National Association of Emergency Medical Technicians
Post Office Box 1400 * Clinton, Mississippi 39060-1400
Phone: 800-34-NAEMT or 601-924-7744 * Fax: 601-924-7325
Website: www.NAEMT.org

November 11, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
P.O. Box 8016
Baltimore, MD
21244-8016

On behalf of the National Association of Emergency Medical Technicians (NAEMT), please accept these comments in response to CMS' comment solicitation for information on the proposed rule: *Medicare Program; Request for Information Regarding Implementation of the Merit Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models.*

NAEMT recommends that the Merit-based Incentive Payment System (MIPS) incentivize Eligible Professionals (EPs) under the Physician Fee Schedule (FPS) include incentives for the use of EMS-based Mobile Integrated Healthcare-Community Paramedicine (MIH-CP) programs to reduce preventable Emergency Room visits, reduce preventable hospital admissions and, in general, meet the goals for the patient and community as articulated in the Institute for Healthcare Improvement's Triple Aim.

Historically, EMS is only paid as a transportation benefit if the patient requires medically necessary transportation and is transported to a covered destination. This creates a perverse incentive for EMS to use the highest cost transportation resource, to transport the patient to the highest cost care facility, and Emergency Room. This incentive may also prevent appropriate care coordination due to the patient being treated by an emergency physician with little knowledge of the patient's medical history as opposed to referring the patient to the patient's medical home when clinically appropriate.

A recent study conducted by the RAND Corporation, in partnership with HHS and published in Health Affairs[1], identified that if EMS agencies were provided the opportunity to transport low-acuity patients to clinically appropriate destinations other than the Emergency Room, the savings to the Medicare program would be $250 million to $500 million annually.

Further, the Journal of the American Medical Association (JAMA) published an editorial supporting alternative payment models for EMS to help reverse the incentive for EMS to transport every patient possible to the Emergency Room simply to be eligible to be paid for the service[2].

Over the past several years, a growing number of emergency medical service agencies have been working collaboratively with local healthcare stakeholders, including primary and specialty care physicians and EMS physician Medical Directors, on programs that support the Institute of Healthcare

[1] doi: 10.1377/hlthaff.2013.0741; HEALTH AFFAIRS 32, NO. 12 (2013): 2142–2148
[2] JAMA, February 20, 2013 – Vol 309, No. 7

Improvement's Triple Aim of improved patient outcomes and satisfaction, and improved population health.

These programs, usually referred to as *Mobile Integrated Healthcare, or Community Paramedicine* (MIH-CP), have been launched across the country by EMS agencies working collaboratively with hospitals and other healthcare providers in their communities to address over-use of emergency rooms, reduce preventable hospital readmissions, and manage chronic illness. Many of these programs have experienced measured success in all types of demographic environments. Further, CMS, through the CMMI, has funded six Healthcare Innovation Award grants that include the use of MIH-CP programs.

Additionally, the Agency for Healthcare Research and Quality (AHRQ) has profiled several of the EMS-Based MIH-CP programs in their Healthcare Innovations Exchange[3,4,5] and Dr. Donald Berwick, in announcing his new Healthcare Leadership Alliance, referenced community paramedicine as a productive new healthcare role[6].

With over 50,000 members, NAEMT is the nation's only organization solely dedicated to representing all EMS practitioners, including paramedics, emergency medical technicians, emergency medical responders and other professionals working in prehospital emergency medicine. NAEMT members work in all sectors of EMS, including hospital-based ambulance services, government service agencies, fire departments, private companies, industrial and special operations settings, and in the military.

NAEMT has joined several other organizations, including the American Ambulance Association, the National Association of EMS Physicians, the American College of Emergency Physicians, the International Association of Emergency Dispatchers and the National Association of State EMS Officials to support the development of these grassroots innovations in patient care.

We encourage CMS to include EMS based MIH-CP in the Alternative Payment Model proposed rule for *Merit Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models.*

We would be excited to work with CMS to develop alternative payment models for EMS to further CMS' goal to move providers to value-based, outcome driven economic models.

Sincerely,

Conrad "Chuck" Kearns, MBA, Paramedic, A-EMD
President, NAEMT

[3] https://innovations.ahrq.gov/profiles/trained-paramedics-provide-ongoing-support-frequent-911-callers-reducing-use-ambulance-and

[4] https://innovations.ahrq.gov/profiles/specially-trained-paramedics-respond-nonemergency-911-calls-and-proactively-care-frequent

[5] https://innovations.ahrq.gov/profiles/data-driven-system-helps-emergency-medical-services-identify-frequent-callers-and-connect

[6] http://jama.jamanetwork.com/article.aspx?articleid=2210910