ET3 Model Application Tutorial Webinar

August 8, 2019

Recording Transcript

Hello and welcome to the Emergency Triage, Treat and Transport Model Application Tutorial webinar. Thank you for joining us. My name is Arpan Parekh and I will be leading this webinar this afternoon.

So we'll go through an overview of the webinar. The webinar will review important components of the ET3 Model and the live application portal and then allow for time at the end of the presentation for Q&A.

The topics we will cover today will largely go over an overview of the ET3 Model, the application process and timelines, a walkthrough of the main sections of the application itself, as well as important information that you will need to collect and include in the application for submission. Please note that while there will be screenshots in each section of the application, they do not show every question that will be present in the application.

The focus of today's webinar is the Request for Applications or RFA application portal, which will be completed by ambulance suppliers and providers. We will leave plenty of time for questions and answers at the end.

First, we will briefly review the goals and structure of the ET3 Model. If you have not done so already, you can review these documents and additional materials on the ET3 Model website, including materials from past webinars and factsheets to familiarize yourself with the model. These materials can help you prepare to submit your application.

So, we will move on to the current state of emergency ambulance services. Medicare currently pays for emergency ground ambulance services as an individual calls 911, and the ambulance will be dispatched to a scene regardless of acuity, and once there, either transports the individual, often to the Emergency Department or another high acuity destination, or the ambulance does not transport the individual.

Currently, Medicare only reimburses for transportation when beneficiaries are transported to a limited number of destinations such as emergency departments, critical access hospitals and skilled nursing facilities, and this creates a perverse 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.

The ET3 Model is focusing on realigning incentives for a future state for emergency ambulance services. The ET3 Model is a voluntary, five-year payment model with the goal of addressing misaligned incentives while providing greater flexibility to ambulance teams to address emergency health care needs of Medicare Fee-For-Service beneficiaries following a 911 call.

In the ET3 Model design, there are new options for an individual making a call to 911. Firstly, an individual with a low-acuity condition may be triaged to discuss their concerns with a health care professional. This could result in a referral to see their doctor or could result in the individual being triaged back to the 911 dispatch system, and ambulance service initiated. Once initiated, an ambulance arriving at the scene has two options to present beneficiaries – transport or no transport. For transport,

they could still go to the emergency room or be transported to an alternative destination if they are eligible under the new protocol and intervention.

Alternatively, they could receive treatment in place by a qualified health care practitioner either through provision of on-site care or via telehealth. Please note that for treatment in place you will always need to involve a Medicare-enrolled practitioner to provide treatment whether it is on site or via telehealth. An important point to note, is that the decision to triage someone into any one of these new options will require a clinical protocol that adheres to state and local requirements and clinical best practices that are approved by the Applicant's Medical Director. Lastly, part of the ET3 Model includes an innovative payment structure that reimburses ambulance suppliers and providers as well as their partners for the services rendered.

Now we will discuss, at a high-level, the ET3 Model payment approach. New payments available under the model will build on Medicare's existing Fee-For-Service's structure to offer greater flexibility. So the two interventions that we have mentioned so far are the transport to alternative destination as well as the treatment in place interventions.

For transport to an alternative destination, ambulance suppliers and providers will be paid based on the level of service provided at either the BLS-E or the ALS1 emergency rate and mileage and applicable adjustments will apply.

For the treatment in place intervention, ambulance suppliers and providers will still be paid based on level of service provided at either the BLS-emergency or the ALS1 emergency rate and the qualified health care practitioner that is providing this treatment in place intervention will be paid based on current Medicare Fee-for-Service rates for all services rendered.

There are also payment adjustments within the payment approach of the model. For afterhours care provided by a qualified health care practitioner within the treatment in place intervention, there will be a 15% increase in rate of reimbursement. Furthermore, performance-based payment adjustment for achievement on key quality measures will be available at a later time.

Now we will review the ET3 Model participants and partners and all eligible entities to apply as well as the partners they may pursue.

This webinar is focused on ambulance suppliers and providers, as they will be responding to the application that is currently open. All Medicare-enrolled ambulance suppliers or hospital-based ambulance providers may be eligible to apply.

While they will not submit an application themselves, there are several main partners who will be involved in delivering care through the ET3 Model. They include the alternative destinations as well as treatment in place providers. We would like to note that the alternative destination intervention is a required intervention and therefore a required partner in this model. While the treatment in place intervention is optional and therefore, a partnership with the providers is also optional. Additionally, we hope that non-Medicare payers will work with the ambulance providers to allow for multi-payer alignment.

We'd like to share a few important details about your model partners. For both alternative destinations and treatment in place interventions, care must be provided by a Medicare-enrolled qualified health

care practitioner who meets state, local, and professional requirements to render particular health care services. These health care practitioners will be vetted by CMS to assure quality of care for all beneficiaries.

We can review recommended relationships as well. The ET3 Model team highly encourages multi-payer alignment in implementing these interventions and we'd also like to note that 911 dispatches can also serve as partners, but will apply through a separate process, outlined at a later time.

We will also review the key requirements for participation in the model. Applicants will need to demonstrate the following to be considered for participation. Transport to alternative destination is a required intervention to participate in the model. There is also a requirement that there is a 24/7 availability of model interventions. This does not mean that any one intervention has to be available 24/7, but there needs to be a plan in place to ensure that one intervention, either alternative destination or treatment in place if it is being pursued, is available 24/7. There is also a requirement that Applicants are able to demonstrate an interoperability plan that demonstrates the Applicant's ability to share patient data among key partners and stakeholders.

When considering applying to the application, Applicants should consider the following: CMS expects to make available conditional payment and policy waivers available to certain Applicants to the ET3 Model, including waiving the telehealth originating site requirement and geographic requirements. Applicants must also describe a strategy for engaging other payers in their area or explain how they would operationalize the model specifically for Medicare Fee-for-Service beneficiaries. Applicants will also be asked to provide information on all proposed partners and payers and should include Letters of Intent to Partner as part of the application.

Next, we will move through the application as well as the questions enclosed, discuss the timeline on a higher level, and some of the components and expectations of the application.

Next, we will go over the timeline on a high level.

In May of 2019 the Request for Applications PDF was released on the ET3 Model website for potential Applicants to review. The RFA Application portal is now open and available for application submission. And in late September 2019 the RFA application portal will close and we will begin the review process. In late 2019, ET3 Model Participants are announced and will be undergoing the process of submitting their Model Participant Agreement. And in early 2020, with the expectation of a January 1st go live date, the ET3 Model will go live. The ET3 Model team would like to note that dates are subject to change.

We will now begin going through the application. This slide summarizes the components of the application that Applicants will have to respond to. CMS will establish guidelines to prioritize applications based on the following components which are available for your review.

Following opening the ET3 Model website and finding the link for the application portal in the RFA section of the website, the Applicant will be sent to the Applicant Registration page which is where they we be able to see an option to register and create a username and password that you will be able to create to access the application as often as you'd like. On this page you'll also find information that allows you to contact the ET3 Model team with any program issues or technical issues that you may have with the application.

Next, we will review the functionality of the portal. We'd like to share some tips about the functionality to help enhance your experience and success with completing the application. As you work on the application and enter information, we recommend that you save often so that you don't lose your work. The portal automatically times out after 30 minutes of inactivity. You do not have to complete the application in one session and can start and stop as often as you need. Please note that you cannot jump forward to sections out of turn, as they are often dependent on previous sections, but you can revisit sections you have previously started or completed, provided that you have saved them. Most fields have a character limit where a text entry is required, which are displayed right below the field where you enter the information and the character count will decrease as you input characters. The application is set up so that all fields are required, unless they are indicated as being optional. You will be able to move forward if you have not answered a required field, but upon submitting your application, you will receive an error message telling you of any missing fields that are required. You can then go back and complete those fields.

We will now turn to the application itself, covering each of the sections in turn to highlight important components and features of each section.

Looking through the applicant eligibility requirements, the ET3 Model requires that Applicants meet certain eligibility requirements, as described in the ET3 RFA. Some areas to consider before beginning the application, which may impact your eligibility, are: whether the ambulance provider or supplier who is applying is currently enrolled in Medicare and in good standing; if the Applicant is operating in a state that meets the minimum transport threshold requirement of 15,000 Medicare Fee-For-Service transports in the 2017 calendar year; and if the Applicant is willing and able to provide the ET3 Model interventions, including ensuring that at least one non-emergency department option is available for care 24/7.

We recommend that all Applicants review the RFA and the eligibility requirements prior to beginning an application. Following entry into the application and following registration, the Applicant will be faced with the "Eligibility" page, which will establish whether or not certain key requirements of the application and the ET3 Model have been met.

The first question will request that you respond to whether or not the Applicant is a Medicare-Enrolled ambulance provider or supplier as they are the only eligible entities allowed to apply. There will also be a question ensuring that Applicants are currently providing emergency ambulance services in the entirety of the region that they've proposed to implement the interventions in and will continue to do so throughout the model. Once these three questions have been attested to, you can continue and enter the rest of the application.

Upon determining that the Applicant is eligible, they will then enter the application and be first faced with the "Model Applicant Information" page. On this page, we request information about the applying organization including legal business name, correspondence address, as well as the national provider identifier number for the organization. Further down on this page we will also require that the individual applying on behalf of the organization, the individual who will be maintaining communication with CMS, provide their contact information as well.

The next section that the Applicant will navigate to is the proposed model region page. All Applicants will need to propose a region that they will serve as part of their application and meet requirements in order to propose an eligible region. We will now review this section of the application.

Applicants to the ET3 Model will need to propose a region where they will be implementing the ET3 Model, based on state or states as well as county, counties or equivalent entities. The proposed model region must be located in a state or states where at least 15,000 Medicare Fee-for-Service emergency ambulance transports occurred in the 2017 calendar year. If you propose a region that includes more than one state, each state must meet that threshold. Preference will be given to Applicants who propose a region that includes at least one county or county-equivalent, where at least 7,500 Medicare Fee-For-Service emergency ambulance transports occurred in the 2017 calendar year.

The ET3 Model team would like to emphasize that the 15,000 Medicare Fee-For-Service emergency ambulance transport volume is a requirement for participation in the ET3 Model, but the 7,500 Medicare Fee-For-Service emergency ambulance transport volume value is a preference under the model and will not serve to exclude anyone. We will share where you can access transport data in a later slide.

One additional thing that the ET3 Model Team would like to add is that CMS will consider the sum of beneficiaries covered by multiple ambulance providers in a particular region when reviewing applications.

When on the “Model Region” page, Applicants will be given the option of selecting a region and adding multiple states and counties. If you plan to include more than one state in your proposed region, you will also need to take additional steps. The following steps will allow you to add all counties and all states you are proposing.

First, you need to select one state at a time in order to view and select the counties within that state. Then, you can add each individual county in your region by highlighting a county from the list and using the blue arrow in the middle of the screen to transfer it over to your selected counties. In this section you will also be attesting to whether or not counties that you are proposing meet the threshold of 7,500 transports within the 2017 calendar year. When you have added all counties from one state, select “Save and new” if you would like to add another state. This will allow you to select other states, and relevant counties.

The transport volume values are available on the ET3 Model website if you scroll down to the additional information page and select the “Appendix D: Number of Medicare Fee-For-Service Emergency Transport Claims by State and County” PDF document. You can use this PDF to verify your proposed state or states to ensure that they meet the 15,000 transport threshold as well as determine if you can strengthen your application by including a county that meets the 7,500 transports preference.

We would now like to run through a regional example to illustrate how an Applicant can confirm that a region meets the emergency transport threshold using Medicare data on the model website.

If you look at the image below, you will see that the proposed service area is Kansas City which lies at the border between Kansas and Missouri. By reviewing the transport volume PDF, you can verify that Kansas had 15,000 Medicare transports in 2017 and that Missouri had 15,000 Medicare transports in 2017 as well. This meets the model requirement of having 15,000 Medicare transports even when you

are proposing a model region that crosses state lines, since each state met the threshold. Using the data provided, you can also check if a county in the proposed service area of Kansas City met the 7,500 Medicare transport preference.

We will now move on to the Governance Structure and Capacity to implement the ET3 Model section. In this section, you will be asked to first describe the organizational structures and mechanisms that will support your ability to implement the ET3 Model innovations and then describe your current transport capacity.

In the top portion of this page, you will need to describe how the governing body or other organizational mechanisms would make and execute decisions related to the ET3 Model, how clinical protocols would be developed, implemented and monitored, as they relate to the ET3 Model interventions, and we also request a description of how the Applicant will develop and oversee compliance with federal fraud and abuse requirements.

The ET3 Model team would like to note that if any structures or organizational types are being employed in implementing the model, that they be outlined in this section.

In the bottom half of this page, you will be asked to provide information about your current unscheduled, emergency ambulance services capacity, including: the number of 911-dispatch generated transports conducted annually, the proportion of total transports per year that are in response to 911 dispatch, as opposed to a scheduled or unscheduled non-emergency transport, as well as, to the extent data is available, the number and percentage of emergency transports of Medicare Fee-For-Service beneficiaries by the Applicant.

We now move into the “ET3 Model Intervention Design” pages where you will be describing how you plan to operationalize the interventions outlined in the ET3 Model. We will start by looking at the section for alternative destinations.

For alternative destination sites, ambulance service providers can partner with both Medicare-enrolled providers such as a hospital that has a walk-in clinic or group practice, or could partner with non-enrolled Medicare entities such as urgent care centers that contract with Medicare-enrolled practitioners. In either scenario, the downstream practitioners that service the beneficiaries at alternative destination sites need to be enrolled in Medicare.

Applicants will be required to demonstrate that their proposed partners have the ability and capacity to serve Medicare Fee-For-Service beneficiaries and the capacity to bill Medicare for services. The view shown on this slide shows the beginning of this section.

You will begin this section by describing how you will implement this intervention, starting with describing groups of beneficiaries that you believe would be appropriate for this intervention. You will also need to answer questions such as how you will ensure that alternative destinations have the capacity to serve those reported and how you will ensure the safety and the quality of care for beneficiaries transported to alternative destinations. The last question in this section is also shown on this slide. You will be asked to indicate at the conclusion of this section if you have established any formal relationships with alternative destinations. If you answer “yes” to this question you will be expected to provide a Letter of Intent for those organizations in a later section.

Now we will discuss the optional intervention—that of treatment in place. If you choose to implement this intervention, you must partner with individual Medicare-enrolled qualified health care practitioners.

If providing care via telehealth, participants must use a qualified interactive telecommunications system that includes audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. In the application, you will be required to demonstrate that proposed partners for this intervention have the ability and capacity to serve Medicare Fee-For-Service beneficiaries and the capacity to bill Medicare for services. Please note that this slide shows you the beginning few questions of this section and you will be required to answer additional questions in the application.

You will begin this section by indicating whether or not you intend to implement this optional intervention and whether the providers will be rendering services in-person, via telehealth or a combination of the two. You will then be asked to describe a plan for implementing the intervention, including a description of the groups of beneficiaries that you believe would be appropriate for this intervention, as well as how you will ensure their safety and quality of their care. Lastly, just as with the alternative destination section, you will be asked to indicate at the conclusion of the questions if you have created any formal relationships with providers for this intervention. If you indicate “yes” you will be asked to include Letters of Intent as part of the application in a later section.

The next section that Applicants will have to complete, is that of the Interoperability Plan. On this page, Applicants will be required to describe how they will be able to share data and information, including protected health information, with partners and key stakeholders.

In this section, you will be asked to describe your current and/or future use of a health information exchange. If you do not plan to use a health information exchange, you will be asked if you are able to use certain functionalities such as that of an Application Programing Interface or an API, JavaScript Object Notation, Fast Healthcare Interoperability Resources, or Extensible Markup Language.

If you are not currently participating in an HIE you will need to demonstrate your understanding and ability to meet the following requirements and standards, which were listed previously. You may also need to demonstrate that you have a thorough understanding of state and federal privacy laws, including HIPAA and that you have a plan to comply with all of those regulations. Lastly, you’ll need to identify when and how patient consent and authorization will be obtained through the course of implementing these model interventions.

There are many partners who may be involved in data sharing. This slide illustrates some of those potential partners and stakeholders who will need to access various levels of patient data during the ET3 Model. Please note that this is not an exhaustive list and that the actual list of entities who you will need to communicate with will depend on your environment as well as which interventions you choose to implement. Examples of partners include: alternative destinations and treatment in place providers, primary care providers or other providers who routinely care for your beneficiaries, and payers in your region who are aligning with the ET3 Model.

The next section of the application that Applicants will complete is that of the Compliance Analysis and Plan.

On the “Compliance Analysis and Plan” page, Applicants will be required to conduct a compliance analysis to identify risks and then create a plan to mitigate risks and avoid inappropriate utilization, including over-use of interventions and under-triaging the patients. Additionally, CMS recognizes the diverse legal landscape governing emergency medical services, including differing standards across and within states so your plan should explain how you will successfully implement the proposed intervention design within the context of applicable laws, regulations, and policies in your proposed geographic service area.

On the slide below, you can see the top portion of this section of the application. You will first need to describe your current compliance program and risks. Then you will need to describe a compliance plan specific to ET3 implementation. A resource is provided to OIG’s Voluntary Compliance Program Guidance for Ambulance Suppliers, which should guide the creation of this plan. The last question shown here requires a plan for avoiding under-triage and successfully implementing the proposed intervention design. The application has an additional question about ensuring your intervention design meets all applicable medical laws and regulations.

The next section of the application discusses a payer strategy. As described in other ET3 events and resources, CMS recommends engaging with other payers in your region to participate and align with ET3 interventions and payment options. We will now discuss this component and the associated section of this application.

The ET3 Model Team recommends reaching out to other payers in your region that have a significant presence. This may include Medicaid plans, Medicare Advantage, commercial payers and others. The goal is to achieve multi-payer alignment, which we believe will assist the Applicants in achieving the ET3 cost and quality goals. Therefore, as part of the application, we require that all Applicants describe their plan for either engaging other payers in their region or, alternatively, to describe how they will plan to implement ET3 innovations for Medicare Fee-For- Service beneficiaries only. You will also need to describe your plans to identify eligibility for the innovations.

On the slide below, you can see some of the questions that the Applicant must respond to. If you decide to pose a multi-payer strategy, you will be led to the section in the application shown on the screen now. You’ll be required to describe your overall strategy and timelines for engaging payers, as well as payment for ET3 innovations. You must also describe how you will determine eligibility for these services between payers. As with the alternative destination and treatment in place sections of the application, you will be asked if you have engaged specific payers at the time of the application and if so, you will be asked to provide letters of intent from them in a later section.

If you have selected that you will only be implementing interventions with Medicare Fee-For-Service beneficiaries, you will be asked to complete the section shown on the screen now to describe your plans for implementing interventions in that population. Please note that you will also need to describe how you will identify Medicare Fee-For-Service beneficiaries by coverage status.

The next section of the application is that of the “Patient-Centered Design.” Another important goal of the ET3 Model is to provide the most appropriate care at the most appropriate time and place for each individual patient. The design of the model inherently puts patient-centered, quality care at the center. Therefore, we ask all Applicants to design their interventions such that they ensure patient-centered care.

The ET3 Model should be implemented in such a way that beneficiaries are getting the care they need and want, in the location that is most appropriate and desired by the beneficiary. This right time and place of care, which offers beneficiaries more options, provides them with more opportunity to have greater control over their care.

The ET3 Model intervention design should emphasize shared decision making with the beneficiaries and/or families or caregivers, ensuring that their preferences and choices are valued, and that appropriate care is provided in alignment with state and local requirements and Medicare necessity requirements. In your application, you will demonstrate the capability to communicate effectively in-person at the scene and throughout the delivery and coordination of the ET3 Model interventions.

In this section of the application shown below, you will describe your current patient-centered design policies that are aligned with, or will become aligned with, your proposed ET3 intervention design. You will need to describe your overall plans for incorporating shared-decision making into your care, including for patients, family members and caregivers who may have communication limitations such as low literacy or health literacy or limited English proficiency. You will also need to describe how you will inform patients, family members, and caregivers about the ET3 interventions on the scene of the 911 call.

The final section of the application is the “Letters of Intent” page.

In this section of the application you will be submitting Letters of Intent from formal partners who have agreed to participate as your partner in the ET3 Model. Please note that these Letters of Intent are not required and should only be submitted for partners who have already agreed formally to the partnership. We anticipate that by the close of the application not all potential partnerships will be formalized. You may continue to solidify partnerships after the close of the application period, but must provide a timeline of when these partnerships will be formed as part of your application.

In the section of the application shown on the slide below, you will see that you have the ability to upload any letters of intent that you have acquired from formal partners, whether they be treatment in place providers, alternative destinations, or other payers. As stated, these LOIs are only for partners who have agreed to a formal partnership at the time of application and thus they are not required.

Depending on answers to previous sections, some of the buttons in this section may not be functional for you. For example, in the “Treatment in Place Intervention” page, if you had suggested that you will not be implementing this intervention, you will not have an ability to upload an LOI for the treatment in place section of this page.

If you believe you should be able to complete a section and you cannot, you should refer back to previous questions to identify if you need to change any previous selections.

Following completion of all sections of the ET3 Model application, you will be navigated to the certify and submit page, where you will attest to the fact that all information provided is accurate to the best of your knowledge.

The ET3 Model Team would also like to note that if a third-party entity is submitting this application on behalf of a potential Participant, that information be provided on the third-party entity on this page.

Thank you for joining the webinar today. Resources and contact information for the ET3 Model are available on the slide displayed. The information presented today in the webinar will be available in a written format on the ET3 Model website shortly after the webinar ends. Any questions about the model or the application can be directed to the model team through the email address listed on the slide. The ET3 Model would just like to emphasize that when reaching out with any questions related to the application, please include in the subject line of the email “application assistance.” Thank you very much for joining today and for your interest in the ET3 Model and we look forward to your application.