Emergency Triage, Treat, and Transport (ET3) Model
ET3 Model and Medicaid: Opportunities for Alignment Webinar

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TRANSCRIPT[1]

Andrea Amodeo (ET3 Learning System): Welcome to today's webinar, ET3 Model and Medicaid: Opportunities for Alignment. Before we begin, I'd like to review a few technical instructions, all attendees are currently in listen-only mode. Please place any comments or questions into the chat box as you think of them today, simply type your question or comment in the location marked "Type here" and press enter. Questions will be answered during the Q&A session later in the hour. The slides are also available for download in the Files to Download pod just underneath the chat box. Place your cursor over the file name, which will allow you to see a download symbol. Click that symbol to download the file to your local computer.

This webinar will provide an overview of the innovative payment mechanisms that are part of the ET3 Model. We'll cover the benefits that are associated with multi-payer alignment, specifically those related to Medicaid, and also highlight key considerations that state Medicaid programs can take into account when determining if and how to align with the ET3 Model.

As you can see on the slide, today's webinar agenda will cover the following topics, some history and background about the ET3 Model, some of the benefits associated with multi-payer alignment, an overview of ET3 Model Participant characteristics and their locations, key details regarding the ET3 Model program design, how ET3 translates to Medicaid, and alignment considerations for state Medicaid programs. We'll conclude with the question and answer session.

We'll start by introducing the various speakers you will hear from today, and then review the objectives of this webinar. To provide this information, it is my pleasure to welcome Alexis Lilly, the ET3 Model Lead. Alexis, welcome, and the floor is yours.

Alexis Lilly (CMMI): Thank you, Andrea, we have an excellent panel of speakers today, you will hear from a few of our ET3 Model team members, including myself as well as our multi-payer leads, Jane McClenathan and Lauren McDevitt. We are also joined by Richard Kimball, from the Center for Medicaid and CHIP Services. Welcome to all of our presenters.

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The focus of today's webinar is three-fold. First, we will introduce the ET3 Model's aims and overall construct. Second, we will describe the benefits of multi-payer alignment with the ET3 Model for state programs, providers, and Medicaid beneficiaries. Finally, we will cover key considerations that state Medicaid agencies should keep in mind when planning to implement ET3-like services in their state.

A resource that we have highlighted here in the last bullet is a 2019 CMS Joint Informational Bulletin that lays out helpful information for Medicaid programs in designing ET3-aligned interventions for ambulance care teams to address the emergency health care needs of Medicaid beneficiaries. It also summarizes several studies that provide recommendations for building effective payment approaches to avoid unnecessary transport to the ED.

We will dive into the content by first covering some foundational information on the background and rationale behind the ET3 model. The ET3 Model is a voluntary five-year payment model that aims to reduce expenditures and preserve or enhance the quality of care for Medicare fee-for-service beneficiaries by providing person-centered emergency services. There are two key interventions specific to ET3 – transport to an alternative destination, also referred to as TAD, and the provision of treatment in place, also referred to as TIP. The intent behind these interventions is that Medicare beneficiaries receive the appropriate level of care, delivered safely at the right time and place, while having greater control over their health care through the availability of more options.

Under the ET3 Model, TAD is required and TIP is optional, although most of our Participants will be implementing TIP given the current COVID-19 Public Health Emergency. Entities that operate or have authority over a Public Safety Answering Point in these communities also had the opportunity to apply for funding to implement or expand a medical triage line. Please note that the ET3 Model is for emergency care only and does not include scheduled or non-emergency care.

Historically, Medicare has only paid for emergency ground ambulance services when the beneficiary is transported to a covered destination, typically a hospital emergency department. This creates an incentive to bring beneficiaries to a high-acuity, high-cost setting even when a lower-acuity, low-cost setting may more appropriately meet an individual's needs. ET3 interventions realign incentives and create flexibility for participating ambulance suppliers and providers to address the emergency health care needs of Medicare fee-for-service beneficiaries following a call to 911. It is important to note that payments are the same to ambulance suppliers and providers regardless of which intervention is implemented – transport to an ED, TAD, or TIP.

Studies have shown significant savings from transporting patients to sites of lower acuity than the ED. These savings would likely be achieved under Medicaid coverage. The interventions of the ET3 Model build on evidence gathered from Health Care Innovation Award demonstration sites, states, and local governments. For example, in 2012, the Regional Emergency Medical

Services Authority, also known as REMSA, launched a system of community health interventions, which included alternative destination transport, to improve access to an appropriate level of emergency services throughout Washoe County, Nevada. The system offered new referral and treatment pathways to ensure the safest and most appropriate care for patients with low-acuity medical conditions. Over four years, REMSA saved $9.66 million in healthcare payments, compared to $9.06 million in program expenditures. By year four, the programs achieved an 84% return on investment—avoiding $1.84 in payments for every $1 in expenditures.

I will now turn it over to Lauren McDevitt to discuss the benefits of multi-payer alignment in the ET3 Model.

Lauren McDevitt (CMMI): Thanks, Alexis, for that background. Now we will discuss the potential benefits that may be realized when multiple payers align their coverage and policy with those of the ET3 Model.

Although ET3 is a Medicare fee-for-service payment model, the Model will be most successful if other payers, such as Medicaid, adopt similar policies and programs. CMS has strongly encouraged Model Participants to pursue multi-payer alignment within their communities. Ambulance suppliers or providers may reach out or may have already reached out to their state Medicaid agency to initiate discussions on incorporating ET3-like interventions into their programs. States are encouraged to work with Model Participants, CMS, and the various stakeholders at the state Medicaid agency on how best to incorporate ET3-like services into their programs.

State agencies are welcome to work directly with CMS to explore how to implement ET3-like services, such as transporting a beneficiary to an alternative destination or allowing for treatment in place after a 911 call. State Medicaid agencies will have the opportunity to participate in the ET3 Model Learning System, which will facilitate peer-to-peer sharing of best practices, lessons learned, and useful tools among stakeholders. We will share information later in this webinar about how to express interest in joining the ET3 Learning System. CMS will also include state Medicaid provisions in the ET3 Model's overall program evaluation of cost and quality.

So, diving a bit more into some of the potential benefits of multi-payer alignment. First and foremost, for patients, alignment may allow access to more appropriate services, potentially faster care via TIP or TAD, and also possibly safer care when avoiding potential exposure associated with treatment in the ED. There also may be lower out-of-pocket costs when treated in a lower-acuity setting, and there would be consistent benefits for the patient regardless of what insurance they have.

Ambulance suppliers and providers may benefit from consistent clinical protocols across patients, consistent billing requirements across payers, reduced compliance costs, and for

those that already participate in the Model, efficient use of resources that were previously invested in ET3 Model participation.

As Alexis mentioned, Medicaid agencies may also experience similar cost savings as observed in the Medicare program and other demonstration projects. There also may be potential to improve quality of care for beneficiaries by offering care in an alternative setting vs. the ED. Also, Medicaid programs might be able to leverage insights from Medicare and their peers and ET3 Model Participants through the ET3 Learning System. So even if there are no current Model Participants in your state, all states are welcome to participate in ET3 Learning System activities. As mentioned, state Medicaid programs may also take advantage of being included in the ET3 Model's program evaluation.

And finally, in terms of the overall state healthcare system, alignment will allow streamlined 911 call triaging, regardless of what insurance the beneficiary has. In addition, alignment could lead to a reduction in overall ED crowding. And finally, aligning with ET3 may simplify the regulatory oversight of ambulance suppliers and providers.

So now I will describe some of the Model Participant characteristics and share some more about the various stakeholders of the ET3 Model. On January 1, 2021, CMS launched the ET3 Model with 184 ambulance suppliers and providers from 36 states. Selected Participants are required to partner with at least one alternative destination, such as an urgent care. Additionally, at least one Model intervention must be available 24 hours per day. Participants that choose to only partner with alternative destinations must ensure that the alternative destination is available 24/7; those that opt to offer treatment in place must ensure that either an alternative destination, treatment in place intervention, or combination of the two, is available 24/7.

ET3 Model Participants are located in rural and urban regions and represent various organizational types including private for-profit, private not-for-profit, fire-based, hospital-based, and government-owned ambulance suppliers and providers.

This map provides a visual of ET3 Model participant distribution by county. As you can see, there is a large representation of Participants in the southwest region and Colorado, as well as in the states of Louisiana, Texas, and Minnesota. In this map, you can see ET3 coverage of the Medicare fee-for-service population, similar to the previous slide you can see that there are a larger number of beneficiaries that reside in the Southwest region, as well as in Louisiana. And there is also slightly higher ET3 coverage in the states of New York and New Hampshire.

There are a variety of different stakeholders involved with the ET3 Model. The primary stakeholders are Model Participants, which include Medicare-enrolled ambulance suppliers and hospital-owned ambulance providers. Another stakeholder group are the Qualified Health Care Partners, or QHCPs, which our Model Participants partner with to furnish covered services to ET3 Model beneficiaries as part of an in-person TIP intervention or telehealth TIP intervention. Examples of QHCPs include, but are not limited to, a Medicare-enrolled group practice, a

Medicare-enrolled physician or non-physician practitioner, a non-Medicare enrolled entity that contracts or employs a Medicare-enrolled physician or non-physician practitioner to furnish covered services to ET3 Model Participants as part of a TIP intervention. And a third stakeholder group are the ADPs, or Alternative Destination Partners, which are organizations that have agreed to serve as alternative destinations for the ET3 Model. These include sites such as Federally Qualified Health Centers, physician offices, behavioral health centers, and urgent care centers. Please note that both QHCPs and ADPs typically operate as separate entities from the ET3 Model Participants, unless the ET3 Model Participant is hospital-based. Paramedics and EMTs are not reimbursed under Medicare. I will turn it over to my colleague Jane McClenathan to discuss key details regarding the ET3 Model program design.

Jane McClenathan (CMMI): Thanks, Lauren. The next few slides will walk through exactly how Medicare reimburses ET3 Model constructs and who exactly is allowed to provide services. As previously mentioned, there are three interventions that ambulances participating in the ET3 Model may initiate at the scene of a 911 response. These interventions are a standard transport to a Medicare covered destination, such as an ED, a transport to an alternative destination covered by the ET3 Model, or treatment in place facilitated by a qualified healthcare partner. In all three interventions, the ambulance gets paid the same standard transport rate that they typically bill. Either the emergency basic life support, of BLS rate, or advanced life support or ALS rate, depending on the acuity of the patient. This is true even for treatment in place where no transport occurs, which is unique to Medicare's ET3 Model and would likely be constructed differently if implemented by a Medicaid program.

Then, in addition to the transport payment that the ambulance receives, there is also of course the payment made to whichever providers actually served the patient. In the case of a standard intervention, that payment goes to the emergency department. In the case of a transport to an alternative destination, the payment goes to that alternative destination, such as an urgent care physician office. And finally, in the case of treatment in place, that payment goes to the Qualified Healthcare Partner who provided services to the patient, such as a doctor, nurse practitioner or physician assistant.

So, this slide provides the detailed information of exactly what codes are billable under Medicare’s ET3 Model. As you can see, for both TAD and TIP, ambulances can bill either A0429 or A0427. They’re the standard transport fee. In addition, they can bill A0425 for mileage if transporting to an alternative destination. This is obviously disallowed for treatment in place since there is no actual transport in that intervention. Additionally, the ambulance must provide the most relevant destination modifier for all ET3 Model claims – “C” for community mental health care center, “F” for FQHC, “O” for physician office, “U” for urgent care, and finally “W” for treatment in place. In a situation where the patient is offered an ET3 specific intervention but refuses and is transported to an emergency room, the ambulance must bill “G2022” instead of the ET3 destination modifiers.

The billing for alternative destinations and treatment in place providers is much simpler than that for the ambulance. Both types of ET3 partners are allowed to bill for their services as usual. There are only two ET3 specific billing rules that apply to ET3 partners. First, an additional non-paying HCPCS code “G2021” needs to be added to all treatment in place claims for identification purposes. Second, treatment in place providers can bill a special modifier for a 15% rate bump if they provide services between 8 PM and 8 AM local time. For more details about how Medicare billing works for ET3, please reference our billing and payment factsheets which can be provided upon request after this presentation.

So now that we have talked through exactly how the payment construct works for Medicare, let's briefly go over who is actually allowed to receive these payments. First, it’s important to note that the ET3 Model has waived several standard Medicare fee-for-service rules, including the requirement that ambulances perform a transport in order to be paid. While Medicare fee-for-service only covers transports from hospitals, SNFs, and dialysis centers, the ET3 Model expands allowable transports to include any practice site capable of providing real-time ET3 services. However, we have otherwise maintained Medicare’s standard requirements for allowable provider types. The providers serving our patients, either at an alternative destination or through treatment in place, must meet all licensure requirements for Medicare and be subsequently Medicare enrolled. This means that EMTs and paramedics may not furnish treatment in place under Medicare’s ET3 Model. Additionally, we expect that most providers furnishing treatment in place via telehealth will be physicians, physician assistants, nurse practitioners, licensed clinical social workers, clinical nurse specialists, or clinical psychologists. However, while the COVID-19 Public Health Emergency is in effect, a broader set of practitioners is allowable under Medicare.

With that, now that we have reviewed some of the key elements of Medicare’s ET3 Model construct I’ll hand it off to our Center for Medicaid and CHIP Services colleague, Richard Kimball, who will go over how ET3 Model interventions can translate to the Medicaid space.

Richard Kimball (CMCS): Thanks, Jane. I will be discussing how to translate the ET3 Model to Medicaid. There are two major components for Medicaid agencies to consider when implementing any ground emergency medical transportation program in their state plan. These two components are the covered provider types and the reimbursement methodology. Medicaid transportation policy at 42 CFR §431.53 guarantees transportation to and from providers, so unlike Medicare, Medicaid allows the flexibility for states to define where a beneficiary is transported in their state plan. Under the ET3 Model, this is called transport to alternative destinations, that is those destinations other than an emergency department. Some states already allow this in their state plan, and some states cannot do this because of state laws barring transportation to alternative destinations.

Treatment in place usually would not include a transport in Medicaid, but under certain circumstances it could, if there is a distinct service provided to the beneficiary for instance. In Medicaid, health care practitioners can be directly reimbursed for treatment in place through a

variety of mechanisms, or they can bill through their ambulance company. For instance, ambulance-employed practitioners, including paramedics and EMTs in some states, could bill under their state plan's "other licensed practitioners'" benefit. Additionally, hospital-owned ambulances may be able to bill under the hospital benefit, depending on the type of provider who rendered the treatment in place service.

So, Medicaid programs who wish to align their state plans to ET3 have options: they could bill for transportation of beneficiaries to varying destinations and allow defined providers to bill directly for other Medicaid services provided to beneficiaries, or the ambulance company could bill on behalf of their employed practitioners for both transport to alternative destinations and treatment in place.

Medicaid agencies can align their state plans to ET3 by defining covered provider types and the covered Medicaid 1905(a) services they will be able to provide. While licensure and scope of practice is limited for Medicare, Medicaid agencies have more flexibility to choose what provider types they cover, depending on their state and local laws. For example, Medicaid agencies can make use of the 1905(a)(6) authority to recognize the services of other licensed practitioners that are not recognized under Medicare rules. This could allow paramedics, EMTs, or other providers to provide and be reimbursed for providing treatment in place. Additionally, telehealth treatment in place could be allowed by Medicaid agencies who would define the licensure standards and allowable provider types within the scope of their State Practice Acts. Again, this allows state Medicaid agencies to choose who can provide telehealth services to Medicaid beneficiaries.

And now I have highlighted some of the ways that Medicaid agencies could align their state plan with the ET3 Model, I'll turn it over to Jane, who will go over some key considerations for states to keep in mind regarding transportation to alternative destinations and/or treatment in place interventions.

Jane McClenathan (CMMI): Thanks so much, Richard. Now that we have gone over how the ET3 Model works for Medicare, and how this construct translates to the Medicaid space, we wanted to go over some key considerations for states to keep in mind if you are interested in implementing a similar construct for your Medicaid program.

We recommend that states seeking to design Medicaid coverage that aligns with the ET3 Model first conduct a readiness assessment in partnership with the ambulance providers in your state. The questions on these slides may assist in completing this readiness assessment. That said, we understand that each Medicaid program is unique, and we welcome you to reach out to us with your specific plan before beginning implementation. With that said, I won't read through all of the questions listed here and on the next slide, but feel free to reference the recording or the slide deck for this webinar as you think through potential implementation of ET3-like services in your own state. And with that, we have concluded the content portion of our presentation. I'll now turn it over to our moderators who will open the floor for questions.