Please Support Medicare Reimbursement for EMS Treatment in Place (TIP)

REQUEST
Please support H.R. 2538, the Comprehensive Alternative Response for Emergencies (CARE) Act, sponsored by Reps. Mike Carey (R-OH), Lloyd Doggett (D-TX), Carol Miller (R-WV), and Pat Ryan (D-NY). This bill would create a pilot program to test and evaluate the Treatment in Place (TIP) model under the Center for Medicare and Medicaid Innovation (CMMI).

BACKGROUND:
The goal of all healthcare should be to provide patients with the right care, at the right time, and in the most cost-effective manner. The historical payment model for EMS contradicts this goal by only reimbursing EMS if the most expensive means of response and transport – an ambulance – is used to take patients to the most expensive setting – the emergency department.

Unfortunately, Medicare currently does ***not*** reimburse EMS practitioners for TIP. EMS is only reimbursed for care when a patient is brought to the hospital. The hospital emergency department is one of the most expensive places to receive care, with recent estimates of $2,500-$5,000 per visit, many times the amount it would cost to treat non-emergent patients in place. However, the current Medicare economic model incentivizes EMS transportation to a hospital emergency department, even when a less expensive level of care is appropriate.

Many patients who call 9-1-1 have non-emergency medical conditions that do not require transport to the emergency department and could be more appropriately managed on-scene, potentially in conjunction with a telemedicine physician or a subsequent referral to a primary care physician. Payment for TIP will allow EMS agencies to implement patient-centric protocols for patients who use the 9-1-1 system but have conditions that can be treated in the comfort of their home. This is especially important for people with disabilities and mobility limitations whose lives are upended when they must go to the hospital. TIP can facilitate referral of care to the patient's own caregivers, who know the patient and their medical history, as opposed to emergency department staff who typically do not know much about the patient.

TIP will also shorten task times for EMS agencies struggling with workforce shortages, help decompress overcrowded hospitals and emergency departments, and meet patients' needs without long waits at the hospital. Many hospitals hold EMS personnel for hours waiting for an available bed in the emergency department, keeping EMS responders from getting back into service and ready for the next emergency in the community.

To learn more or to cosponsor the CARE Act, please contact Emily Graeter in Rep. Carey's office at Emily.Graeter@mail.house.gov or Afton Cissell in Rep. Doggett's office at Afton.Cissell@mail.house.gov.

ADDITIONAL INFORMATION:

Reimbursing EMS agencies for TIP will save Medicare billions of dollars

CMS issued a waiver for ambulance services to allow for treatment reimbursement in lieu of transport during the COVID-19 public health emergency. Medicare also paid for TIP during the Emergency Triage, Treat, and Transport (ET3) demonstration program. These opportunities gave EMS the flexibility to navigate patients to the right care in the right setting, and the results were very promising.

An external analysis of the CMS ET3 TIP model identified an average net savings to Medicare of $537.51 for each patient encounter when a patient was treated in place instead of being transported by ambulance to the hospital emergency department.

Medicare beneficiaries make up about 40% of patients treated by EMS and between 12.9 and 16.2% of Medicare-covered 911 transports involve medical conditions that do not require a hospital ER visit.[1] Using those figures, NAEMT estimates between 2.17 and 2.82 million emergency department visits by Medicare beneficiaries each year would be potentially eligible for TIP, saving Medicare between $1.5 and $1.95 billion annually.

[1] "Giving EMS Flexibility in Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings," *Health Affairs* December 2013, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0741