Thank you to our sponsors
Welcome

**Introductions**
- In-person & Web Ex participants

**Goal**
- Collaborate and optimize our ability to influence Medicare’s future reimbursement model

**Overview**
- Share the Work Group’s efforts to date

**Dialogue**
- Voluntarily agree on Medicare payment reform structure; interest-based negotiation addresses all parties interests
Why are you here?

- Influence, Knowledge, Expertise
- Thought-leader regarding future of EMS
- Understanding of stakeholders impacted by Medicare reimbursement
Work Group
How did this project start?

- Volunteer subject matter experts in reimbursement, clinical & research, finance & accounting, small & rural provider, innovation, public policy, EMS system design, revenue cycle management, MIH

- Larry Clark
- Deb Gault
- Jimmy Johnson
- Asbel Montes
- Mike McEvoy (invited)
- Kevin Munjal, MD
- Vince Robbins
- Brenda Staffan
- Jonathon Washko
- Matt Zavadsky
Who is impacted?

- EMS Providers
- EMS Personnel
- Hospitals
- Physicians
- Nurses
- EDs
- Payers

Patients & Public
What problem are we trying to solve?

- Below-cost Medicare & Medicaid reimbursement
- Misunderstood value proposition; treated as commodity in Medicare & Medicaid payment policy
- Safety net provider status; unresolved uncompensated care
- Not enough focus on EMS workforce concerns
- High cost drugs/technology not funded
- Funding for current EMS system components beyond ambulance transport (such as first response & medical direction)
- Funding for evidence-based innovations beyond transport
Issues Requiring Dialogue & Consensus

- Scope of Practice = Expanded Role versus Expanded Scope
- Role of Medics Outside EMS System = Sole Provider versus member of Care Coordination Team
- Rural Health Care Challenges & Rural Reimbursement Options
- Funding for EMS Medical Director/Medical Direction; Role of physicians, physician assistants and nurse practitioners in the EMS system
- Treatment without Transport, Treat/Release, Treat/Refer, Treatment in Place
- Definition of Global Budget = Factoring in Bad Debt, Memberships, Local Tax Support
- Funding for High Cost Drugs & Technologies
- New Services & Service Levels = Community Paramedic, Nurse Triage, Alternative Destination, NP/PA Staffed Ambulances, Others?
- Workforce Development/Resiliency Issues
- Model Differences Associated with Provider-type Specific Innovation
- Assembling the Evidence-base for Alternative Solutions
Are there unintended consequences of our actions?

- Lose the Medicare add-ons
- Lose principle of prudent layperson definition of emergency
- Rejection of uncompensated care/safety net issues
- Loss of cost shift to commercial insurers
- Increase in medical necessity denials
- Rates are cut/overall funding is lower
- Lose credit for innovation savings
- Medicare never modernizes
- Unintended bad behaviors/bad actors
- Unintended consequences of bad policy

Risk of Failure?
Can we agree to collaborate?

Are these the problems we are trying to solve?

Pros/Cons of interest-based consensus process?

Feedback on Payment Reform Principles?
<table>
<thead>
<tr>
<th>Section</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>• How did we get here?</td>
</tr>
<tr>
<td>Value-based Reimbursement</td>
<td>• Where are we going?</td>
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<tr>
<td>Payment Reform Principles</td>
<td>• How do we decide?</td>
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<tr>
<td>Model 3.0 Framework</td>
<td>• Where do we start?</td>
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<tr>
<td>Task Force/Work Group</td>
<td>• Who is working on this project?</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>• How can the industry get involved?</td>
</tr>
</tbody>
</table>
BACKGROUND

How did the industry get here?
Ambulance Payment Evolution

Model 1.0
Reasonable Cost or Charge (Before 2002)

Model 2.0
Prospective Fee Schedule (As of 4/1/2002)

Model 3.0
Modernize Payment Policy (Begin Development 2018)

Temporary Rate Extenders (Beginning 7/1/2004 - Current)
Medicare Reimbursement Model 1.0 to 3.0

1994 - HCFA Proposed Medicare Ambulance Rule

1997 - BBA Authorizes Medicare Ambulance Fee Schedule

2002 - Medicare Fee Schedule

2008 - IHI Establish Triple Aim

2012 - HCIA Round One & 2014 HCIA Round Two

2014 - NAEMT MIH Survey / NFPA Guide / PIE Project

2017 - Cost Data Collection

Model 1.0

Model 2.0

Model 3.0
BBA 97 Authorizes Medicare Ambulance Fee Schedule

- Chapter 3, Section 4531: Payments for Ambulance Services
- Interim Reductions: 1%
- Establish Prospective Fee Schedule for Ambulance Services through a negotiated rulemaking process
- Considerations. In establishing the fee schedule, the Secretary shall
  - establish mechanisms to control increases in expenditures for ambulance services
  - establish definitions for ambulance services which link payments to the type of services provided
  - consider appropriate regional and operational differences
  - consider adjustments to payment rates to account for inflation and other relevant factors
  - phase in the application of the payment rates under the fee schedule in an efficient and fair manner

- Savings
  - Global budget
  - Annual updates based upon CPI-Urban

- Consultation
- Limitation on Review
- Restraint on Billing
- Uniform Coding System
- Effective Date
- Payment for Paramedic Intercept Service to Providers in Rural Communities
Negotiated Rulemaking Committee
Interest Groups

- Health Care Financing Administration (HCFA/CMS)
- American Ambulance Association (AAA)
- American Health Care Association (AHCA)
- American Hospital Association (AHA)
- Association of Air Medical Services (AAMS)
- International Association of Fire Chiefs (IAFC)
- International Association of Fire Fighters (IAFF)
- National Association of Counties (NACO)
- National Association of EMS Physicians/American College of Emergency Physicians (NAEMSP/ACEP)
- National Association of State EMS Directors (NASEMSD)
- National Volunteer Fire Council (NVFC)
Core Components:
Other Medicare Prospective Payment Systems

- **Base rate**
  - Single rate
  - Multiple rates tied to services

- **Adjustors**
  - Geographic
  - Service complexity
  - Patient characteristics
  - Low volume

- **Address high costs**
  - Pass-through payments
  - Outlier policy

- **Update mechanism**
  - Market basket

- **Quality**
  - Bonus
  - Reduction
Core Components:
Medicare Ambulance Fee Schedule

Base rate
- Single rate
- Multiple rates tied to services

Adjustors
- Geographic
- Service complexity
- Patient characteristics
  - Low Volume

Address high costs
- Pass-through payments
- Outlier policy

Update mechanism
- Market basket

Quality
- Bonus
- Reduction
Current Medicare Ambulance Fee Schedule

Base payment
- Base rate
  - Relative value unit
  - Ambulance conversion factor
- Adjusted for geographic factors
  - 70% labor-related portion, adjusted by geographic adjustment factor
  - 30% non-labor related portion

Mileage payment
- Adjusted for mileage
  - Mileage
  - Mileage rate

Total fee schedule ambulance payment

PE
GPCI
Federal Reports Focus on Ambulance

<table>
<thead>
<tr>
<th>Year</th>
<th>Report Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>US GAO 2003</td>
<td>Medicare Payments Can be Better Targeted to Trips in Less Densely Populated Areas (GAO-03-986)</td>
<td></td>
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<tr>
<td>OIG/HHS 2006</td>
<td>Medicare Payments for Ambulance Transports</td>
<td></td>
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<tr>
<td>OIG/HHS 2011</td>
<td>Semiannual Report to Congress</td>
<td></td>
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<tr>
<td>US GAO 2012</td>
<td>Costs &amp; Expected Medicare Margins Vary Widely; Transports of Beneficiaries Have Increased (GAO-13-6)</td>
<td></td>
</tr>
<tr>
<td>MedPac 2013</td>
<td>Mandated Report: Medicare Payment for Amb Service (June 2013)</td>
<td></td>
</tr>
<tr>
<td>MedPac 2018</td>
<td>Assessing Payment Adequacy &amp; Updating Payments in Fee-for-Service Medicare (March 2018)</td>
<td></td>
</tr>
</tbody>
</table>
VALUE-BASED REIMBURSEMENT

Where is health care going?
# Value-Based Programs

<table>
<thead>
<tr>
<th>Legislation Passed</th>
<th>Program Implemented</th>
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</thead>
<tbody>
<tr>
<td><strong>2008</strong></td>
<td><strong>2010</strong></td>
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<tr>
<td>MIPPA</td>
<td>ACA</td>
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**Legislation**
- ACA: Affordable Care Act
- MIPPA: Medicare Improvements for Patients & Providers Act
- PAMA: Protecting Access to Medicare Act

**Program**
- APMs: Alternative Payment Models
- ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
- HACRP: Hospital-Acquired Condition Reduction Program
- HRRP: Hospital Readmissions Reduction Program
- HVRP: Hospital Value-Based Purchasing Program
- MIPS: Merit-Based Incentive Payment System
- VM: Value Modifier or Physician Value-Based Modifier (PVBM)
- SNF-VBP: Skilled Nursing Facility Value-Based Purchasing Program
“The President’s budget makes investments and reforms that are vital to making our health and human services programs work for Americans and to sustaining them for future generations. In particular, it supports our four priorities here at HHS: addressing the opioid crisis, bringing down the high price of prescription drugs, increasing the affordability and accessibility of health insurance, and improving Medicare in ways that push our health system toward paying for value rather than volume.

HHS Secretary Azar, February 18, 2018

“I don’t intend to spend the next several years tinkering with how to build the very best joint-replacement model — we want to look at bold measures that will fundamentally reorient how Medicare and Medicaid pay for care, and create a true competitive playing field where value is rewarded handsomely.”

HHS Secretary Azar, March 20, 2018
“Secretary Azar and I are working for competition and better value by moving away from a fee-for-service approach, to a system that is value-based - and that rewards value over volume. This means paying providers on the outcomes they achieve, making people healthier rather than how many procedures they perform.”

Remarks by CMS Administrator Seema Verma
HIMSS18 Conference, March 6, 2018
Progression of Payment Reform

CMS is increasingly linking fee-for-service payment to value

- **Category 1**: Fee for Service - No link to quality
- **Category 2**: Fee for Service - Linked to quality
- **Category 3**: Alternative Payment Models on fee for service architecture
- **Category 4**: Population-based Payment

Source: CMS Innovation Center
CMS Payment Initiatives

- Alternative payment models (categories 3-4)
- FFS linked to quality (categories 2-4)
- All Medicare FFS (categories 1-4)

### Historical Performance
- 2011: 68%
- 2014: >80%
- 2016: 85%

### Goals
- 2018: 90%
Background on Value-Based Care

Provided by Reid Kiser.
**Bundled Payments for Care Improvement (BPCI)**

**Model 1**
- Episode of Care initiative MS DRG

**Models 2 & 3**
- Retrospective bundled payment initiative
- Include inpatient stay and 90 days follow up related to episode of care
- Actual billings vs. target price reconciled at end of episode for additional payment or recoupment
- Begin 10/2013

**Model 4**
- Single, prospective payment made to hospital for all services related to episode of care.
- Physicians and other practitioners submit “no pay” claims to Medicare and are paid by hospital out of bundled payment.
- Begin 10/2013
Capitation & Shared Savings

Capitation or sometimes referred to as “per member per month”
- At risk model
- FFS detail required for analytical reporting but payment is bundled

Shared Savings with health plan if targeted downstream savings achieved
### Replication of Successful Innovations/Pilots

<table>
<thead>
<tr>
<th>Sustain</th>
<th>• Lock in the progress &amp; assure funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spread</td>
<td>• A system to accelerate improvement by spreading change ideas within and between organizations</td>
</tr>
<tr>
<td>At Scale</td>
<td>• A large improvement initiative across a health care system, region, state or nation</td>
</tr>
</tbody>
</table>

Source: Institute of Healthcare Improvement
3
PAYMENT REFORM
PRINCIPLES
How does the industry decide?
How will we decide what to recommend?

- What are your interests?
- Why is consensus important?
- How do we decide what to recommend?
Why is Consensus Important

BBA 97 Authorizes Medicare Ambulance Fee Schedule Considerations

- Establish mechanisms to control increases in expenditures for ambulance services.
- Establish definitions for ambulance services which link payments to the type of services provided.
- Consider appropriate regional and operational differences.
- Consider adjustments to payment rates to account for inflation and other relevant factors.
- Phase in the application of the payment rates under the fee schedule in an efficient and fair manner.
Interest-based Negotiation

- A facilitated process (Title 5, USC) which drives toward consensus among affected stakeholders; used for complex topics: legislative or regulatory issues & collective bargaining; a workgroup is assembled:
  - Determine which stakeholders that should be at the table based on interests
  - Define the purpose and desired outcome of successful negotiations
  - Create ground rules and principles for negotiations; identify interests
  - Identify issues of agreement and disagreement
  - A facilitated process which drives toward consensus
Interest-based Negotiation

- Alternative solutions are considered, a consensus decision is reached which address each party’s concerns, even if each party did not achieve their most desired outcome.

- Consensus means that each party can support the proposed language.

- When any party does not agree to proposed language, the party is asked to:
  - State their concern
  - Identify an alternative that would address their own concerns as well as stated interests of other stakeholders
  - Seek evidence-based solutions
Interest-based Negotiation

- Process is repeated until all parties agree to final language on each specific issue
- Stakeholders are committed to work in good faith to achieve consensus
- Stakeholders are responsible for updating and consulting with their respective organizations between regular meetings
Interest-based Negotiation

**Consensus is...**

- A search for the best decision through a process to explore and incorporate each stakeholder’s thinking into the final decision
- Not a vote with a majority rule
- Specific language is acceptable to all parties
- Everyone understands, can explain, and will support the decision
MODEL 3.0 FRAMEWORK

Where does the industry start?
Joint Statement on Ambulance Reform

Policymakers Should Examine Short- and Intermediate-Term Policies to Promote Innovation in the Delivery of Emergency and Non-Emergency Care Provided by Ambulance Services

Joint Statement of the
American Ambulance Association;
National Association of EMS Physicians;
National Association of EMTs; and
National Association of State EMS Officials
Joint Statement Objectives

**Short-term**
- Build current add-ons into the base rate (conversion factor)
- Establish cost surveys
- Shift ambulance service from supplier to provider

**Intermediate-term**
- Provide coverage and payment for alternative destination transports
- Establish coverage and payment for response, assessment, referral at scene without transport
- Define more specifically non-emergency services

**Long-term**
- Seek coverage and reimbursement for triage & community paramedicine services
- Seek more comprehensive payment reform related to the ambulance fee schedule: refine payment categories, address high-cost items, consider patient characteristics and ambulance provider adjusters

March 2016
Compendium of MIH-CP Research and Reports

Many EMS system stakeholder (internal and external) have asked about a compendium of peer reviewed studies and reports on the new EMS model of Mobile Integrated Healthcare and Community Paramedicine.

AIMHI is beginning to compile as much of this information as possible for use by EMS agencies, as well as our key stakeholders.

If you would like to have your report or study listed here, or would like to have a study you find added to the compendium, email MZavadsky@medstar911.org.

http://aimhi.mobi/compendium-of-mih-cp-research-and-reports/
### Numbers And Costs Of Emergency Medical Services (EMS) Transports Of Medicare Beneficiaries, By Level Of Severity Of Emergency Department (ED) Discharge Diagnosis

<table>
<thead>
<tr>
<th>Level of severity(^*)</th>
<th>Primary care treatable</th>
<th>Emergent, ED care needed</th>
<th>ED visits related to:(^*)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nonemergent</td>
<td>Emergent</td>
<td>Preventable or avoidable</td>
</tr>
<tr>
<td>Transports not admitted to hospital(^*)</td>
<td>14.1%</td>
<td>20.4%</td>
<td>10.3%</td>
</tr>
<tr>
<td>5% MEDICARE SAMPLE, 2005–09</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transports</td>
<td>114,028</td>
<td>165,196</td>
<td>83,382</td>
</tr>
<tr>
<td>Out-of-pocket costs (millions)</td>
<td>$10.06</td>
<td>$15.11</td>
<td>$7.77</td>
</tr>
<tr>
<td>Ambulance</td>
<td>18.32</td>
<td>30.70</td>
<td>15.59</td>
</tr>
<tr>
<td>ED</td>
<td>$38.01</td>
<td>$57.25</td>
<td>$29.46</td>
</tr>
<tr>
<td>Medicare costs (millions)</td>
<td>55.90</td>
<td>99.81</td>
<td>52.95</td>
</tr>
</tbody>
</table>

EXTRAPOLATED TO NATIONAL MEDICARE POPULATION, PER YEAR

- Transports | 456,112 | 660,782 | 333,528 | 1,053,566 | 518,896 | 66,776 | 22,648 | 2,792 |
- Out-of-pocket costs (millions) | $40.24 | $60.46 | $31.09 | $99.77 | $45.51 | $5.85 | $2.08 | $0.25 |
- Ambulance | 73.29 | 122.79 | 62.36 | 246.52 | 92.76 | 6.93 | 2.37 | 0.33 |
- ED | $152.06 | $229.00 | $117.85 | $378.04 | $170.61 | $21.77 | $7.63 | $0.96 |
- Medicare costs (millions) | 223.59 | 399.24 | 211.81 | 801.97 | 258.89 | 24.27 | 8.41 | 1.16 |
- Total Medicare costs | 375.65 | 628.23 | 329.66 | 1,180.01 | 429.51 | 46.04 | 16.04 | 2.12 |

**Source:** Authors’ analysis. **Note:** All costs are in 2011 dollars, adjusted for inflation by the medical Consumer Price Index. *See Billings J, et al., Emergency department use (Note 10 in text). *ED visits not assigned a level of severity by Billings J, et al., Emergency department use (Note 10 in text). N = 811, 306. Percentages do not sum to 100 because 4 percent of transports not admitted to the hospital had an unclassified severity level.

“Medicare alone could save nearly $600 million.”
Framework for Model 3.0

Consider Reimbursement Methods of Other Providers

• Hospitals
• Physicians/Physicians Assistants/Nurse Practitioners
• Home Health
• SNF

Consider Structure of Current Medicare Amb Fee Schedule

• Service Levels/Relative Value Units
• Global Budget/Rates/Limitation of Rural Base Rate
• Geographic Adjustment/GPCI
• GAO Reports/MedPac Recommendations/OIG Reports/Cost Data Collection
Consider Current Published Research

- Current EMS systems, standards & personnel
- Independent Evaluations/ALMHI Research Compendium

Identify Challenges/Threats

- Lose credit for savings
- Fail to deal with uncompensated care/safety net issues
- Medicare never modernizes
- Unintended bad behaviors/bad actors
- Unintended consequences of bad policy
Framework for Model 3.0

Address Outstanding Issues

- Address Urban Cost of Readiness
- Address Rural Cost of Readiness & Disappearing Volunteer Labor Force
- Identify Funding for First Response, Medical Direction, High Cost Drugs & Technologies
- Address Workforce Resiliency, Safety, Retention
- Gain Safety Net Status & Funding
- Define the EMS Global Budget
- Address Supplier to Provider
- Design CMMI Pilot of Advanced Practice Paramedic
- Explore EMS System Population-based Model
Progression of Payment Reform

CMS is increasingly linking fee-for-service payment to value

Category 1
- Fee for Service - No link to quality

Category 2
- Fee for Service - Linked to quality

Category 3
- Alternative Payment Models on fee for service architecture

Category 4
- Population-based Payment

Source: CMS Innovation Center
Replication of Successful Innovations/Pilots

**Sustain**
- Lock in the progress and assure funding

**Spread**
- A system to accelerate improvement by spreading change ideas within and between organizations

**At Scale**
- A large improvement initiative across a health care system, region, state or nation

Source: Institute of Healthcare Improvement
### Implement Cost Data Collection

<table>
<thead>
<tr>
<th>What?</th>
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<tbody>
<tr>
<td>• Bipartisan Budget Act of 2018 (H.R. 1892) directing CMS to collect ambulance cost data and included a 5-year extension of the Medicare ambulance add-ons</td>
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<table>
<thead>
<tr>
<th>Why?</th>
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<tr>
<td>• Provides data to validate need for permanent increase to Medicare fee-for-service amounts and future Reimbursement Model 3.0 data needs</td>
</tr>
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<table>
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<tr>
<th>How?</th>
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<tbody>
<tr>
<td>• Various industry cost data collection tools recommended (i.e., GEMT, Moran Company Report); Rand currently meeting with ambulance stakeholders</td>
</tr>
</tbody>
</table>

Why is allowable/non-allowable important: Medpac margin analysis, CMS definitions from other healthcare cost reports, lessons learned from other healthcare providers
Medicare Payment Advisory Commission

4 Factors in Determining Adequate Payment

1. Beneficiary Access to Care
2. Quality of Care
3. Providers’ Access to Capital
4. Providers Medicare margin

www.medpac.gov
Margin Analysis

The resulting margin indicates the provider’s cost for treating Medicare patients:

\[
\text{Margin} = \frac{\text{Medicare payment rate} - (\text{total Medicare costs})}{\text{Medicare payment rate}}
\]
Marginal profit provides information on whether a provider has financial incentive to treat Medicare beneficiaries.

\[
\text{Rate of Marginal Profit} = \frac{\text{Medicare payment rate} - (\text{total Medicare costs} - \text{fixed building & equipment costs})}{\text{Medicare payment rate}}
\]
Allowable vs. Non Allowable Costs

**Allowable Costs**
- Reasonable cost
- Directly tied to patient care
- System for allocation is imperative
- Unique design of EMS REQUIRES advocacy with CMS

**Non Allowable Costs**
- Franchise fees and other assessments
- Professional education and training

*Medicare Provider Reimbursement Manual, Part 2, Provider Cost Reporting Forms, Chapter 45, Form CMS-2088-17*
### Transition from Supplier to Provider

<table>
<thead>
<tr>
<th>What?</th>
<th>Why?</th>
<th>How?</th>
</tr>
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<tbody>
<tr>
<td>• Designate ambulance services as providers in order to establish &quot;status as health care provider&quot; &amp; optimize the value proposition</td>
<td>• From a payer perspective, supplier reimbursement is based on commodity pricing methods (i.e., DME)</td>
<td>• Requires Survey or Accreditation Process, CMS Participation Agreement, Electronic Claims Submission (except for low volume providers), Cost Data Collection, Quality Data Reporting</td>
</tr>
</tbody>
</table>
Gain Safety Net Provider Status

What?
• Develop a program to identify EMS as a safety net provider

Why?
• EMS safety net providers could be defined as 15% (to be determined by cost data collection) or greater un- and underinsured and provide emergency response services through a 9-1-1 system or equivalent

How?
• States could request State Plan Amendment or waiver under Section 1115(a)(2) to allow for additional payment
Design better targeted rural reimbursement

<table>
<thead>
<tr>
<th>What?</th>
<th>Why?</th>
<th>How?</th>
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</thead>
<tbody>
<tr>
<td>- Address the “lack of adequate options to recognize low volume, rural ambulance providers” (NRM Committee, 2/11/01)</td>
<td>- Recommendations of 2003 US GAO Report (GAO-03-986)</td>
<td>- Incorporate better options in the Medicare ambulance fee schedule, assess Critical Access Hospital rules, assess Rural Hospital Flexibility Program</td>
</tr>
</tbody>
</table>
5 TASK FORCE

Who is working on this project?
Purpose

Research, design, test, evaluate & recommend payment and service delivery updates to the current Medicare payment system for ground ambulance service
Work Group

How did this project start?

- Volunteer subject matter experts in reimbursement, clinical & research, finance & accounting, small & rural provider, innovation, public policy, EMS system design, revenue cycle management

- Larry Clark
- Deb Gault
- Jimmy Johnson
- Asbel Montes
- Mike McEvoy (invited)
- Kevin Munjal, MD
- Vince Robbins
- Brenda Staffan
- Jonathon Washko
- Matt Zavadsky
Task Force
Who will decide?

Groups or constituencies that are directly impacted selected by a neutral convenor using an interest-based negotiation process

- Medicare Beneficiaries/Taxpayers
- EMS/Ambulance Service Providers-Non-government (Private For-profit/Non-profit)
- EMS/Ambulance Service Providers-Government
- EMS/Ambulance Service Providers-Volunteer
- Receiving Healthcare Facilities
- EMS/Ambulance Workforce
- Patients
- Physicians & Healthcare Providers
- Local Government EMS Regulators-State
- Local Government EMS Regulators-Local
Task Force
Who are the sponsors?

- **Champions** of the goal that the industry can voluntarily agree on a Medicare payment reform structure through an interest based facilitation process which is designed to get all parties interests into consensus

- Interested individuals and companies
- National organizations
- Future non-profits
Work Group
What outcome will be achieved?

By Dec 2018, identify Model 3.0 components, including supporting evidence & measurement strategy:

- Recommend to CMMI for pilot replication
- Include in cost data collection tool

By June 2019, build a value-based framework for all four categories of the progression of payment reform:

- FFS - No Link to Quality
- FFS Linked to Quality
- Alt Payment Model
- Population based Model
<table>
<thead>
<tr>
<th>Category 1: FFS-No Link to Quality</th>
<th></th>
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<tbody>
<tr>
<td>Category 2: FFS-Linked to Quality</td>
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<tr>
<td>Category 3: Alternative Payment Model</td>
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STAKEHOLDERS

How can the industry get involved?
Who is impacted?

- EMS Providers
- EMS Personnel
- Hospitals
- EDs
- Nurses
- Physicians
- Payers
- Patients & Public
What is our compass heading?

EMS Reimbursement Reform

A people centered EMS system

Triple Aim

Smarter Spending, Healthier People & Better Care

Promote innovation in care delivery provided by ambulance services

Establish quality payments & expand alternative payment models

Test innovative payment & service delivery models

What is our compass heading?
Establish fundamental truths or propositions that serve as a foundation and rationale for Model 3.0

- Patients, payers & providers wants, needs, preferences, positions *interests*
- Current external realities and evolving dynamics
- Current industry strategic position and capacity
What should Payment Reform accomplish?

- Payer Aligned
- Value Based
- Triage Focused
- Provider Flexible
- Evidence Based
- Health System Integrated
- Patient Engaged
- Inherently Safe
- Technology Supported
- Compliant
Payment Reform Principles

Consider Current Published Research
- Current EMS systems, standards & personnel
- Independent Evaluations/AlMHI Research Compendium

Identify Challenges/Threats
- Lose credit for savings
- Fail to deal with uncompensated care/safety net issues
- Medicare never modernizes
- Unintended bad behaviors/bad actors
- Unintended consequences of bad policy
## Payment Reform Principles - DRAFT

| People Centered | • Achieves informed patient consent via enhanced patient engagement & education (i.e., against medical advice vs accept medical advice);
|                | • Addresses work force resiliency. |
| Inherently Safe & Effective | • Prevents patient exposure to harm, unintended consequences & adverse outcomes;
|                                | • Prevents provider exposure to unnecessary increased liability. |
# Payment Reform Principles - DRAFT

| Integrated & Seamless | • Recognizes expanded triage tools which enable new pathways of care based on prudent layperson definition of emergency;  
• Expands care coordination amongst emergency care, primary care, mental health & social care systems. |
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<td>Reliable &amp; Prepared</td>
<td>• Connects to evidence base in clinical, operational &amp; payment research.</td>
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<tr>
<td>Socially Equitable</td>
<td>• Adapts to various provider types &amp; geographic (urban/rural) settings, encourages local and state laws to evolve.</td>
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| Sustainable & Efficient | • Builds off of current Medicare ambulance fee schedule and leads to a multi-payer system, facilitates referral to in-network care for low acuity conditions & is broadly adopted by non-federal payers;  
• Neutralizes volume incentives, achieves provider cost transparency (including increased treatment/drug costs) & generates net payer return on investment;  
• Complies with federal waste, fraud & abuse regulations and principles. |
### Payment Reform Principles - DRAFT

| Adaptable & Innovative | • Optimizes & funds existing and new health care and health information technologies & achieves electronic exchange of patient records & data.  
• Follows the four phases of payment reform progression: 1) fee-for-service, 2) fee-for-service linked to quality, 3) alternative payment model on fee-for-service architecture; 4) population-based. |
Next Steps

- Provide feedback & support to the work group
- Build informal network of supporters
- Work group begins to research policy options
- Identify additional champions & sponsors
Can we agree to collaborate?

Are these the problems we are trying to solve?

Pros/Cons of interest-based consensus process?

Feedback on Payment Reform Principles?

Dialogue
At end of today’s session
Thank you for sharing the road!