

TURNING THE CORNER

New economic models are changing the face of EMS delivery

By Matt Zavadsky, MS-HSA, NREMT, Chris Cebollero, & Jay Moore, MD

It's taken more than 20 years, but it seems EMS has finally turned the corner on the vision imagined by the authors of the preamble for the EMS Agenda for the Future, written more than 20 years ago. They predicted a future where EMS is key to "community-based health management that is fully integrated with the overall health care system."¹

Although the authors note that EMS remains the public's emergency medical safety net, EMS agencies would also have the "ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to the treatment of chronic conditions and community health monitoring."¹

Thanks to the hard work of innovative EMS agencies—large and small, public and private—and key industry associations like NAEMT, NAEMSP, ACEP and the IAFC,

healthcare payers have begun to see the true value EMS brings to the table.

A representative pivot point to this realization occurred on Dec. 13, 2017, when *JEMS* hosted the first EMS webcast sponsored by a commercial payer, Anthem Blue Cross and Blue Shield.

Not surprisingly, the title was "New Payment Models for EMS," and was facilitated by Jay Moore, MD, from Anthem, Chris Cebollero from Cebollero and Associates, and Matt Zavadsky, MS-HSA, NREMT, from MedStar Mobile Healthcare.

The webcast came on the heels of the October 2017 announcement that Anthem would begin paying EMS agencies for healthcare common procedure coding system (HCPCS) code A0998: Ambulance response and treatment, without transport.

This code has existed for years, but because the 1965 Medicare statute includes ambulance

transportation as a covered benefit, Medicare and most other payers, generally don't cover an ambulance response that doesn't result in a transport.

The webcast covered not only the strategy being implemented by Anthem, but the reasons for the decision, and a discussion on the regulatory changes that may (or may not) need to happen to implement this revolutionary new EMS payment model.

After 60 minutes of presentation and a question and answer session, there were several questions left unanswered, so the presenters offered to publish the answers to some of the most commonly asked questions in *EMS Insider*.

Why is Anthem doing this?

Jay: For 40 years, payers have incentivized EMS to use the "you call, we haul" method of EMS services by only paying for the transport. Many of the patients assessed and treated by EMS don't need care in an ED.

A recent analysis by ACEP revealed that 17% of the patients brought to an ED are brought there by EMS, and 61% of these patients are treated and released from the ED.

Many patients can be more appropriately treated in alternate, more patient-centered settings like urgent care or primary care.

Anthem believes that if we de-couple payment from transport, it allows EMS personnel to help patients make informed, patient-centered medical care decisions based on clinical need—without having to rely on transport to an ED as the basis for payment.

We believe that you should be paid for the care you deliver, not whether or not you transport someone to an ED.

How did Anthem determine the reimbursement rate for A0998?



Anthem believes that if we de-couple payment from transport, it allows EMS personnel to help patients make informed, patient-centered medical care decisions based on clinical need. Photos courtesy Matt Zavadsky

Chris: Anthem will reimburse EMS at 75% of the state average of the allowed payment for all ambulance trips.²

Let's use Missouri as an example: The state average allowed amount for an ambulance trip is \$688—that includes ALS, BLS, emergency and non-emergency. Seventy-five percent of \$688 is \$516.08, the amount allowed for the A0998 payment.

This basis considers regional variations, such as the geographic practice cost index that Centers for Medicare and Medicaid Services (CMS) uses for the ambulance fee schedule. It costs more to provide EMS service in California vs. Mississippi, and this methodology accounts for those variations.

Are regulatory changes needed for an EMS agency to do this?

Matt: As with most transformational things in EMS, it depends. Generally, patients have the right to refuse transport to an ED, but EMS is typically not reimbursed for the refusal against medical advice (AMA). Under this model, you can bill A0998 and get paid.

Many EMS agencies have protocols that don't allow the EMS provider to initiate the conversation about alternate destinations for

a 9-1-1 patient, and some states have regulations about this as well. Historically, this is because the transport economic model didn't encourage EMS agencies, medical directors or regulators to do anything different.

In this model, we can offer options to patients who meet clinical eligibility guidelines as established by the medical director. This may require some regulatory and statutory changes.

How will patient safety and quality be assured?

Jay: EMS agencies should have already established patient safety and quality metrics for patients who are treated and not transported.

For example, if a patient AMAs, do you end up responding to the same patient within 24 hours for a related complaint? Did the patient have any other adverse outcome as a result of the AMA?

In this new payment model, we would expect the EMS agency and the medical director to expand that quality assessment process.

If the patient was referred to an urgent care or primary care center, did the patient end up at an ED within six hours? Was there any other adverse outcome?

We're encouraged by the group of EMS innovators working on national outcome measures for ambulance transport alternatives, and we anxiously await the release of the measures they develop regarding patient safety and quality.

Can these payment models be used by other payers?

Chris: Most certainly! Anthem is breaking the mold for EMS reimbursement by taking this comprehensive approach across the 14 states where they operate, but we anticipate other payers to follow suit.

In fact, more than 10 years ago Medicare began paying for cardiac arrest patients who are treated and pronounced dead on scene.

Conventional wisdom tells us this was adopted by Medicare to avoid the incentive for EMS transport to an ED—and CMS incurring the ED expense—for a patient who had no chance of survival.

One of the most innovative payers in the country, Medicaid, has begun reimbursing for mobile integrated healthcare (MIH) services in states such as Minnesota, Nevada and Idaho. Any payer who recognizes the value of this type of model can reimburse for it.

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Are there other economic models being tested by commercial payers?

Matt: Yes. In addition to the models mentioned already, MedStar is implementing a model with another commercial payer, and a managed Medicaid payer, to pay a capitated, per member, per month (PMPM) fixed rate for their members in our service area. The PMPM covers traditional ambulance and MIH services.

This allows us to use all our MIH strategies (9-1-1 nurse triage, community paramedicine and ambulance transport alternatives) to help navigate patients to the most appropriate healthcare resource based on their clinical need—not based on whether or not we transport them to an ED.

Additionally, a managed Medicare payer is working with us to implement a regional MIH program to manage high utilizer members in their network. That model will pay MedStar a monthly fee for each high utilizer enrolled in the program.

How can we learn more about how to approach payers in our community about changing the EMS economic model?

Matt: First, keep reading *JEMS* and EMS Insider for updates. The National Association of EMTs has developed numerous resources to help the EMS transformation.

Their website (www.naemt.org) has an EMS 3.0 resource section that contains value statements for discussions with commercial payers, accountable care organizations (ACOs), hospitals, home health agencies and other stakeholders. The NAEMT will also be hosting their next EMS 3.0 Transformation summit on April 10, 2018, in Washington, D.C., as part of the EMS on the Hill Day. **JEMS**

REFERENCES

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Chris Cebollero is a senior partner at Cebollero and Associates, a medical consulting firm. He previously held leadership positions in several EMS organizations throughout the U.S. Since 2015, he has helped develop and implement a number of community paramedic programs around the country.

Jay Moore, MD, is the senior clinical officer for Anthem. Prior to joining Anthem, he was the vice president of medical affairs and chief medical officer of SSM DePaul Health Center.

