Juliana Tiongson): So, we've had pretty robust engagement with stakeholders over a period of several months and we do believe that there are many ambulance suppliers and providers that are interested in transport to alternative destinations, and some are interested in the treatment without transport, as well.

(Tracy Raddy): OK. Yes, I was just curious from a monetary, I guess, standpoint, so. I mean it's interesting and I think everyone should be on the cutting edge anyway because I think it will probably all go that way. So, it's great that they are starting to. Thank you.

(Juliana Tiongson): Yes.

Operator: And your next question is from (Gina Riley).

(Gina Riley): Yes. At the beginning of your discussion, you had said that the beneficiary could override the crew's choice whether it be to transport them to an alternative location or to do this treatment with no transport.

In that case, all of that would have to be documented in the chart as part of the transport and would that be a problem to cover medical necessity for that transport, if the crew is saying the patient didn't have to go to the hospital?

(Juliana Tiongson): I don't think it would be a problem. We – the way this is intended to work is that the beneficiary will be offered if they are deemed eligible by the crew to either go someplace else such as urgent care or just say for the purpose of this example, and they say no because they're familiar with going to the ED, "No, I'd really rather go to the ED," then that's what will need to happen.

We do want to preserve beneficiary choice here. They're calling 911 for an emergency. We're looking at having a code that participants would include on the claim, just so that we can track instances of when one of these alternative services were offered but ultimately refused by the beneficiary.

(Gina Riley): OK and as a second part to this, in this instance, I'm assuming that a special signature form would be required, showing what the beneficiary chose and agreed to?

(Juliana Tiongson): We're not anticipating a special form for that right now, although – until the RFA and all of that comes out, you know, that is subject to change but currently we're not anticipating that.

(Gina Riley): OK, thank you.

(Juliana Tionson): Yes.

Operator: And your next question is from (Jay Founders).

(Jay Founders): Hi, thank you for taking my question. It has been asked and answered, thank you so much.

Operator: Your next question is from (Shelley Miller).

(Shelley Miller): Yes, I want to know if you can elaborate some on the Notice of Funding for a local government agency that offers the 911 component and the ambulance service for their geographic area? What does the Notice of Funding consist of? And the benefits back to the agency?

(Juliana Tionson): Yes, so I really can't get into the details of the Notice of Funding opportunity until it's publicly released, but again it's an opportunity with funding to establish a medical triage line that's integrated with the 911 dispatch center.

So, not a separate number but one that's fully integrated. And that will only be available in areas where we have participating ambulance providers and suppliers enrolled in the model.

So if you are an entity that – as somebody earlier called in was – that operates ambulances – Medicare enrolled ambulances and oversees a 911 dispatch center, you could conceivably apply for both of those opportunities – the request for applications for the two new ambulance services and then the NOFO for the medical triage line.

(Shelley Miller): OK, thank you.

Operator: Your next question is from (Arsenio De Guzman).

(Arsenio De Guzman): Hi, thank you for taking our call. My question is if we take a patient from scene or from their home to a participating alternative destination

and drop the patient there and later on, we receive a call an hour later to take them to the hospital.

How will we treat that second bill? Is it going to be hospital-to-hospital transfer or clinic-to-hospital transfer? And, that's what I want to know.

(Juliana Tiongson): That's a good question. I don't think it would be hospital-to-hospital because they wouldn't be at a hospital. I ...

(Arsenio De Guzman): Will you create a new category for that kind of a call?

(Juliana Tiongson): I'm going to have to talk to my colleagues here a bit. Could you send that question into the ET3 mailbox please? I will say

It could legitimately happen and we wouldn't deny that second claim to take them to the hospital, but the mechanics of how you would do it in terms of the origin code, I need to speak to some people about that.

(Arsenio De Guzman): Sure. We will send you the e-mail, thank you.

(Juliana Tiongson): OK.

Operator: And your next question comes from (Deb Batteful).

(Deb Batteful): Hi there, thank you for taking my question. From a billing standpoint, I'm wondering if you can provide some clarification on whether is this just going to be available for traditional Medicare beneficiaries only or how would we handle or how would it affect those beneficiaries that have a Medicare replacement plan?

(Juliana Tiongson): So when you say Medicare replacement plan, do you mean a Medicare Advantage Plan?

(Deb Batteful): Yes, the Medicare Advantage, that they signed their benefits over to a different payer.

(Juliana Tiongson): Yes, so ...

(Deb Batteful): To be (Medicare), yes.

(Juliana Tiongson): Right. So, we can only control Medicare fee-for-service. We would like this to be a multi-payer approach and we feel like some of the ways we're helping to align other payers is through the medical triage line, (NOFO), because every payer will benefit from the medical triage line, because anybody calling 911 at that dispatch center could get triage.

But, we're also looking for applicants to speak to how their geography is really ripe for EMS innovations such as these, including other payers that are supporting this, whether it be Medicaid, Medicare Advantage, private insurers.

Because we do realize it's difficult to know right at the time of emergency and pickup, you generally don't know what someone's insurance is. So this would work most effectively in areas where other payers were somewhat aligned with these innovations.

(Deb Batteful): OK, thank you.

Operator: And your next question comes from (Breta Bergen).

(Breta Bergen): Hi, thank you for taking my call. And I think – so you were mentioning that this is for the Medicare fee-for-service, is Medicaid – the Medicaid state offices, are they onboard just yet or is this just kind of like a trial run for those five years?

(Juliana Tiongson): Yes, so it is a five-year pilot. Again, we can only control Medicare fee-for-service. We are collaborating with our colleagues over at the center for Medicaid and I know that some states do offer some EMS innovations.

I don't have an exhaustive list or understanding of all the ones that do, but we're certainly going to provide education for other payers and encouragement. But beyond that, at the end of the day, we can only promise to pay the claims for Medicare fee-for-service.

(Breta Bergen): Thank you.

Operator: And your next question is from (Hilda Cameron).

(Hilda Cameron): I have a question about the medical triage line and the healthcare professionals qualified to staff that line. Are they the same as the healthcare practitioners that are qualified through Medicare to do the treatment on scene, or is this a different group of people?

(Juliana Tiongson): So thank you for your question. That is something that will be released in the Notice of Funding opportunity. I can't provide that level of detail at this time.

(Hilda Cameron): OK. And one follow-up question to my earlier question about telehealth and audio video and does FaceTime, Skype, any of that count?

(Juliana Tiongson): FaceTime and Skype. I believe that it could. There's also the issue of transmitting potentially some test results. I – it may ...

(Hilda Cameron): Correct.

(Juliana Tiongson): ... it may be able to work but – yes.

(Hilda Cameron): Right, I don't know if they're – I don't think they're HIPAA compliant.

Sarah Shirey-Losso: I think you just have to go and check the rules regarding Medicare telehealth.

(Hilda Cameron): OK. OK, very good.

Operator: And your next question is from (Nancy Crenshaw).

(Nancy Crenshaw): Yes, my question is in regards to the treatment transport and the qualified healthcare professionals that are onsite. If this healthcare professional like a nurse practitioner happens to be credentialed as a paramedic as well, so it's one and the same person, would that person qualify as an onsite, even though they are part of the EMS crew that was dispatched?

Sarah Shirey-Losso: If they're enrolled as a Medicare provider and can bill for the services rendered, yes, that would be fine.

(Nancy Crenshaw): OK, thank you.

Operator: And your next question is from (Michelle Ash).

(Michelle Ash): Hi, thank you. Question – two questions, for the medical triage line, are private 911 dispatch companies allowed to enroll for that? And then second question on that, if this private 911 dispatch also dispatches (for) city entities (of Fire) and EMS, would they also be allowed to enroll?

(Juliana Tiongson): I think any entity that operates a 911 dispatch center is eligible to apply for the NOFO provided that they have ambulance suppliers and providers that were selected to participate through the request for application.

(Michelle Ash): All right, thank you.

Operator: And there are no further questions at this time.

Sarah Shirey-Losso: Well, that was a lot of questions on the model. I think (Juliana) has lots of notes, so and we'll look for some of the – there are a couple of questions I think that were going to come through on the mailbox. We'll take a look for those in the next few days. So, thank you again for joining us and have a great afternoon.

(Juliana Tiongson): Thank you.

Operator: Thank you for participating in today's Ambulance Open Door Forum Conference Call. This call will be available for replay beginning at March 28, 2019 at 5 o'clock pm Eastern.

The conference ID number for the replay will be 6695896. The number to dial for the replay is 855-859-2056. Thank you and you may now disconnect.

END