ET3 Model RFA Webinar

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Recording Transcript

Hello and welcome to the Emergency Triage, Treat, and Transport or (ET3) Model Request for Applications Webinar. My name is Carlye Burd and I am the program lead for the ET3 Model and I'm going to be leading the presentation today.

This webinar will walk you through important components of the recently released RFA and then allow a good chunk of time for question and answers on RFAs. I wanted to note that we at CMS have released the RFA as a pdf preview, but we will be opening an online portal where ambulance suppliers and providers will submit their actual applications to CMS in order to participate in the model later this summer. So, the current RFA online is the preview, and there's no current way to send your application to CMS at the time, stay tuned, in a couple of months we will open up that application portal.

The topics today that we're going to cover in this webinar, include a brief overview of the ET3 Model and its goals. If any of you have attended the previous webinar, you'll recognize some of the slides that we're using. We're actually going to go to the RFA itself and walk through the document highlighting participant eligibility requirements, model payment structure and the application process and timeline. The focus of this webinar will be the highlight sections of the RFA that cover these topics in ET3 and also how payments will work under the model. We will leave plenty of time for question and answers to cover these, or other sections in RFA that won't be covered in as much detail during the presentation.

To begin, we're going to briefly review the goals and structure of the ET3 Model. If you have not done so already, you should definitely check out our website for all of the materials including the previous webinar that goes into more detail on high level overview of the ET3 Model as well as fact sheets and FAQs. These materials can help you prepare to submit your application.

In the current state of ambulance services, an individual calls 911 and an ambulance is often dispatched to the scene regardless of acuity and once there, either transports the individual most often to the emergency department or the ambulance does not transport the individual. This chart really represents that flow of activities that currently exist.

Now Medicare only covers emergency ground transportation when Medicare beneficiaries are transferred to a limited number of covered destinations such as emergency departments within a hospital. That's the most common destination currently for a patient to be transported. This creates the perverse incentive to always bring beneficiaries to higher acuity, high cost settings, even when a lower acuity, lower cost setting or treatment plan might be more appropriate to meet an individual's needs.

In the future state that is envisioned by the model, the ET3 interventions would realign these incentives and create some flexibility for ambulance care teams to address emergency health care needs of Medicare beneficiaries following the 911 call. The model design offers new options for individuals making a call to 911. Firstly, someone who calls 911 with a low acuity condition may be triaged to discuss their concerns with a qualified health practitioner. This could result in a referral back to see the doctor or could result in being triaged back to the 911 dispatch and an ambulance

service initiated. If initiated, the ambulance arriving at the scene has two options to either transport the individual or not transport them.

An individual could be either transported to the emergency room as a standard under the Medicare Fee-for-Service fee schedule or be transported to an alternative destination under the ET3 Model. Alternatively, an individual could receive treatment in place by a qualified health practitioner either on-site where they are or through telehealth. Treatment in place, in this option would always involve a Medicare-enrolled practitioner either on-site or through telehealth. To support that ability for participants to provide treatment in place under the ET3 Model, we are issuing a waiver and this is talked about in the RFA. This will allow for the use of telehealth in areas not typically covered such as non-rural locations.

I wanted to note a really important point here. All of these new options that are shown in the blue boxes, these options would follow a clinical protocol that would have to be approved by an ambulance service medical director. So these new options definitely will have to go through the same type of rigorous protocol development that currently exist and are overseen by medical directors.

Within the model, Medicare test two new payments to participants in the model. One is for payments to transport Medicare beneficiaries to alternative destinations, and the other is payment for treatment in place where appropriate. So that's represented by those two boxes at the bottom. Those two payments are talked about in great detail in this RFA. Those interventions, either treatment in place or transport to an alternative destination will be provided by the applicants that are applying to the RFA that was released.

The box up on the upper left-hand corner, which represents the medical triage line that is actually a separate arm of the ET3 Model that will be handled through a Notice of Funding Opportunity, which will be released later this fall. The RFA doesn't touch on that box on the triage line, it really focuses on applicants for the ET3 intervention for treatment in place and transport to an alternate destination. I just wanted to make that point here and we'll talk about that a little bit more on the next couple of slides.

We're going to start by discussing what potential applicants should consider before submitting an application to participate in the ET3 Model, such as eligibility requirements for both applicants and their non-participating partners—so those partners that are either providing alternative destinations or the treatment in place. There are two types of organizations that have the opportunity to apply to participate in the ET3 Model as I was just mentioning. The first is Medicare-enrolled ambulance suppliers and providers and they can apply to be participants through the RFA that has just been issued. Later this year, local governments or other entities that operate 911 dispatches will be able to apply for a funding opportunity for a triage line through the NOFO (through a Notice of Funding Opportunity) in the areas that ambulance providers have been selected as ET3 Model participants. It's important to note here again, this RFA will not accept applications from 911 dispatch systems. This RFA is solely for the ambulance service providers and suppliers that will be providing the ET3 treatment in place or alternate destination intervention.

Before I move on to the specific eligibility requirements, I wanted to mention a few points about overall eligibility. Medicare-enrolled ambulance suppliers or hospital-based ambulance providers are the types of providers that will be eligible to apply through the RFA to participate in the ET3 Model. This is a national model, so ambulance providers across the country that meet eligibility

criteria are encouraged 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 and treatment in place providers. These are not the types of providers that will apply for the RFA. They will be partners to applicants, to the ambulance suppliers and providers, but urgent care centers, for example, or group practices that decided to take on patients as an alternative destination those are not the types of entities that will apply to CMS for this model. The ambulance service provider will partner with those types of entities and include their information in their application to CMS. We will discuss more about these non-participant partners later on in this presentation.

Okay, so now we're going to go to the actual RFA itself and we're going to start on Page 7 and this is where the RFA talks about some of the overarching application requirements and participant eligibility. Here in this section, the RFA lays out that at a minimum, applicants must partner with and offer transportation to at least one alternative destination site. Applicants can choose whether or not they also implement the treatment in place option. This option is not required to apply, but preference will be given to any applicants who proposes to offer both options. So that means if an applicant is offering both alternative and treatment in place options, they will be awarded extra points in the scoring of the application. Applicants must also propose a plan where at least one option will be available 24 hours a day. This could be either an alternative destination site or treatment in place.

This 24-hour coverage can be made from a combination of different services and options. So for example, an urgent care center that is open till 11:00 PM and a treatment in place provider could cover the overnight hours after 11:00 PM until the physical urgent care site is open the next morning.

Now we're going to talk about the regional eligibility requirements. Applicants will need to propose a region they will serve based on a county, counties or equivalent entity. This doesn't have to be one county, two counties, it can be a proposed region that the applicant is serving. The proposed model region must be located in a state or states where at least 15,000 Medicare ambulance transports have occurred in the 2017 calendar year. We did post a data table on our website that lists the estimated number of transports per county and per sate that we will navigate to in just a second here so I can show you that table. If an applicant proposes a region that includes more than one state, each state must meet that threshold—so must meet that 15,000, Medicare Fee-for-Service transport in 2017 threshold. Preference will be given to applicants who proposed the region that includes at least one county or county equivalent where at least 7,500 transports have occurred in the 2017 calendar year.

Now let's navigate and I'll show you where this data table is on the ET3 website. Here is a screenshot of our website where we're highlighting where the links to the data table is. If you click on that link, it will open up a very long pdf that has two tables. The first table is a list of all 50 states and territories and the numbers of Medicare Fee-for-Service transport that have that been estimated for 2017 and below that table is a list of all the transports by county. Using this table, let's go through an example. Let's say that you're interested in applying to implement the ET3 Model in and around Kansas City, which straddle two states; Kansas and Missouri and you would like to include counties in both states.

The first thing you would need to do is ensure that both Kansas and Missouri meets the 15,000 Medicare ambulance transport threshold, which according to this table they do. Then in identifying

the specific counties you'd like to include, you should also look at the number of Medicare transports in each individual county you intend to include. You might want to consider including the county on your application that meets that 7,500 transports per county threshold to increase the strength of your application. So again, that 15,000 per state transport threshold is a requirement, but that 7,500 transports per county threshold is not a requirement. It's simply something that can help strengthen your application.

We now are going to navigate to Page 8 of the RFA which goes over the requirements for non-participating partners. This is the section of the RFA that speaks to the partnering organizations in the model. As we previously mentioned, participants, which are the ambulance suppliers and providers, are required to offer at minimum transport to an alternative destination as part of this model. For alternative destination sites ambulance service suppliers and providers can partner with both Medicare-enrolled providers such as a hospital that has a walk-in clinic or a group practice that works within an urgent care center.

In either scenario the downstream practitioners that service the beneficiaries at an alternative destination site must be enrolled in Medicare. For treatment in place interventions, a participant must partner with individual Medicare-enrolled qualified health practitioners. Paramedics and EMTs are not considered qualified health practitioners who can offer reimbursable treatment in place. Treatment in place can be provided either on-site or through telehealth and if providing care via telehealth participants must use a qualified health telehealth communication system which is defined in the RFA as a multimedia communication equipment that includes at a minimum audio and video equipment permitting two-way real time interactive communication between a patient in a distance site physician or a practitioner.

As previously mentioned the ET3 Model is issuing a waiver which allows beneficiaries to repeat telehealth in originating site other than those listed in the regulations in non-rural areas. Applicants will be required to demonstrate that their proposed partners either alternative destination sites or treatment in place providers have the ability and capacity to serve Medicare beneficiaries and the capacity to bill Medicare for services. Lastly, as part of the application, applicants will need to describe their relationship to each partner and submit written consent to CMS documenting that each partner is willing to participate in the ET3 Model as partner.

Now we're going to go back to the slide deck where we're going to talk through some high-level points about the model team and structure before going back to these aspects of the actual RFA. Just to overview the ET3 Model payment, there will be new payments under this model for transport to an alternate destination or for providing treatment in place. The goal here is to make the payments for transport to an alternate destination or treatment in place equal to the payment the ambulance provider would receive if they had brought them to the emergency department. The idea here is to realign the payments so that there is no longer an incentive to always bring someone to the emergency department even if their condition doesn't warrant it.

It is important to note here that the ET3 Model will apply Medicare's medical necessity requirements still for Part B ambulance services, transportation to an alternative destination and Medicare ambulance suppliers or providers will receive better care payment for transport to alternative destinations if they don't meet that medical necessity requirement. We're happy to answer any questions about that. I think there has been quite a few stakeholder questions that we've received about that one. In addition to the new payment to participants for transport to alternative destinations and treatment in place, there will also be a performance-based payment

adjustment within the model for achievement of key quality measures. These will not be implemented until after the first couple of years of the model.

We would also like to note that while this is a Medicare payment model, we do encourage participants to engage other payers in their service area to increase opportunity for success in this model. As part of the RFA, applicants will be required to describe their strategy for engaging other payers in their region or they will have to explain how they will successfully implement the model within Fee-for-Service Medicare beneficiaries only.

Now we'll navigate back to Page 10 of the RFA where we discussed the model payments. As I mentioned, there's going to be two new Medicare payments available to participants. There will be a payment for transport to alternative destinations and a payment for treatment in place. If we scroll down to the payments to participants section: A participant that transports a beneficiary to an approved alternative destination through the model will bill and receive a payment that is equivalent to the Medicare Part B ambulance fee scheduled base rate for emergency basic life support, otherwise known as the BLS-E ground ambulance rates. This is currently billed under HCPCS Code A0429. But there will be some billing instructions that we will release later this year or early next year that will help guide the ambulance suppliers and providers in how they should bill for these services. The important thing for you to know is that BLS rate will be the equivalent rate for BLS services.

We have also included emergency advanced life support Level 1 ALS1-E ground ambulance rate so either the BLS-E rate or the ALS1-E rate can be billed for transport to alternative destination where appropriate. The appropriate payment rate is based on the existing definitions of BLS-E and ALS1-E services. In order to bill at the ALS1-E level, a participant must render services that meet the Medicare definition of advanced life support, including transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, including the provision of an ALS assessment by ALS personnel or at least one ALS intervention.

In other words, if transport to an alternative destination does occur, but prior to that, at dispatch, it was determined that the condition that the individual had when they called 911 met the criteria to dispatch at an ALS level and the ALS assessment was provided and all of the other requirements were met to bill for ALS, but then the patient was transferred to an alternative destination then the ambulance supplier provider can bill at that ALS1 rate. Alternatively, if BLS services are provided and then the individual is transported to an alternative destination that BLS rate applies.

The model participants will also receive payment for treatment in place intervention either in person or through telehealth should they choose to implement that intervention. If you recall earlier in the presentation we talked about how alternative destinations are required for all applicants, but treatment in place is not required, although it is strongly encouraged for applicants to propose treatment in place. For treatment in place a participant that facilitates this type of service will be paid at an amount equivalent to that BLS-E or ALS1-E base rate. In order to bill for the ALS rate, a participant must again provide medically necessary type of services that meet those ALS requirements by an ALS personnel with the provision of at least one ALS intervention. Of course for treatment in place transport is not happening so mileage is not paid for treatment in place. A participant that facilitates treatment in place via telehealth will be paid at a modified telehealth rate equivalent to either the BLS-E or ALS1-E base rate depending on the level of service provided. As we discussed earlier all treatment in place interventions must be provided by a qualified health practitioner that is enrolled in Medicare.

Now we'll talk about the non-participant partners and the payment that they would receive under this model. Now we're not developing new payments for the non-participating partners, these payments will be for the services that either the alternative destination providers render or the services rendered by the treatment in place providers. To receive payment at an alternative destination site, providers will bill using their applicable HCPCS Codes for the service furnished at the site as part of ET3 intervention. These services and the billing will be pursuant to the Medicare Fee-for-Service rules.

Similarly, to receive a payment as a qualified health practitioner that is providing treatment in place through telehealth or in person will also bill for Medicare payment using the applicable HCPCS Code for the services furnished pursuant to existing Fee-for-Service rule. Non-participant partners are also eligible for an upward of payment adjustment for services provided during non-business hours. We also wanted to note that the legal and financial relationship between the participant in an alternative destination site or treatment in place practitioners is governed by independent agreements between the two parties and are subject to all the existing laws including federal fraud and abuse laws.

Now we're going to navigate to Page 12 of the RFA. There are two key payment adjustments under the ET3 Model. One is for the qualified health practitioners who have partnered with model participants and the other is for the ambulance suppliers and providers themselves. Any qualified health practitioner that provides services either within the treatment in place intervention either through telehealth or on-site or at an alternative destination and who provides these services between 08:00 p.m. and 08:00 a.m. local time will receive a 15% increase in the rate that is billed for that service by submitting a claim with the model specific modifier associated with an after-hours payment adjustment.

This is applicable to any of the Medicare-enrolled qualified health practitioners who are servicing beneficiaries in the model under either an alternative destination or treatment in place either in person or through telehealth and that is a 15% after-hours payment adjustment between 08:00 p.m. and 08:00 a.m. The second payment adjustment is for model participants that demonstrate high quality care based on performance metrics. This is the performance-based payment adjustment. Participants may be eligible for up to a 5% upward adjustment for their payments for treatment in place or transport to an alternative destination based on their performance in the previous year. This would be a 5% upward adjustment to either that ALS or BLS rate that they bill for either providing treatment in place or providing transport to an alternative destination. These performance-based payment adjustments will not begin until at least year three of the model, so we're not going to go into great detail about them during this presentation.

Now we'll navigate back to the slide deck. We wanted to discuss timeline and the actual process and scoring criteria for the application itself. Again, we didn't go over all of these sections of the RFA, but we are happy to answer any questions as we feel like we tried to highlight the most important parts of the section that will get potential applicants prepared to submit their application.

We will be putting together another webinar after the application is released. That will be more tutorial version and we'll walk ambulance providers and suppliers through the application itself.

All right, so here we're going to go over a quick timeline, high level. The RFA for the first round of the applications was released on May 22nd and can be found on the ET3 website. The application

portal for the RFA will open later this summer and we anticipate collecting and announcing participants this fall. Separately, the Notice of Funding Opportunity will be released in the winter time after the ET3 Model participants are announced. We anticipate the model going live in January 2020.

Now we'll navigate back to the RFA and cover some key details of the application process for ambulance suppliers and providers. We do anticipate that there will be up to three rounds of applications and each one will have its own respective application process. This round taking place this summer will be the first, any additional rounds wouldn't take place until after the end of the first round. Part of the application you will need to identify all proposed partners that you have already established relationships with for this model. Any alternative destination sites or treatment at place providers that applicants already have existing relationships with will have to be disclosed as part of the application and we will also need a letter of intent. It is still possible to apply for the ET3 Model if those relationships haven't been established, but then you need to provide us with a timeline of when you will establish those relationships. You'll also need to provide additional information for any alternative destinations sites that are not currently enrolled in Medicare as part of the vetting process and there is more information and details on that at the end of the RFA.

Now we're going to navigate to Page 24, this is where we list out some of the application review criteria which are keys to your drafting of application. We plan to establish guidelines for reviewers to prioritize applications and use a standardized approach to assessing all applicants. There is a list of key components that will be considered and these are found on Page 25 of the RFA. The key application criteria are listed here. I'm not going to walk through them and read them to you, but just keep those in mind as you prepare your organization for your application. More detailed descriptions of these criteria and how they will be weighted is found between Page 26 and 33. We really recommend that you review that section carefully as you begin to create plans for the application and again as you draft the application itself.

So now navigating back to the slide deck, there are several steps that you can take now to start preparing your application. First you can determine which model interventions are viable options for your organization. For example, what resources are available in your area for either alternative destination sites or treatment in place, how can you ensure that at least one option is available 24/7 which is the key requirement under this model, and who are you partnering with already. We suggest that you start identifying and talking to partners now because getting information from them such as letters of intent and other demographic information on where they're located, and their business name, and identifying numbers will be required as part of the application. You should also start talking to payers in your region now to potentially create aligned ET3 interventions that are covered under the payers that you are currently contracted with.

Lastly, you can sign up for upcoming ET3 Model webinars including a tutorial that we will be doing after the online portal opens up. These links to register to the webinar will be on the model website as well as sent through our listserv which you should, if you haven't already, sign up for on our website.

So, in summary, during today’s webcast, we reviewed some of the key elements of the RFA, such as the purpose and goals of the ET3 Model, the payment model for ET3 participants, which provides a new payment for both transportation to alternative destination and for treatment in place. We reviewed the condition of participation including eligibility considerations, and the interventions

that participants will offer as ET3 participants. And finally we went over the application process and reviewed criteria including where to find details on the application criteria in the RFA.

The ET3 Model is an exciting addition to the Center for Medicare and Medicaid Innovation Payment Models, so we are really thrilled that you joined us today and we hope that you hope to continue to engage with us in through future webinars. And definitely use the website as a resource. There is a list of links at the end of the slide deck that can take you to frequently asked questions, the RFA itself, and how you can sign up for our listserv and email us if you do have questions that can't be answered through materials on the website.

I also want to remind you to please take the post event survey. We really really appreciate your feedback on whether this webinar was helpful and what we can do to make future webinars better.

So, thanks again for participating and we hope to see you at our next event.