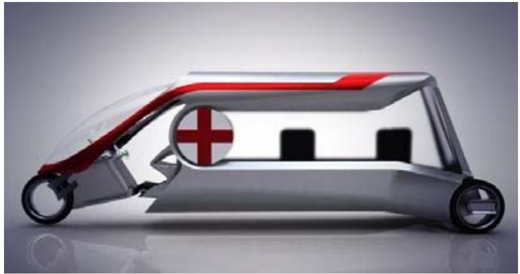
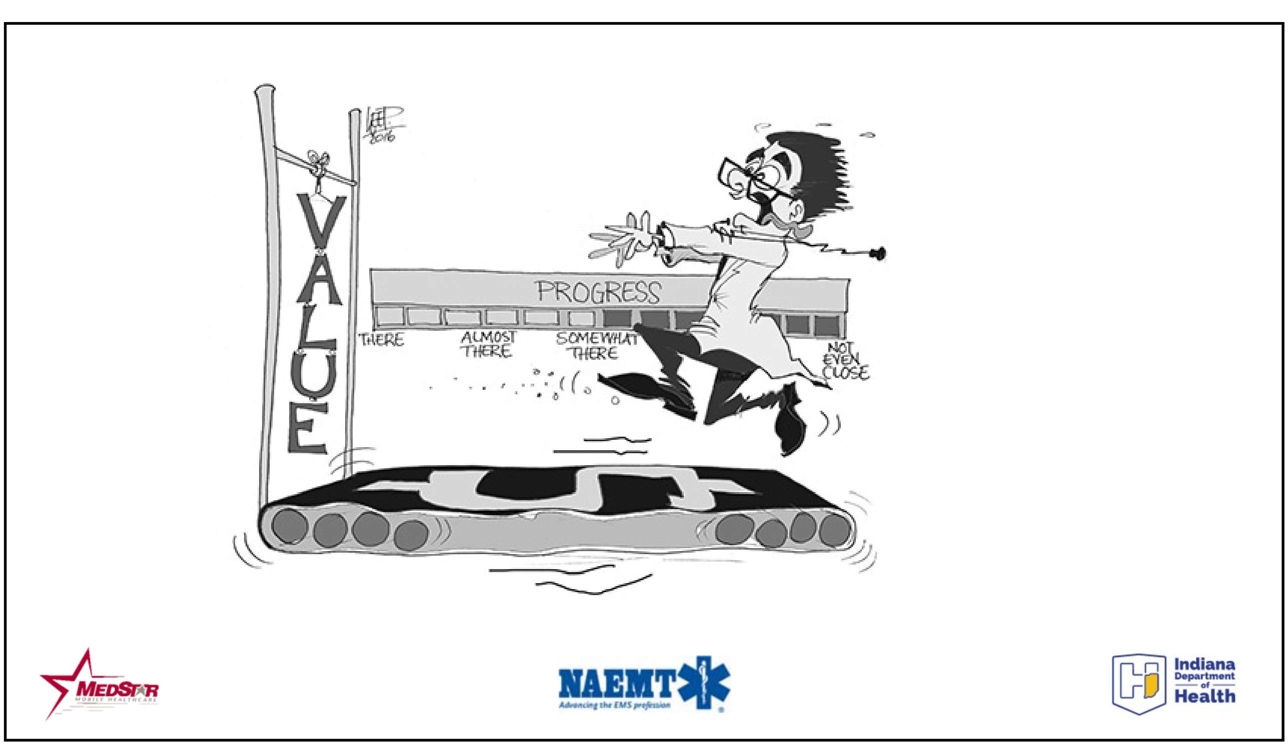
# Beyond MIH-CP:
## *The Transformation Continues*



## What we're gonna do…

- Understand the ways the role of EMS continues to evolve.
  - With a focus on the 'pandemic effect'
- Learn five new programs that have been implemented over the past year.
- Understand the ways value is being determined for these new programs.

- *And, learn insights into life under quarantine...*


VALUE
PROGRESS
THERE
ALMOST THERE
SOMEWHAT THERE
NOT EVEN CLOSE
MEDSTAR
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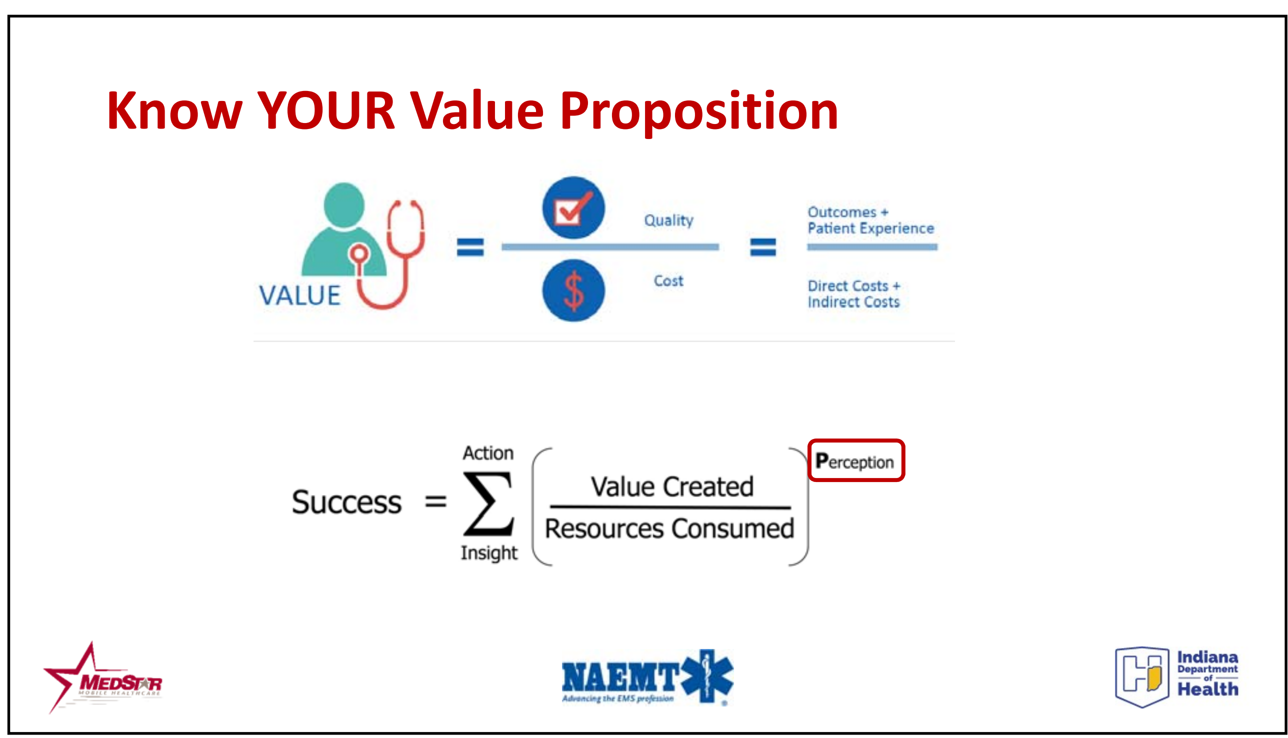
Indiana Department of Health


Know YOUR Value Proposition
VALUE
=
Quality
Cost
=
Outcomes + Patient Experience
Direct Costs + Indirect Costs
Success = Σ Action Insight ( Value Created / Resources Consumed ) Perception
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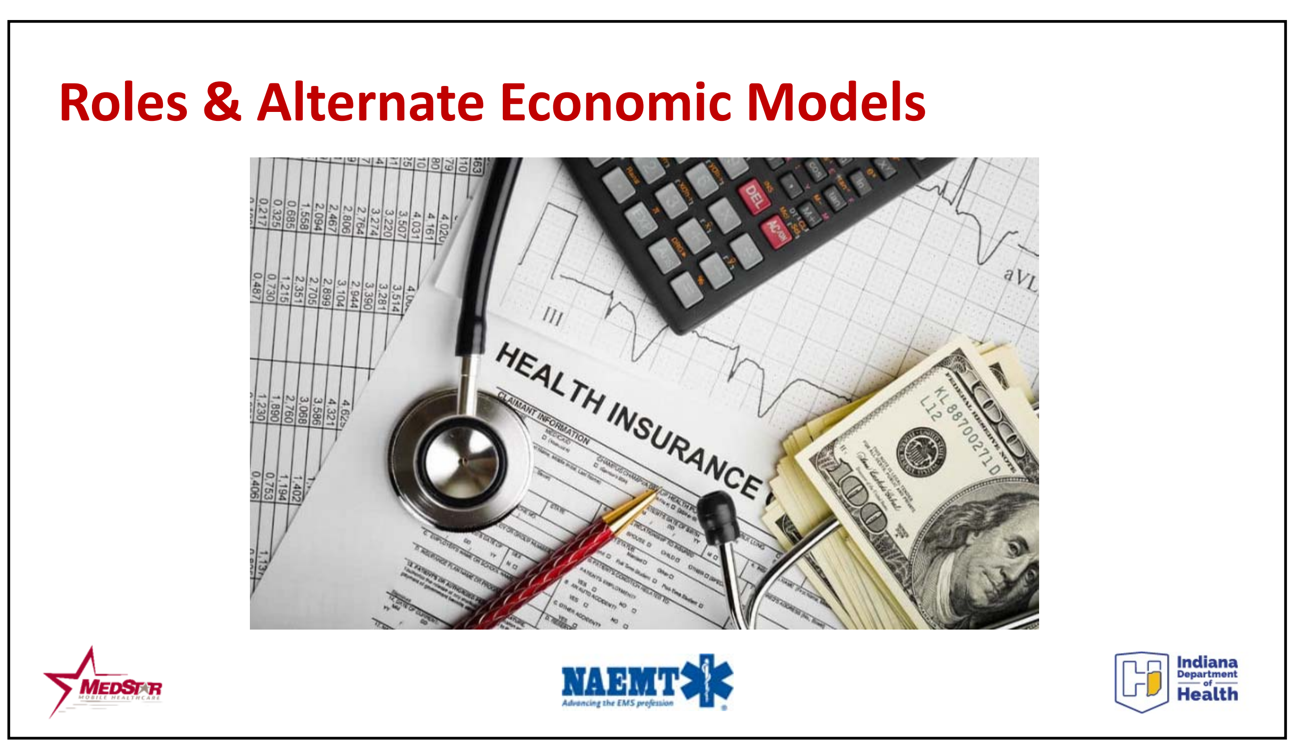
Roles & Alternate Economic Models
HEALTH INSURANCE
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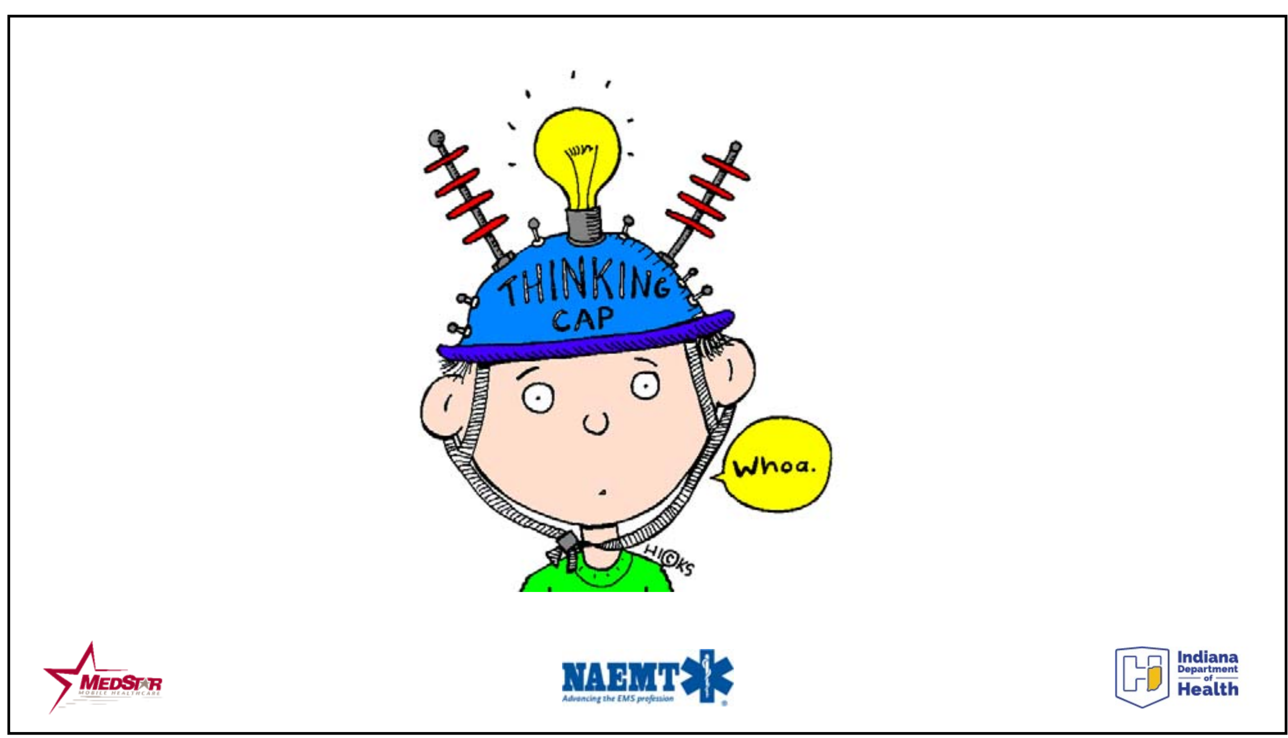
THINKING CAP
Whoa.
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# The Problem – Misaligned Economics/Value

- **EMS only paid for transport to an Emergency Department (ED)**
  - Results in many patients being transported ***by*** the highest cost resource ***to*** the highest cost resource
  - Even when an alternate disposition may be more appropriate

---

COST & PAYMENT

DOI: 10.1377/hlthaff.2013.0741
HEALTH AFFAIRS 32,
NO. 12 (2013): 2142–2148
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The People-to-People Health
Foundation, Inc.

By Abby Alpert, Kristy G. Morganti, Gregg S. Margolis, Jeffrey Wasserman, and Arthur L. Kellermann

## Giving EMS Flexibility In Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings

**Abby Alpert** is an assistant professor of economics and public policy at the Paul Merage School of Business, University of California, Irvine.

**Kristy G. Morganti** is a health policy researcher at the RAND Corporation in Pittsburgh, Pennsylvania.

**Gregg S. Margolis** is director of the Division of Healthcare Systems and Health Policy, Department of Health and Human Services, in Washington, D.C.

**Jeffrey Wasserman** (jeffrey@rand.org) is director of RAND Health and vice president of the RAND Corporation in Santa Monica, California.

ABSTRACT Some Medicare beneficiaries who place 911 calls to request an ambulance might safely be cared for in settings other than the emergency department (ED) at lower cost. Using 2005–09 Medicare claims data and a validated algorithm, we estimated that 12.9–16.2 percent of Medicare-covered 911 emergency medical services (EMS) transports involved conditions that were probably nonemergent or primary care treatable. Among beneficiaries not admitted to the hospital, about 34.5 percent had a low-acuity diagnosis that might have been managed outside the ED. Annual Medicare EMS and ED payments for these patients were approximately $1 billion per year. If Medicare had the flexibility to reimburse EMS for managing selected 911 calls in ways other than transport to an ED, we estimate that the federal government could save $283–$560 million or more per year, while improving the continuity of patient care. If private insurance companies followed suit, overall societal savings could be twice as large.

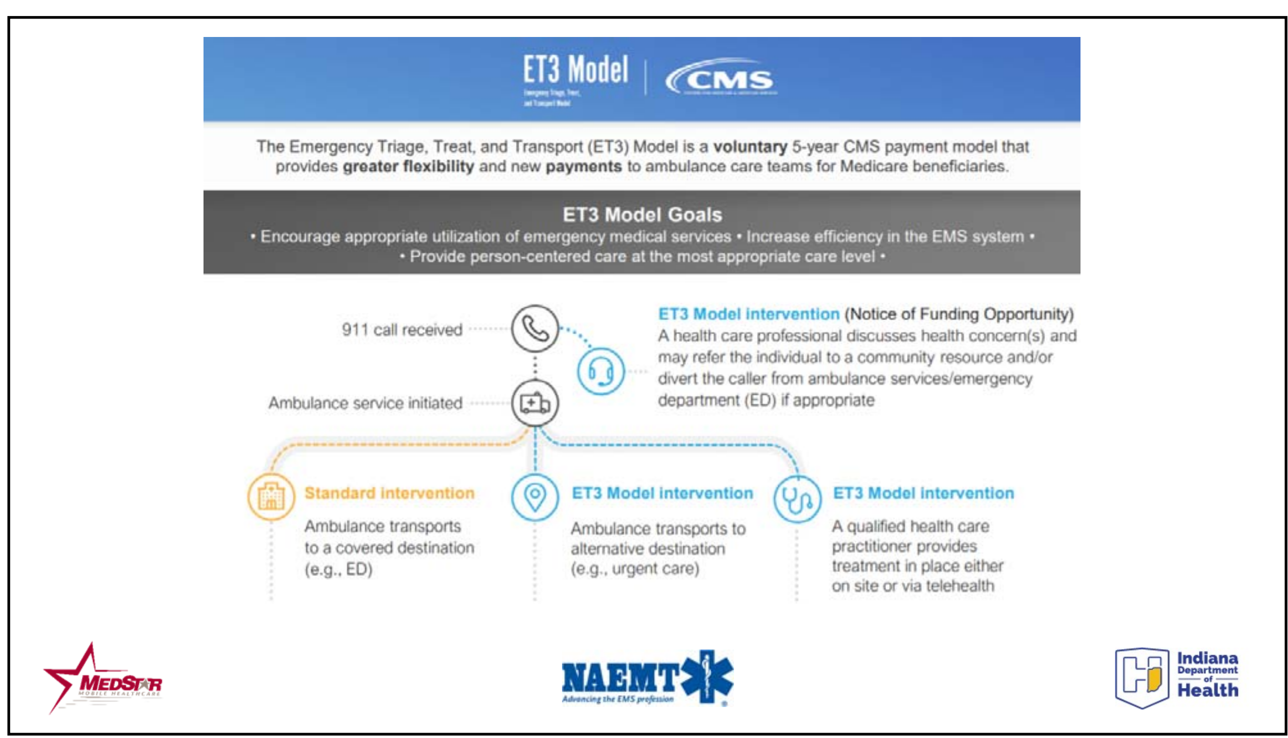
*"EMS providers regularly encounter patients whose complaints might be better managed in settings outside the ED."*

*"Bringing patients unnecessarily to the ED places needless demands on an already overburdened system."*

**Conclusion**

*"Giving CMS the flexibility to reimburse EMS services for alternative handling of 911 callers could save Medicare $283–$560 million or more per year. If private third-party payers followed suit, the societal savings could be twice as large."*

https://pubmed.ncbi.nlm.nih.gov/24301398/


ET3 Model
CMS
The Emergency Triage, Treat, and Transport (ET3) Model is a voluntary 5-year CMS payment model that provides greater flexibility and new payments to ambulance care teams for Medicare beneficiaries.
ET3 Model Goals
• Encourage appropriate utilization of emergency medical services • Increase efficiency in the EMS system •
• Provide person-centered care at the most appropriate care level •
911 call received
Ambulance service initiated
ET3 Model intervention (Notice of Funding Opportunity)
A health care professional discusses health concern(s) and may refer the individual to a community resource and/or divert the caller from ambulance services/emergency department (ED) if appropriate
Standard intervention
Ambulance transports to a covered destination (e.g., ED)
ET3 Model intervention
Ambulance transports to alternative destination (e.g., urgent care)
ET3 Model intervention
A qualified health care practitioner provides treatment in place either on site or via telehealth
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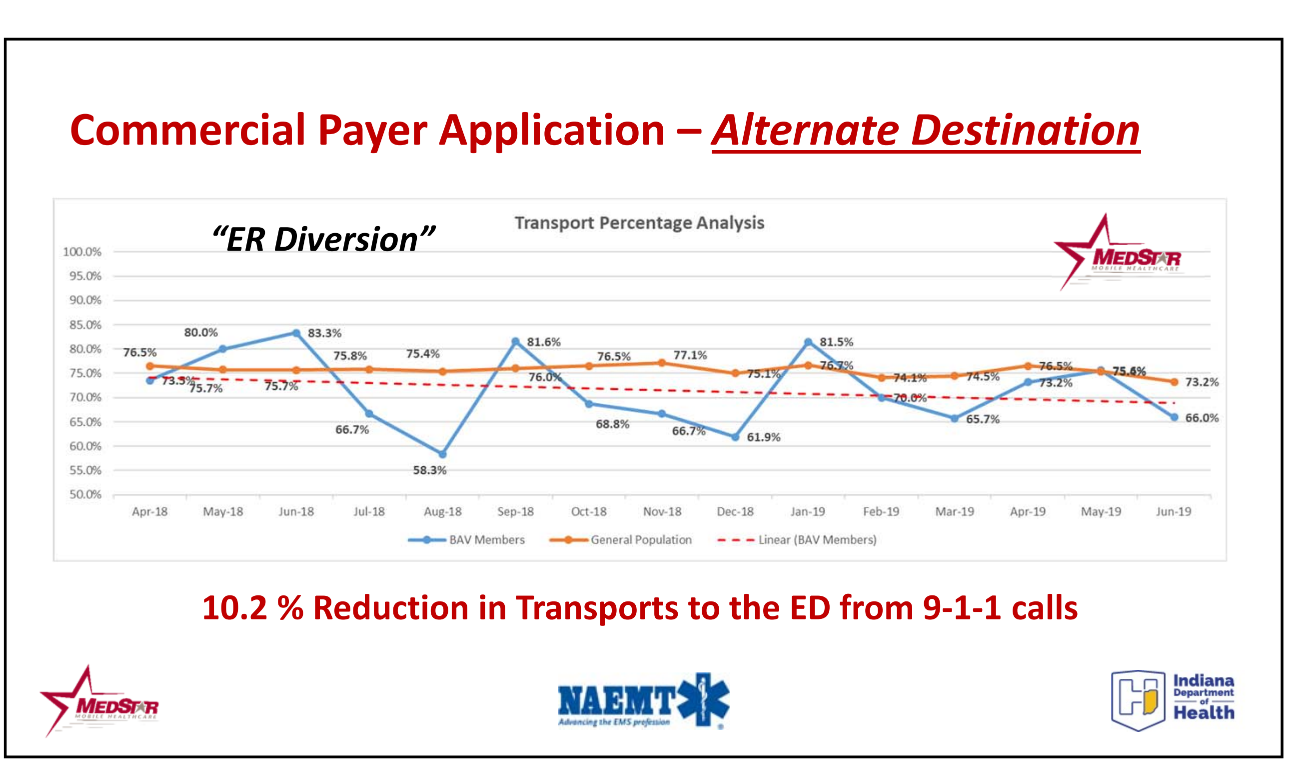
Commercial Payer Application – Alternate Destination
"ER Diversion"
Transport Percentage Analysis
MEDSTAR MOBILE HEALTHCARE
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
76.5%
73.3%
80.0%
75.7%
83.3%
75.7%
75.8%
66.7%
75.4%
58.3%
81.6%
76.0%
76.5%
68.8%
77.1%
66.7%
75.1%
61.9%
81.5%
76.7%
74.1%
70.0%
74.5%
65.7%
76.5%
73.2%
75.6%
73.2%
66.0%
BAV Members
General Population
Linear (BAV Members)
10.2 % Reduction in Transports to the ED from 9-1-1 calls
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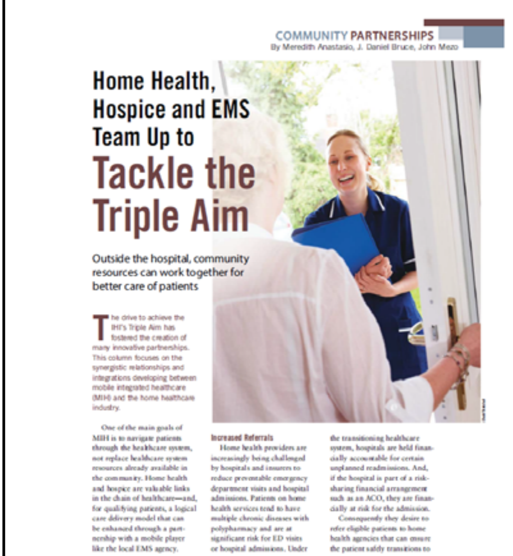

COMMUNITY PARTNERSHIPS

By Meredith Anastasio, J. Daniel Bruce, John Mezo

Home Health, Hospice and EMS Team Up to

Tackle the Triple Aim

Outside the hospital, community resources can work together for better care of patients

The drive to achieve the IHI's Triple Aim has fostered the creation of many innovative partnerships. This column focuses on the synergistic relationships and integrations developing between mobile integrated healthcare (MIH) and the home healthcare industry.

One of the main goals of MIH is to navigate patients through the healthcare system, not replace healthcare system resources already available in the community. Home health and hospice are valuable links in the chain of healthcare—and, for qualifying patients, a logical care delivery model that can be enhanced through a partnership with a mobile player like the local EMS agency.

**Increased Referrals**

Home health providers are increasingly being challenged by hospitals and insurers to reduce preventable emergency department visits and hospital admissions. Patients on home health services tend to have multiple chronic diseases with polypharmacy and are at significant risk for ED visits or hospital admissions. Under the transitioning healthcare system, hospitals are held financially accountable for certain unplanned readmissions. And, if the hospital is part of a risk-sharing financial arrangement such as an ACO, they are financially at risk for the admission.

Consequently they desire to refer eligible patients to home health agencies that can ensure the patient safely transitions to

www.ihdelivery.com | Mar/Apr 2015 | Integrated Healthcare Delivery 17

# Home Health & Hospice Partnerships

## VITAS Hospice Program Summary

*January 2012 - July 2020*

| | # | % |
|---|---|---|
| Referrals (1) | 644 | |
| Enrolled (2) | 474 | |
| Deceased | 333 | 70.3% |
| Active | 4 | |
| Revoked (3) | 49 | 10.3% |
| Activity: | | |
| Emergency Calls | 227 | |
| Transports | 118 | 52.0% |
| Transports to IPU | 17 | 14.4% |
| Transports to ED | 101 | 85.6% |
| Episodic Requests | 100 | |
| Transports | 2 | |

**Utilization Outcome Summary** **As of: Aug. - 20**

***Home Health Partnership - Rollup***

| | # | % |
|---|---|---|
| **Enrollments by Home Health Agency** | **2,650** | **100.0%** |
| 9-1-1 calls by Enrolled Patients | 1,901 | 71.7% |
| ED Transports when CP on Scene | 714 | 72.3% |
| Home Visits Requested by Agency | 454 | 17.1% |
| ED Transports from home visits requested by Agency | 27 | 5.9% |

## MedStar saves lives.
*Membership saves money.*

**There's no need to worry** when trouble strikes because MedStar's industry leading health heroes are always around the corner to swoop in and take care of your urgent medical needs. And now, MedStar can save you from financial trauma, too. For only $350 per year, a **MedStar Saver+Plus** membership shields you from out-of-pocket costs your insurance does not cover ***AND*** helps you navigate your urgent healthcare needs.

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*Ambulance ride covered*

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**StarSaver+PLUS Benefits:**

- ✓ **Physical & medical assessment of the Primary and Secondary StarSaver+Plus Member**
  - Identification of any perceived medical or healthcare gaps
  - Medication inventory
  - Documentation of any relevant medical documentation
- ✓ **Registration in MedStar's Mobile Integrated Healthcare (MIH) Program**
  - Notification to the Primary and Secondary Member's Primary Care Physician (PCP) of their enrollment into the StarSaver+Plus program
  - Specialized protocols used in the MIH program
  - Primary and Secondary member tracked in MedStar's 9-1-1 Dispatch System
  - Up to two (2) additional non-emergency in-home visits per year at the request of the primary or secondary StarSaver Plus Member

Join today | www.medstarsaver.org
Membership@medstar911.org |
817.923.3700, ext. 135

From: Gingold, Janelle (CMS/CMMI)
Sent: Thursday, November 19, 2020 10:47 AM
To: Asbel Montes; Johnson, Sven; McMullen, Jack; Matt Zavadsky
Cc: Friedman, Rivka H. (CMS/CMMI); Seagrave, Susanne
Subject: Request for meeting re: treat in place

Dear Colleagues,

Thank you for your previous engagement with CMS on EMS challenges during the COVID-19 pandemic, particularly related to reimbursement for treatment in place.

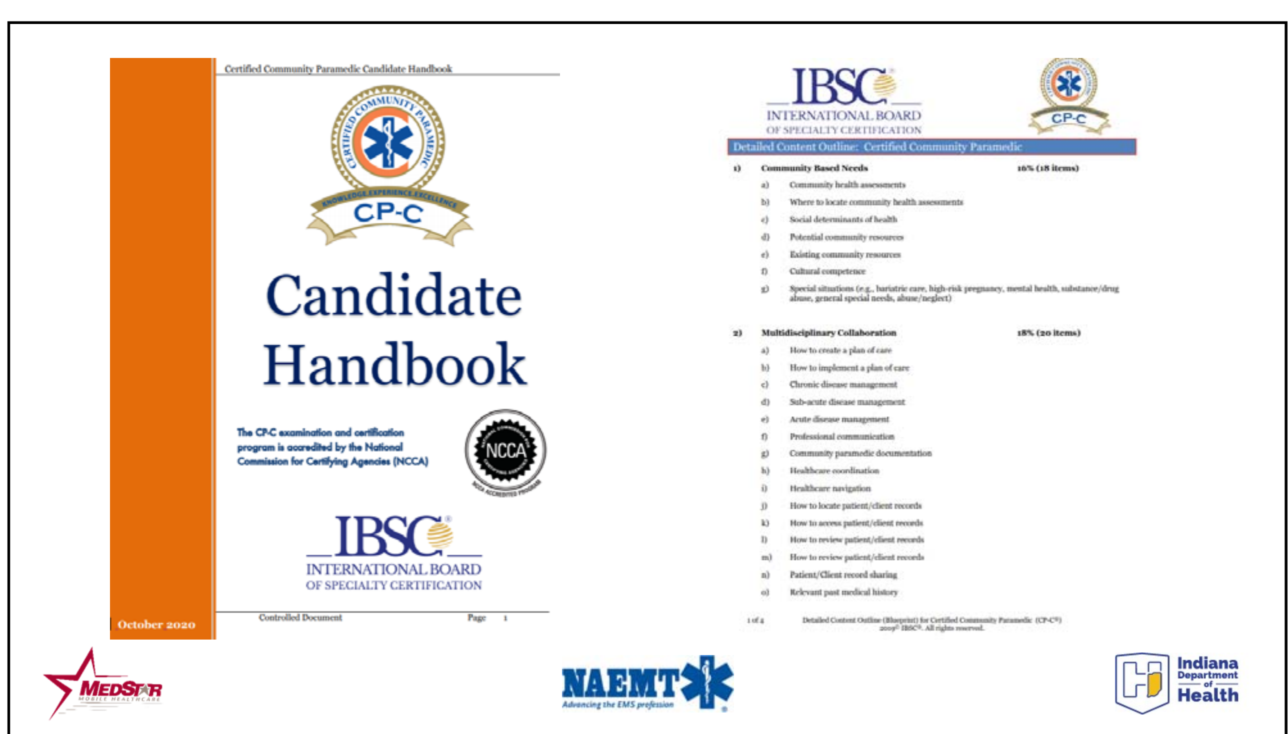
*We would appreciate an opportunity to connect with you today or tomorrow to discuss further. As you know, CMS has encountered barriers to identifying a viable pathway for reimbursement. We continue to work to determine whether a path may be possible*. While we do this, we would like you to have the opportunity to share with us your thoughts on the value proposition for CMS in providing this reimbursement in the event that one is possible.

Times that would work for us include (30 minutes):

- Today: between 2-3
- Tomorrow: 10-11, 12-1, 2-4

Thank you in advance!

**Janelle Gingold**
Director, Division of Health Innovation and Integration
Center for Medicare & Medicaid Innovation



Certified Community Paramedic Candidate Handbook

CP-C

Candidate Handbook

The CP-C examination and certification program is accredited by the National Commission for Certifying Agencies (NCCA)

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October 2020 | Controlled Document | Page 1

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CP-C

Detailed Content Outline: Certified Community Paramedic

1) **Community Based Needs** — **16% (18 items)**
   a) Community health assessments
   b) Where to locate community health assessments
   c) Social determinants of health
   d) Potential community resources
   e) Existing community resources
   f) Cultural competence
   g) Special situations (e.g., bariatric care, high-risk pregnancy, mental health, substance/drug abuse, general special needs, abuse/neglect)

2) **Multidisciplinary Collaboration** — **18% (20 items)**
   a) How to create a plan of care
   b) How to implement a plan of care
   c) Chronic disease management
   d) Sub-acute disease management
   e) Acute disease management
   f) Professional communication
   g) Community paramedic documentation
   h) Healthcare coordination
   i) Healthcare navigation
   j) How to locate patient/client records
   k) How to access patient/client records
   l) How to review patient/client records
   m) How to review patient/client records
   n) Patient/Client record sharing
   o) Relevant past medical history

1 of 4 Detailed Content Outline (Blueprint) for Certified Community Paramedic (CP-C®)
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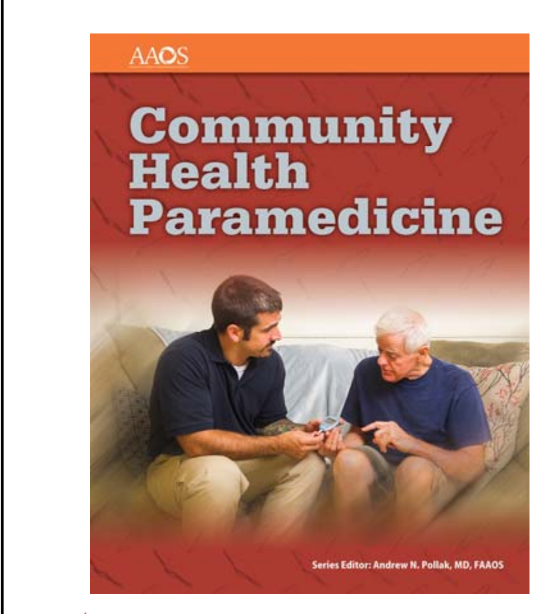
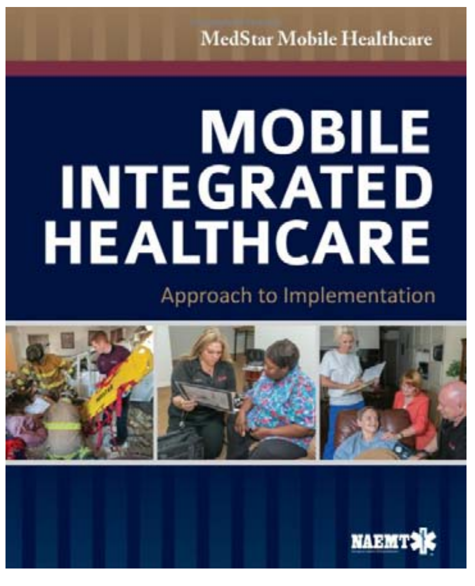

AAOS
Community
Health
Paramedicine
Series Editor: Andrew N. Pollak, MD, FAAOS


MedStar Mobile Healthcare
MOBILE
INTEGRATED
HEALTHCARE
Approach to Implementation
NAEMT

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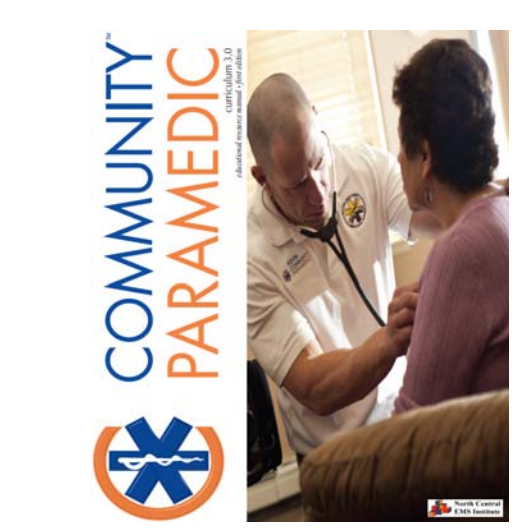
Department
of
Health


COMMUNITY
PARAMEDIC
curriculum 3.0

NAEMT
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Indiana
Department
of
Health

# Tale of Two 'Times'

**BC (*Before Coronavirus*)**

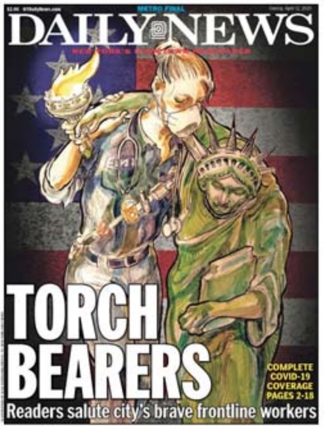
**AC (*After Coronavirus*)**

# Before Coronavirus

- "*E*MS"
- **Paid for Transport to the ED**
  - Supplier vs. Provider
- **Public Safety vs. Healthcare**
- **"So, what does EMS stand for again?"**

## After Coronavirus

- More than "EMS"
- Paid for care and navigation
- Part of front-line healthcare
- Community recognition



## Role Innovations: *Alternate Destinations*

- Transport to Alternate Destinations
  - Local urgent/primary care centers
  - MD offices
  - Anywhere!

## Ambulances: CMS Flexibilities to Fight COVID-19

The Trump Administration is issuing an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Made possible by President Trump's recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) to ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 2) remove barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states so the healthcare system can rapidly expands its workforce; 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

*CMS Hospital without Walls (Temporary Expansion Sites)*

- During the Public Health Emergency (PHE) for the COVID-19 pandemic, we are temporarily expanding the list of allowable destinations for ambulance transports. During the COVID 19 PHE, ambulance transports may include any destination that is able to provide treatment to the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services are being furnished. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, CAH or SNF, community mental health centers, federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), any other location furnishing dialysis services outside of the ESRD facility, and the beneficiary's home.

[DISCUSSION DRAFT]

116TH CONGRESS
2D SESSION

# H. R. ______

To amend title XVIII of the Social Security Act to provide payment for certain treatment-in-place services furnished by a provider or supplier of ambulance services under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

Mrs. AXNE introduced the following bill; which was referred to the Committee on ______________

## A BILL

To amend title XVIII of the Social Security Act to provide payment for certain treatment-in-place services furnished by a provider or supplier of ambulance services under the Medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE.**
4 This Act may be cited as the "____________ Act
5 of 2020".

2

1 **SEC. 2. PROVIDING PAYMENT FOR CERTAIN TREATMENT-**
2 **IN-PLACE SERVICES FURNISHED BY A PRO-**
3 **VIDER OR SUPPLIER OF AMBULANCE SERV-**
4 **ICES UNDER THE MEDICARE PROGRAM.**
5 (a) IN GENERAL.—Section 1834(l) of the Social Se-
6 curity Act (42 U.S.C. 1395m(l)) is amended by adding
7 at the end the following new paragraph:
8 "(18) PAYMENT FOR CERTAIN TREATMENT-IN-
9 PLACE SERVICES FURNISHED DURING THE COVID–19
10 EMERGENCY.—
11 "(A) IN GENERAL.—In the case of a treat-
12 ment-in-place item or service (as defined in sub-
13 paragraph (B)) furnished to an individual by a
14 provider or supplier of ground ambulance serv-
15 ices during the period beginning on March 1,
16 2020, and ending on the last day of the emer-
17 gency period described in section
18 1135(g)(1)(B), such item or service shall be
19 deemed to be an ambulance service payable
20 under the fee schedule established under this
21 subsection, regardless of the condition of such
22 individual or whether such individual is trans-
23 ported by such provider or supplier to any loca-
24 tion, if such provider or supplier attests that
25 such item or service was furnished in accord-
26 ance with—

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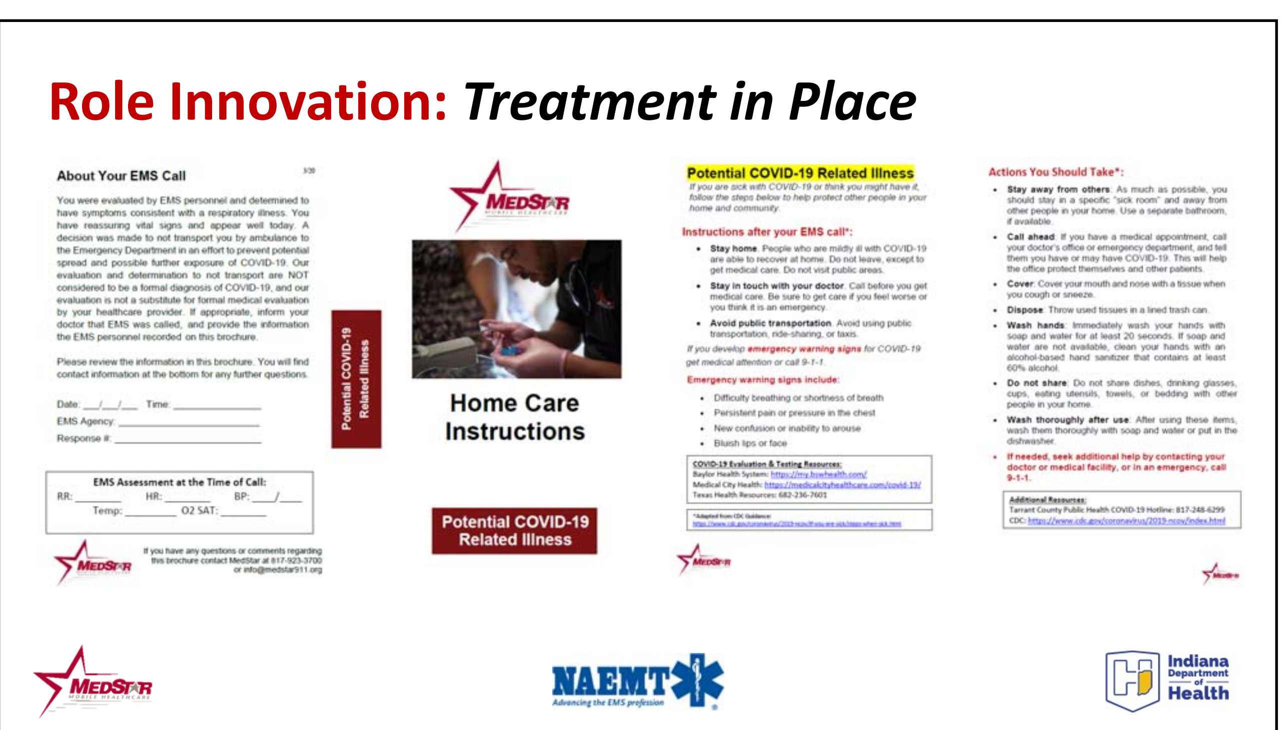


# COVID-19 Non-Transport Protocol
## (*Patients w/COVID related assessments*)

| Month | COVID Potential Assessments | COVID Non-Transport Protocol |
|---|---|---|
| Mar-20 | 553 | 56 |
| Apr-20 | 2103 | 152 |
| May-20 | 1978 | 79 |

**Follow-up on Patients Treated and Navigated Under COVID-19 Non-Transport Medical Directive**

**Summary Data for Dates of Service 3/25 - 7/21/2020**

| | | | |
|---|---|---|---|
| Total Patients Navigated Under the Protocol with Phone Number in the ePCR: | **330** | | |
| Follow-Up Calls Able to be Completed: | **93** | **28.2%** | |
| | **Better** | **Worse** | **Same** |
| How are you feeling now? | 93<br>100.0% | 0 | 0 |
| | **Yes** | **No** | **Not Indicated** |
| Did you follow the recommendations for follow-up care the MedStar Crew Left You? | 89<br>98.9% | 1<br>1.1% | 3<br>3.2% |
| | **No** | | **Yes** |
| Did you seek medical care within 72 hours of the MedStar encounter? | 75<br>89.3% | *ER*<br>4<br>4.8% | *PCP/UCC*<br>5<br>6.0% |
| | | | DX? |
| | | *ETOH*<br>*UTI* | *Common Cold*<br>*Mono*<br>*Sinus Infection*<br>*Back Pain*<br>*COVID-19* |

| | No | Yes | | |
|---|---|---|---|---|
| Did you get tested for COVID-19? | 47 | 45 | | |
| | 51.1% | 48.9% | | |
| | | *Positive* | *Negative* | |
| If so, what was the result of the test? | | 21 | 24 | |
| | | 46.7% | 53.3% | |

| One scale of 1 - 5, with 5 being most satisfied, how satisfied were you with the MedStar experience? | **5** | **4** | **Other** | **Average** |
|---|---|---|---|---|
| | 91 | 1 | 0 | **4.99** |
| | *98.9%* | *1.1%* | | |

| | |
|---|---|
| MedStar Medicaid 911 *transport* volume last year | 17,600 trips |
| 17,600 ED visits by ambulance at $2,500 | $44 million ED expenditures |
| 15% reduction in transport volume = 2,640 less trips @ $2,500 | $6.6 million in ED expenditure savings |
| Current Medicaid transport ratio = 86% | |
| If TIP paid, 14% additional EMS services paid, 2,464 @ $281 | $692,000 |
| Net savings to Medicaid just for FORT WORTH | $5.9 million if we can alt dispo 15% of the patients |

*So, for each additional $1 paid to EMS for TIP, $8.50 saved*

## State Examples of Payment for Treatment in Place

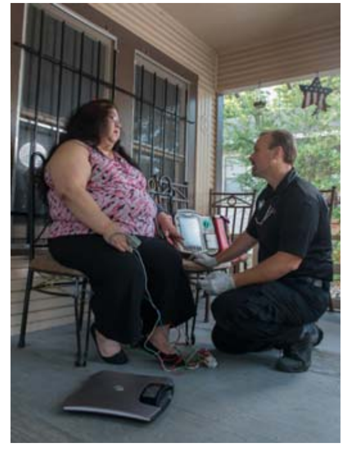
- **Arizona**
  - Medicaid reimburses EMS agencies for Treatment in Place
- **Georgia**
  - Medicaid reimburses EMS agencies for Treatment in Place
- **Indiana**
  - New law that takes effect July 1st allows payment for procedures performed on scene during PHE
- **Minnesota**
  - Medicaid reimburses for 'on-demand' & scheduled community paramedic services
- **New Mexico**
  - Medicaid reimburses for 'on-demand' & scheduled community paramedic services

## State Examples of Payment for Treatment in Place

- **Pennsylvania**
  - Health plans licensed in the state are required to pay for treat and no transport
- **Washington**
  - Medicaid reimburses for 'on-demand' & scheduled community paramedic services
- **Wyoming**
  - Medicaid reimburse for treat and no transport and community paramedic home visits
- **Anthem**
  - Pays for treat and no transport in all Anthem states

## Role Innovation: *Mobile Healthcare*

- **Home visits**
  - Scheduled & episodic
    - Enhanced training for 'routine' emergencies
      - ❑ Sutures, medical device troubleshooting



## Role Innovations: *Mobile Healthcare*

- **Physician extender role**
  - Facilitate telemedicine
  - Contracts with Physicians
- **Healthcare Navigator**
  - Episodic and scheduled

**[CMS-1744-IFC]**
**RIN 0938-AU31**
**Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency**
**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.
**ACTION:** Interim final rule with comment period.

"….. We note that in specifying that direct supervision includes virtual presence through audio/video real-time communications technology during the PHE for the COVID-19 pandemic, *this can include instances where the physician enters into a contractual arrangement for auxiliary personnel as defined in § 410.26(a)(1), to leverage additional staff and technology necessary to provide care that would ordinarily be provided incident to a physicians' service (including services that are allowed to be performed via telehealth). For example, physicians may enter into contractual arrangements with a home health agency (defined under section 1861(o) of the Act), a qualified infusion therapy supplier (defined under section 1861(iii)(3)(D) of the Act), or entities that furnish ambulance services in order to utilize their nurses or other clinical staff as auxiliary personnel under leased employment* (§ 410.26(a)(5)). In such instances, the provider/supplier would seek payment for any services they provided from the billing practitioner and would not submit claims to Medicare for such services. For telehealth services that need to be personally provided by a physician, such as an E/M visit, the physician would need to personally perform the E/M visit and report that service as a Medicare telehealth service."

https://www.cms.gov/files/document/covid-final-ifc.pdf

**Dan Trigub left Uber Health to start a new healthcare venture. Here is what he's working on**
by Heather Landi
**Dec 3, 2020**

In his two years at Uber Health, Dan Trigub worked to expand access to medical transportation, and, now, he's focused on building a unique approach to home health.

Trigub and co-founder Inna Plumb have launched MedArrive as a new care management platform that enables healthcare providers and payers to extend services into the home.

***The startup bridges the virtual care gap by integrating physician-led telemedicine with hands-on care from a network of trusted EMS professionals, improving patient outcomes while empowering an underutilized segment of healthcare workers, according to the company.***

***MedArrive taps into a capable workforce of EMS professionals so they can leverage the full scope of their training, earn supplemental income and diversify their day-to-day responsibilities.*** At the same time, patients using MedArrive are able to access trusted medical expertise from the safety of their homes and within their existing health systems, ultimately resulting in better patient outcomes, a better-utilized healthcare workforce and significant cost savings for patients and providers alike, according to the company.

"Care is moving into the home, but how can we do it cost-effectively? By leveraging EMS and existing players in the market to deliver care in a cost-effective way, we can be active in both rural or urban environments," she said.

https://www.fiercehealthcare.com/tech/dan-trigub-left-uber-health-to-start-a-new-healthcare-venture-here-what-he-s-working

# Role Innovations: *Post Acute & On Demand*

- **Safe Transitions**
- **On Demand Services**
  - Hospital in the Home
  - SNF Avoidance

**CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge**
**Nov 25, 2020**

Today, the Centers for Medicare & Medicaid Services (CMS) outlined unprecedented comprehensive steps to increase the capacity of the American health care system to provide care to patients outside a traditional hospital setting amid a rising number of coronavirus disease 2019 (COVID-19) hospitalizations across the country.

Building on CMS's previous actions to expand the availability of telehealth across the nation, these actions are aimed at allowing health care services to be provided outside a hospital setting while maintaining capacity to continue critical non-COVID-19 care, allowing hospitals to focus on the increased need for care stemming from public health emergency (PHE).

Participating hospitals will be required to have appropriate screening protocols before care at home begins to assess both medical and non-medical factors, including working utilities, assessment of physical barriers and screenings for domestic violence concerns.

Beneficiaries will only be admitted from emergency departments and inpatient hospital beds, and an in-person physician evaluation is required prior to starting care at home. ***A registered nurse will evaluate each patient once daily either in person or remotely, and two in-person visits will occur daily by either registered nurses or mobile integrated health paramedics, based on the patient's nursing plan and hospital policies.***

CMS.gov

https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge

## Role Innovation: *Public Health*

- COVID Pandemic
  - Facility-based & in-home ‘testing’
  - Contact tracing

## Role Innovation: *Public Health*

- **Vaccines**
  - Flu, childhood immunizations
  - “Shots across Texas”
- **Opioid Treatment**
  - Suboxone, Narcan
- **COVID Vaccines?**

Last year, MedStar crews responded to over ***1,000 patients with flu like illness…***
***We’d like to help reduce that number this year!!***

**MedStar is being pro-active by offering mobile flu vaccine clinics for 10 or more people at a place convenience for YOU!**

**To schedule an on-site flu vaccine clinic, visit http://www.medstar911.org/medstar-mobile-flu-vaccine-program, call 817-632-0522 or email MZavadsky@medstar911.org**

**Vaccines are $25 each and we will provide documentation for insurance reimbursement**

# Potential EMS Roles in Vaccines and Monoclonal Antibody Infusion

# Logical Partner

EMS-FIRE
PHYSICIAN
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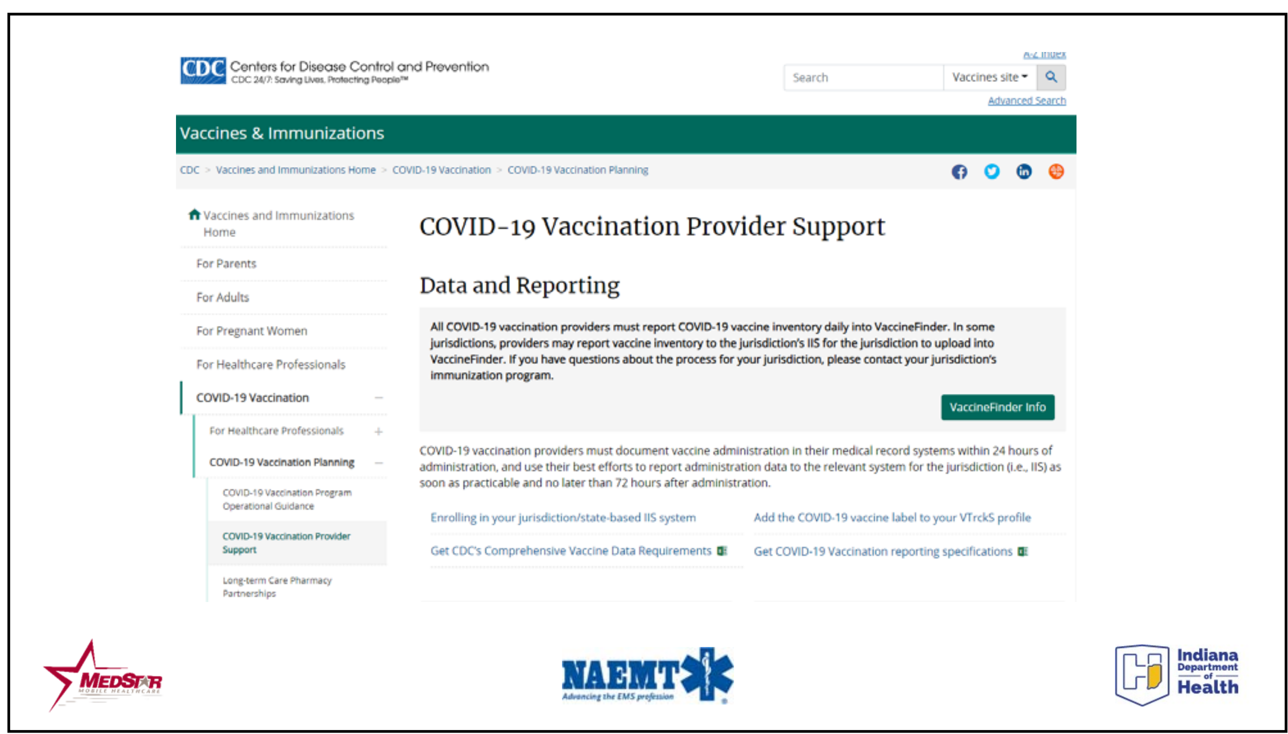
CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
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For Healthcare Professionals
COVID-19 Vaccination
For Healthcare Professionals
COVID-19 Vaccination Planning
COVID-19 Vaccination Program Operational Guidance
COVID-19 Vaccination Provider Support
Long-term Care Pharmacy Partnerships
COVID-19 Vaccination Provider Support
Data and Reporting
All COVID-19 vaccination providers must report COVID-19 vaccine inventory daily into VaccineFinder. In some jurisdictions, providers may report vaccine inventory to the jurisdiction's IIS for the jurisdiction to upload into VaccineFinder. If you have questions about the process for your jurisdiction, please contact your jurisdiction's immunization program.
VaccineFinder Info
COVID-19 vaccination providers must document vaccine administration in their medical record systems within 24 hours of administration, and use their best efforts to report administration data to the relevant system for the jurisdiction (i.e., IIS) as soon as practicable and no later than 72 hours after administration.
Enrolling in your jurisdiction/state-based IIS system
Add the COVID-19 vaccine label to your VTrckS profile
Get CDC's Comprehensive Vaccine Data Requirements
Get COVID-19 Vaccination reporting specifications
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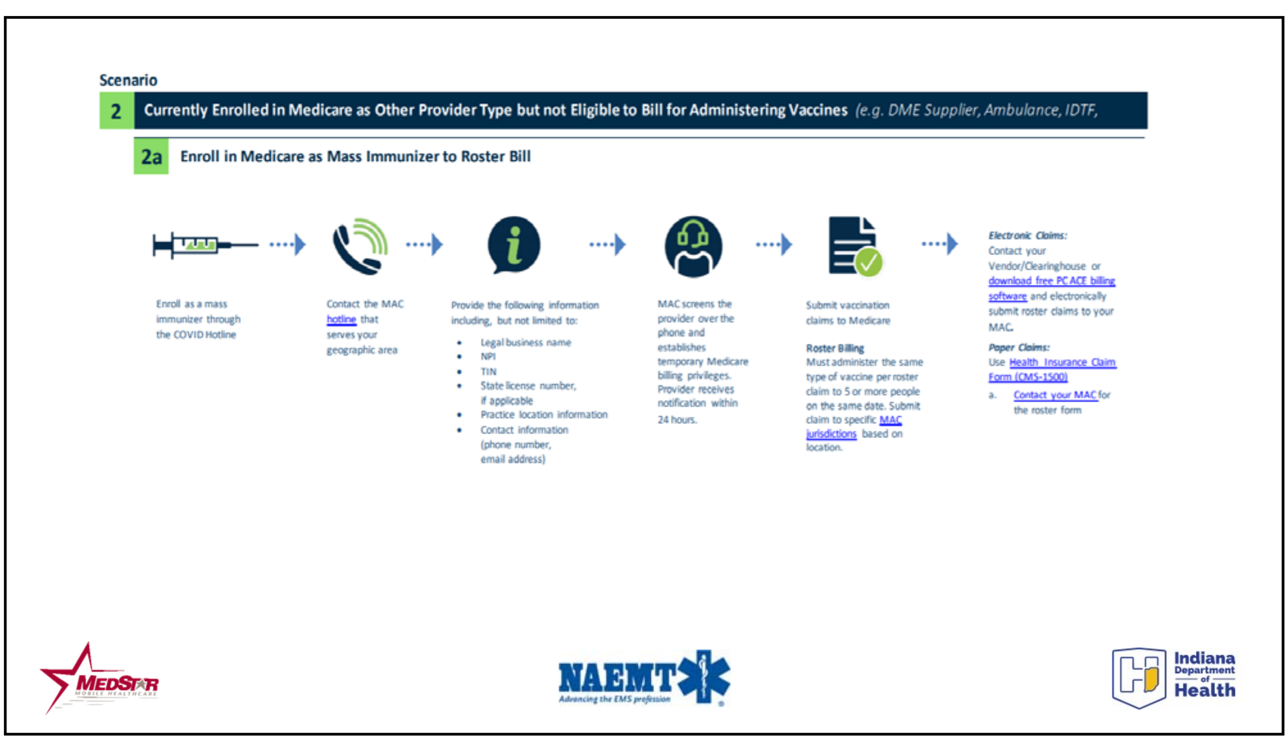
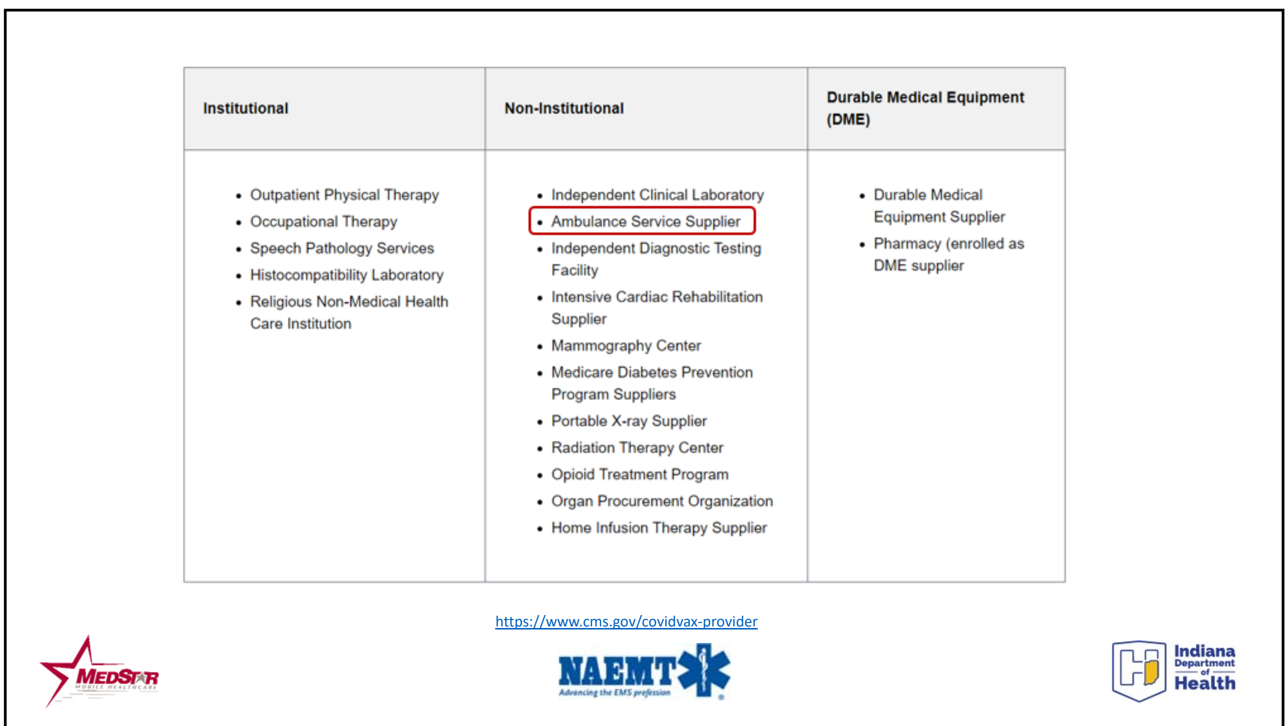


| Institutional | Non-Institutional | Durable Medical Equipment (DME) |
|---|---|---|
| • Outpatient Physical Therapy<br>• Occupational Therapy<br>• Speech Pathology Services<br>• Histocompatibility Laboratory<br>• Religious Non-Medical Health Care Institution | • Independent Clinical Laboratory<br>• Ambulance Service Supplier<br>• Independent Diagnostic Testing Facility<br>• Intensive Cardiac Rehabilitation Supplier<br>• Mammography Center<br>• Medicare Diabetes Prevention Program Suppliers<br>• Portable X-ray Supplier<br>• Radiation Therapy Center<br>• Opioid Treatment Program<br>• Organ Procurement Organization<br>• Home Infusion Therapy Supplier | • Durable Medical Equipment Supplier<br>• Pharmacy (enrolled as DME supplier |

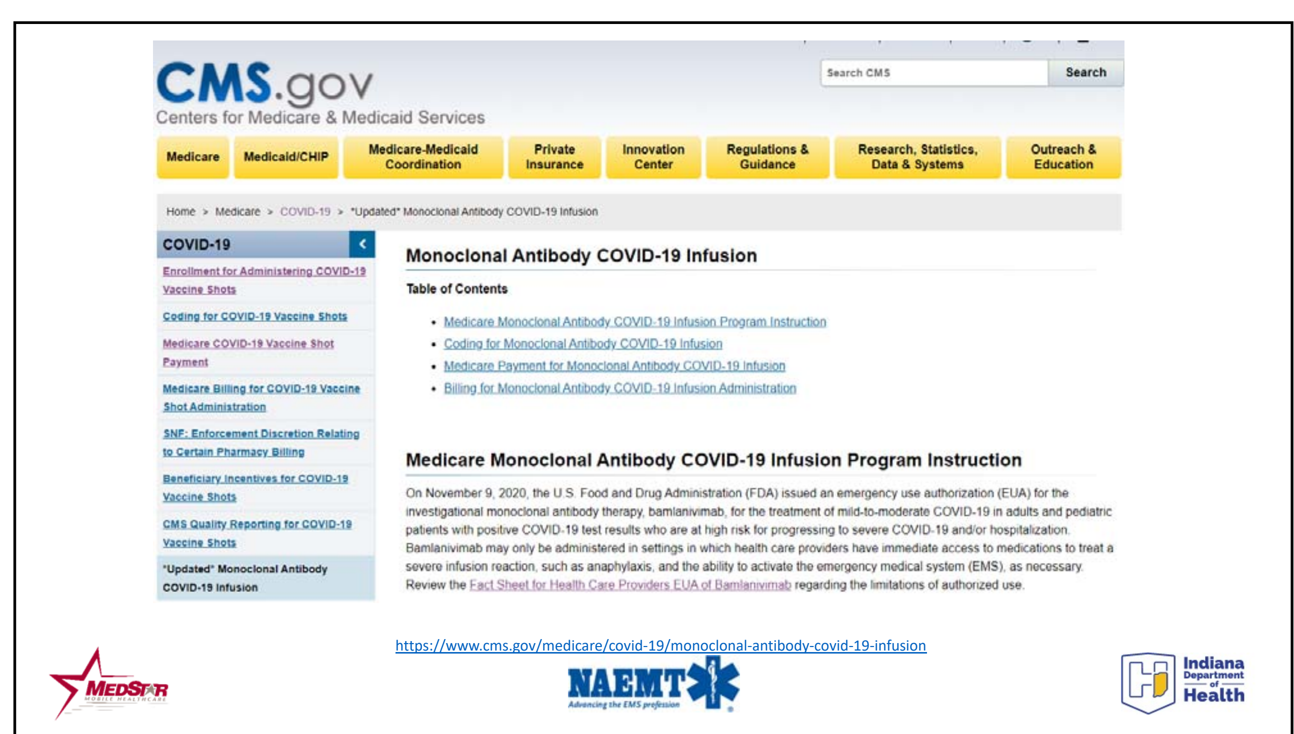
**FACT SHEET FOR HEALTH CARE PROVIDERS**
**EMERGENCY USE AUTHORIZATION (EUA) OF BAMLANIVIMAB**

**AUTHORIZED USE**

The U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) to permit the emergency use of the unapproved product bamlanivimab for the treatment of mild to moderate coronavirus disease 2019 (COVID-19) in adults and pediatric patients with positive results of direct SARS-CoV-2 viral testing who are 12 years of age and older weighing at least 40 kg, and who are at high risk for progressing to severe COVID-19 and/or hospitalization.

**LIMITATIONS OF AUTHORIZED USE**

- Bamlanivimab is not authorized for use in patients:
  - who are hospitalized due to COVID-19, OR
  - who require oxygen therapy due to COVID-19, OR
  - who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity.
- Benefit of treatment with bamlanivimab has not been observed in patients hospitalized due to COVID-19. Monoclonal antibodies, such as bamlanivimab, may be associated with worse clinical outcomes when administered to hospitalized patients with COVID-19 requiring high flow oxygen or mechanical ventilation.



CMS.gov
Centers for Medicare & Medicaid Services

Search CMS | Search

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Home > Medicare > COVID-19 > "Updated" Monoclonal Antibody COVID-19 Infusion

**COVID-19**

- Enrollment for Administering COVID-19 Vaccine Shots
- Coding for COVID-19 Vaccine Shots
- Medicare COVID-19 Vaccine Shot Payment
- Medicare Billing for COVID-19 Vaccine Shot Administration
- SNF: Enforcement Discretion Relating to Certain Pharmacy Billing
- Beneficiary Incentives for COVID-19 Vaccine Shots
- CMS Quality Reporting for COVID-19 Vaccine Shots
- "Updated" Monoclonal Antibody COVID-19 Infusion

**Monoclonal Antibody COVID-19 Infusion**

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- Medicare Monoclonal Antibody COVID-19 Infusion Program Instruction
- Coding for Monoclonal Antibody COVID-19 Infusion
- Medicare Payment for Monoclonal Antibody COVID-19 Infusion
- Billing for Monoclonal Antibody COVID-19 Infusion Administration


**Medicare Monoclonal Antibody COVID-19 Infusion Program Instruction**

On November 9, 2020, the U.S. Food and Drug Administration (FDA) issued an emergency use authorization (EUA) for the investigational monoclonal antibody therapy, bamlanivimab, for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and/or hospitalization. Bamlanivimab may only be administered in settings in which health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis, and the ability to activate the emergency medical system (EMS), as necessary. Review the Fact Sheet for Health Care Providers EUA of Bamlanivimab regarding the limitations of authorized use.

https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion

MEDICARE

12/7/2020

METROPOLITAN AREA EMS AUTHORITY
2900 ALTA MERE DR
FT WORTH, TX 76116

Attention: MATT ZAVADSKY

Reference: National Provider Identifier (NPI): [redacted]
Provider Transaction Access Number (PTAN): [redacted]

Dear METROPOLITAN AREA EMS AUTHORITY:

This letter is written confirmation that you have been granted temporary Medicare billing privileges pursuant to the CMS waiver of certain enrollment and screening requirements during the national emergencies associated with COVID-19. These temporary billing privileges are being established per a phone call on DECEMBER 7, 2020. Temporary billing privileges are being established to provide mass immunization services. Listed above are your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

# Role Innovation: *Public Safety*

- Critical Incident Response Teams
  - Behavioral Health Alternate Resources
  - Examples:
    - **Fort Worth**: Critical Incident Team (CIT)
    - **Dallas**: Right Care
    - **Memphis**: Crisis Assessment and Response to Emergencies (CARE)
    - **Colorado Springs**: Community Response Team (CRT
    - **Eugene**: Crisis Assistance Helping Out on the Streets (CAHOOTS)
    - **Eagle County, CO**: The Hope Center

# EMS Enhanced Services Options for Health Plans

**Mirror Recently Announced CMS Emergency Triage, Treatment and Transport (ET3) payment model**

- 9-1-1 emergency encounters for Health Plan members are assessed, treated and navigated to the clinically appropriate follow-up care
  - *Treatment in Place* without transport through on-line telehealth with a Qualified Healthcare Provider (QHP)
    - Reimbursed on a per encounter basis
    - QHP telehealth also eligible for FFS payment within existing guidelines/rules
    - Billed FFS using appropriate HCPCS code, based on level of on-scene care provided
      - A0427 Ambulance Transport, ALS, Emergency
      - A0429 Ambulance Transport, BLS, Emergency
  - *Transport to alternate destinations* such as Urgent Care, or other care settings
    - Reimbursed on a per encounter basis
    - Billed FFS for the intervention and navigation using appropriate transport HCPCS code + miles
      - A0427 Ambulance Transport, ALS, Emergency
      - A0429 Ambulance Transport, BLS, Emergency
      - A0425 Ambulance Mileage

# EMS Enhanced Services Options for Health Plans

**Enrollment of Health Plan High Utilizer Group (HUG) Members**

- Identified and referred by the Health Plan Case Management team
- Located by EMS and member consents to enrollment
- Members enrolled for 90 days, mirroring EMS-Based High Utilizer model
- Billed FFS for the encounter using CPT Code **99344**: *Home visit for patient evaluation and management*
  - Reimbursed on a per encounter basis

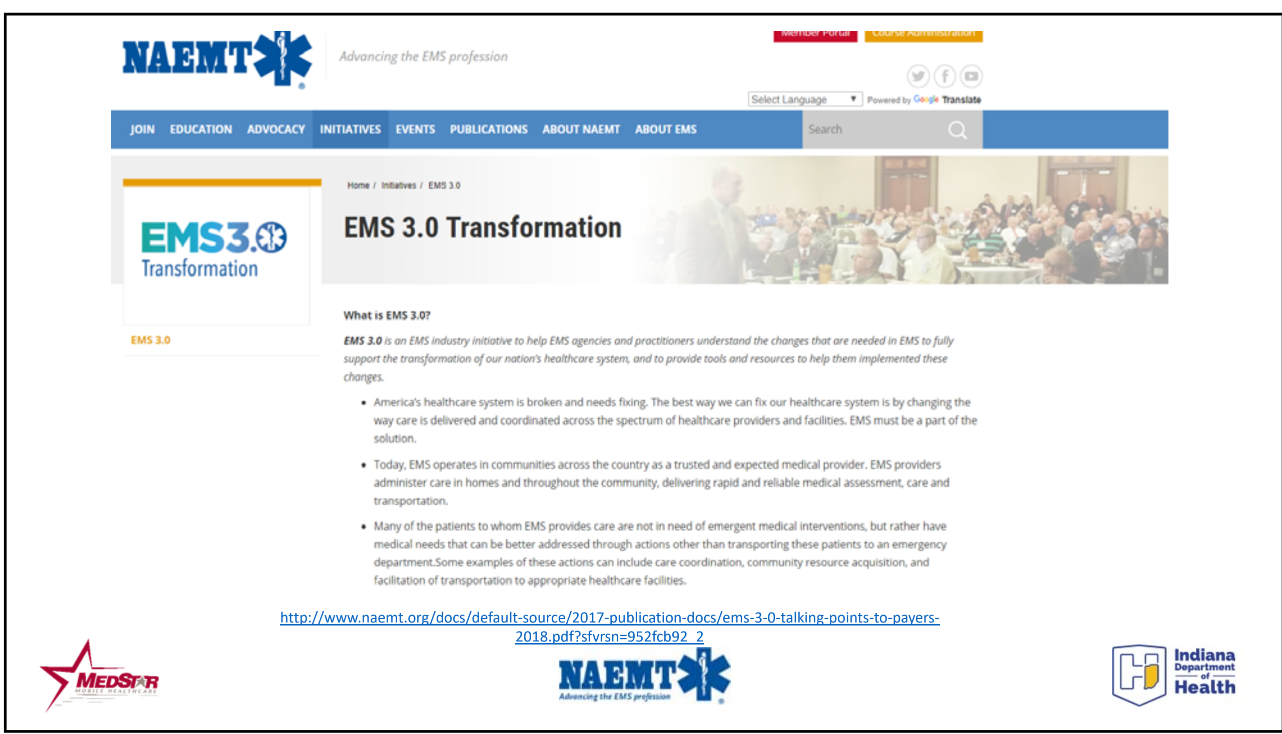
**Safe Transitions**

- Initial home visit for recently discharged in-patients referred by Health Plan Case Managers
  - Assure safety in the home
  - Review discharge instructions
  - Medication inventory
  - Assure follow-up appointment(s) scheduled with PCP, etc.
- Billed FFS for the encounter using CPT Code **99344**: *Home visit for patient evaluation and management*
  - Reimbursed on a per encounter basis

# EMS Enhanced Services Options for Health Plans

**<u>EMS 'On-Demand' Services</u>**

- For any Health Plan *member* through Health Plan Nurse Advice, case management, or other referral source
- As Health Plan *member* benefit for Health Plan members in the EMS service area
- For Health Plan *Case Management Staff* who would like a home visit assessment for an 'at-risk' member
  - Including member education, connection with PCP, other services
- Billed FFS for the encounter using CPT Code **99344**: *Home visit for patient evaluation and management*
  - Reimbursed on a per encounter basis



## NAEMT Value Statements

- Commercial Insurers
- Hospitals
- Home Health
- Hospice
- Post Acute Care Agencies
- Medicaid
- Medicare
- Taxpayers
- Labor Unions

Explaining the Value to Payers

EMS3.0

Explaining the Value to Payers

This document has been created to provide talking points for EMS agencies to explain to payers the value of EMS 3.0 services.

Please review and download as needed the following talking points:

PAYER

City Council/Tax Payers .......... 3
Hospitals .......... 4
Home Care Services .......... 5
Hospices .......... 6
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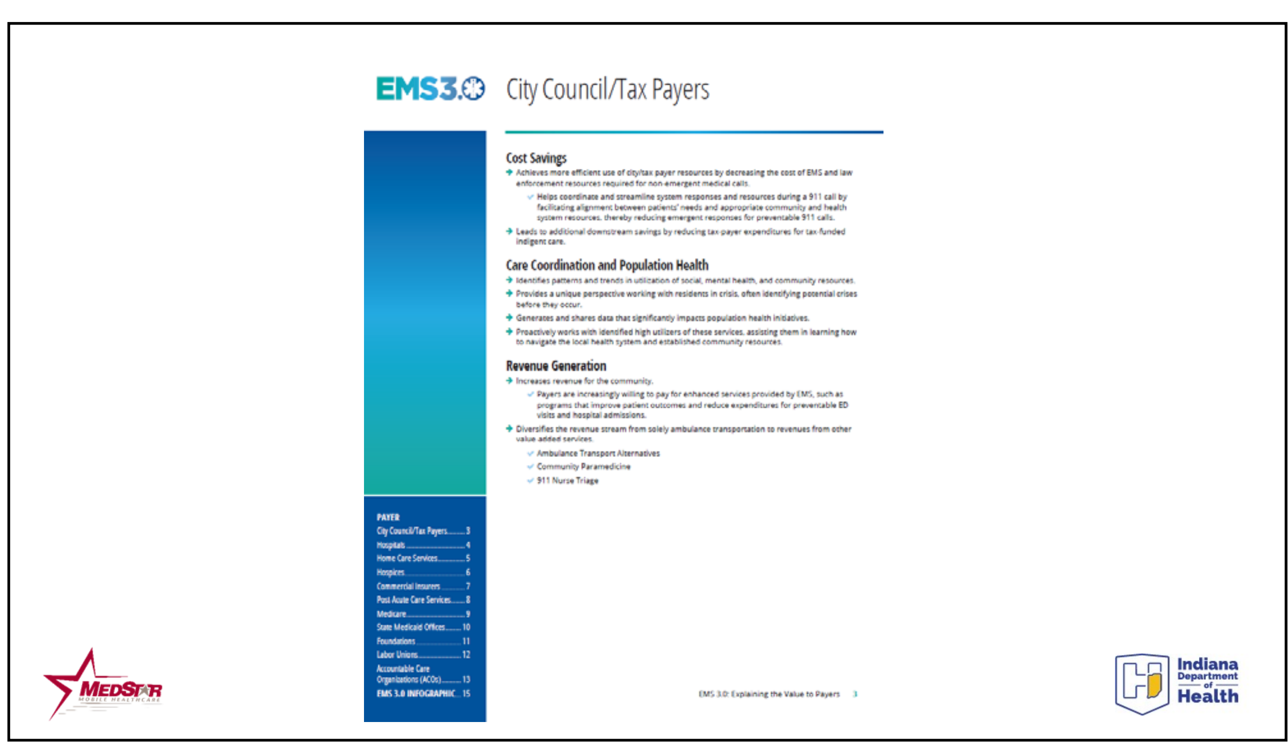
NAEMT

*NAEMT greatly appreciates the work provided by the members of the NAEMT EMS 3.0 Committee to create this guide. Special thanks to Mark Babson, Jason Scheiderer and Matt Zavadsky for their contributions.*

MEDSTAR

Indiana Department of Health


EMS3.0 City Council/Tax Payers
Cost Savings
Achieves more efficient use of city/tax payer resources by decreasing the cost of EMS and law enforcement resources required for non-emergent medical calls.
Helps coordinate and streamline system responses and resources during a 911 call by facilitating alignment between patients' needs and appropriate community and health system resources, thereby reducing emergent responses for preventable 911 calls.
Leads to additional downstream savings by reducing tax-payer expenditures for tax-funded indigent care.
Care Coordination and Population Health
Identifies patterns and trends in utilization of social, mental health, and community resources.
Provides a unique perspective working with residents in crisis, often identifying potential crises before they occur.
Generates and shares data that significantly impacts population health initiatives.
Proactively works with identified high utilizers of these services, assisting them in learning how to navigate the local health system and established community resources.
Revenue Generation
Increases revenue for the community.
Payers are increasingly willing to pay for enhanced services provided by EMS, such as programs that improve patient outcomes and reduce expenditures for preventable ED visits and hospital admissions.
Diversifies the revenue stream from solely ambulance transportation to revenues from other value added services.
Ambulance Transport Alternatives
Community Paramedicine
911 Nurse Triage
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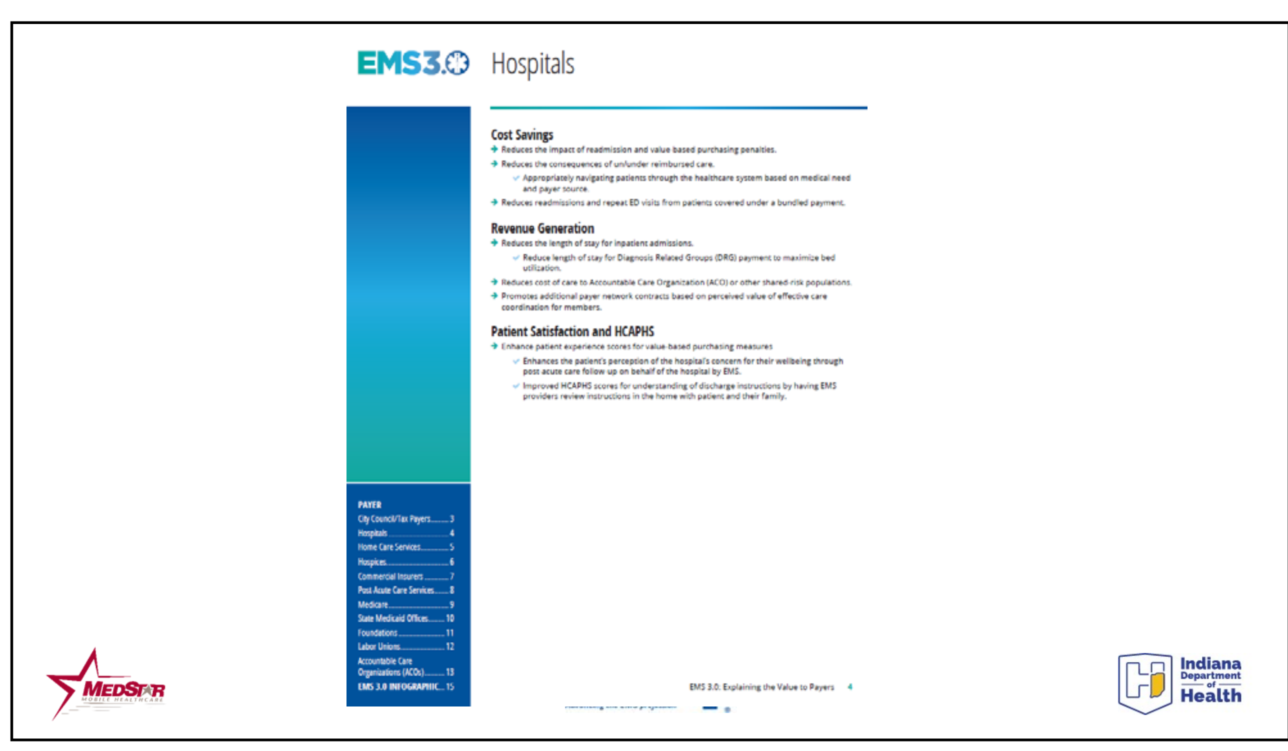
EMS3.0 Hospitals
Cost Savings
Reduces the impact of readmission and value based purchasing penalties.
Reduces the consequences of un/under reimbursed care.
Appropriately navigating patients through the healthcare system based on medical need and payer source.
Reduces readmissions and repeat ED visits from patients covered under a bundled payment.
Revenue Generation
Reduces the length of stay for inpatient admissions.
Reduce length of stay for Diagnosis Related Groups (DRG) payment to maximize bed utilization.
Reduces cost of care to Accountable Care Organization (ACO) or other shared-risk populations.
Promotes additional payer network contracts based on perceived value of effective care coordination for members.
Patient Satisfaction and HCAPHS
Enhance patient experience scores for value-based purchasing measures
Enhances the patient's perception of the hospital's concern for their wellbeing through post acute care follow up on behalf of the hospital by EMS.
Improved HCAPHS scores for understanding of discharge instructions by having EMS providers review instructions in the home with patient and their family.
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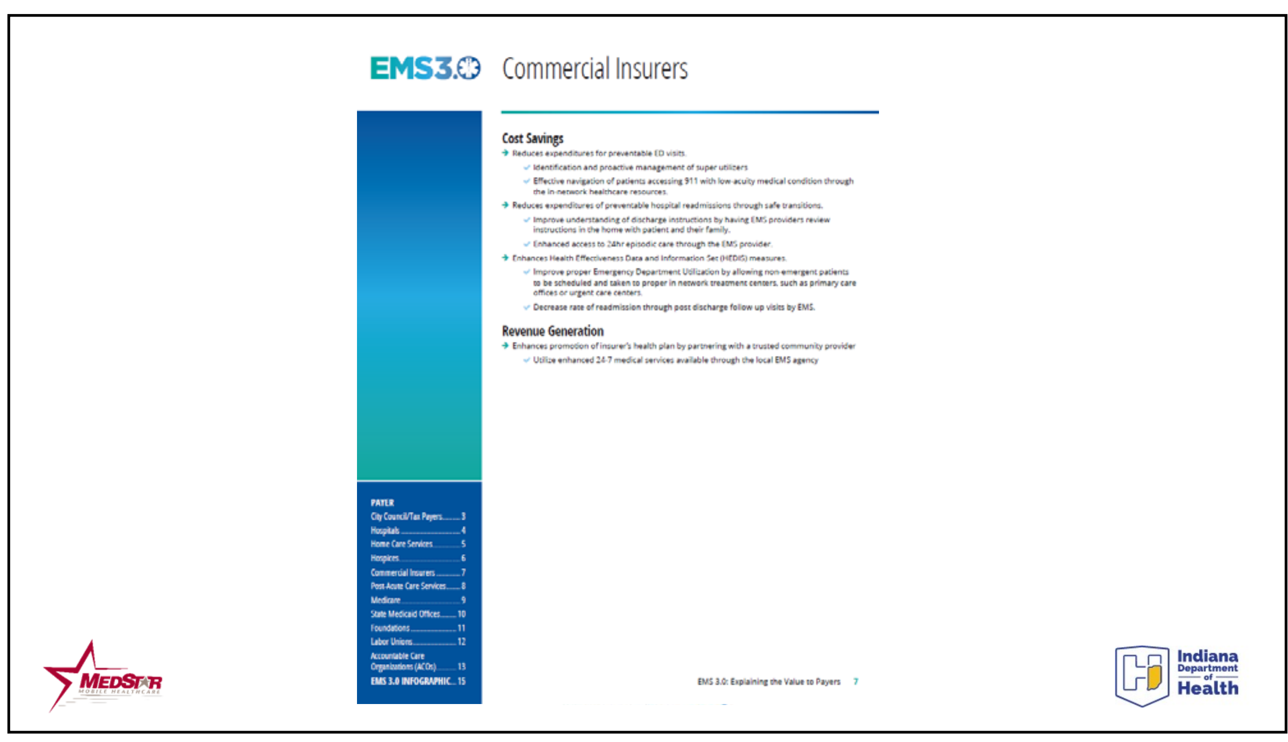

EMS3.0 Commercial Insurers

**Cost Savings**

- Reduces expenditures for preventable ED visits.
  - Identification and proactive management of super utilizers
  - Effective navigation of patients accessing 911 with low-acuity medical condition through the in-network healthcare resources.
- Reduces expenditures of preventable hospital readmissions through safe transitions.
  - Improve understanding of discharge instructions by having EMS providers review instructions in the home with patient and their family.
  - Enhanced access to 24hr episodic care through the EMS provider.
- Enhances Health Effectiveness Data and Information Set (HEDIS) measures.
  - Improve proper Emergency Department Utilization by allowing non-emergent patients to be scheduled and taken to proper in network treatment centers, such as primary care offices or urgent care centers.
  - Decrease rate of readmission through post discharge follow up visits by EMS.

**Revenue Generation**

- Enhances promotion of insurer's health plan by partnering with a trusted community provider
  - Utilize enhanced 24-7 medical services available through the local EMS agency

PAYER

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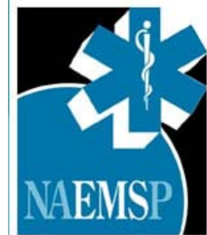
# MIH Learning Action Network (LAN)…



https://mihcp.tmf.org/

# Takeaways…

- Our external environment is changing
- ***WE*** have to prepare
- Know your cost of delivery
- Know your ***VALUE***
- Try new models
- Follow the money!!
  - ***Who is at risk for the expenditure?***
- ***ENGAGE!!***
  - Local, state and national associations