AMBULANCE PAYMENT REFORM

Safety Net, Provider Designation & Revenue Cycle Model 3.0
Overview

- Healthcare Landscape
- Revenue Cycle Model 3.0
- Safety Net Providers
- Provider Designation
- Q&A
Healthcare Landscape
“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.”

Statement by 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
March 16, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Azar:

During your confirmation process, you demonstrated an interest in advancing payment and delivery system reform and an understanding of the importance of this work. Improving quality while reducing health care spending is an achievable goal that Republicans and Democrats share. We write to impress upon you that as the current administration evaluates the previous administration’s efforts, it should not walk away from having clear priorities and goals for advancing payment reform and improving quality, and providing the guidance needed to achieve them.

At your nomination hearing in the Health, Education, Labor, and Pensions Committee, you said “Medicare is the only payer that sits there with enough concentration of lives to change the system.” We agree. As the largest purchaser of health care in the United States, the federal government needs to send a strong signal that paying for volume via fee-for-service is not the direction in which our health care system is headed. Any real or perceived absence of federal leadership will slow private-sector momentum toward alternative payment models.

Retaining momentum is important because the United States has the most expensive health care system in the world, and because health care providers, insurers, states, and other stakeholders across the country have made significant investments to change where, how, and what health care is delivered. This change needs guidance and support from the federal government to be successful.

Sincerely,

Bill Cassidy (R-LA) and Sheldon Whitehouse (D-RI)
AMBULANCE REIMBURSEMENT MODEL 3.0
Present and Future Model(s)

- Value-based Program
- Capitation
- Bundled Billing
- Shared Savings
- Fee-for-Service
VALUE-BASED PROGRAMS

<table>
<thead>
<tr>
<th>LEGISLATION PASSED</th>
<th>PROGRAM IMPLEMENTED</th>
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<tr>
<td>2008</td>
<td>MIPPA</td>
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<td>2010</td>
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<td>MIPS</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
- HACR: Hospital-Acquired Condition Reduction Program
- HRRP: Hospital Readmissions Reduction Program
- HVB: 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

Centers for Medicare and Medicaid Services
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
  - Financial modeling should
- Shared Savings with health plan if targeted downstream savings achieved
CMS Payment Initiative

- 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%
- 2018: 90%

**Goals**
- 2011: 68%
- 2014: ~20%
- 2016: 30%
- 2018: 50%
Ambulance Payment Evolution

Prior to 4/1/2002
Paid on reasonable cost or charge (I,II,III,IV)

BBA of 1997
Established fee schedule, 4/1/2002

Temporary Ambulance Extenders
Effective 7/1/2004
Snapshot of Today

Ambulance Medicare Payment System

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
Mileage
Mileage rate

Total fee schedule ambulance payment

PE GPCI
Core Components of Other Medicare 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
## Ambulance Reimbursement Model 3.0

**Medically Necessary Response Configuration - SAMPLE**

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<td>Nurse Triage - Unscheduled</td>
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<td>7-Digit</td>
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## Relative Value Unit Calculations - SAMPLE

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<tr>
<th>Service Level</th>
<th>Sample Cost Per Tran/Vst/Cll</th>
<th>Sample Relative Value Unit</th>
<th>Sample Relative Value Unit</th>
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<td>Urban</td>
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<td>Super-Rural</td>
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<td>$50.00</td>
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**RVU = 224.00**
Supplier to Provider: Why?

Healthcare Practitioners
Suppliers

• Do not provide healthcare services
• Commodity-driven
  • Equipment
  • Supplies
  • Transportation
• Costs are set based upon commodity
  • DMEPOS subject to competitive bidding
  • Ambulance focuses on the transportation aspect only
EMS Evolution

Past

Present

Future
“The committee’s vision expands the concept of an inclusive trauma system to include all illnesses and injuries, as well as the entire continuum of emergency care—including 9-1-1 dispatch, prehospital EMS, and clinics and urgent care providers that may play a role in emergency care.”
EMS personnel utilizing **disaster triage systems** (sort, assess, life-saving interventions, treatment/transport; simple triage and rapid treatment [START]; and JumpSTART triage methods) so they can **assess patients within 60 seconds** and categorize them for immediate or delayed care.
Examples of Health Care Services

- Induced Hypothermia
- Impedance Threshold Device (RESQPOD)
- Capnography
- Interosseous (IO) Infusion
- 12 Lead ECG Transmission and Interpretation
- Continuous Positive Airway Pressure (CPAP)
- Non-Invasive Positive Pressure Ventilation (NIPPV) (Portable Vent)
- Supraglottic Airway Devices
- Quick Trach
- Met Hemoglobin
- Meconium Aspirator
- Cook’s Catheter

Advances require more training and carrying expensive drugs or equipment on vehicles
Non Emergency: Medical Services

Focusing on Patients’ Medical Needs

- Morbidly Obese
- Mental/Behavioral Health
- Oxygen Administration
- Special Handling/Positioning

Health Care Services Provided

- Ventilation/Advanced Airway Management
- Suctioning
- Isolation Precautions
- Intravenous Fluid Administration
Recognizing Ambulances as Providers

Ambulance services’ core mission is to provide mobile health care services to patients

• Inappropriate to consider for competitive bidding – providing more than lowest bid on transportation
• Payment rates need to recognize the costs of the health care services provided, as well as the transportation
• Important to raise the bar to reduce fraud and abuse
What Will It Mean To My Agency?

1. Survey or Accreditation Process Required*
2. CMS Participation Agreement
3. Electronic Claims Submission, except for low volume providers
4. Cost Reporting or Cost Data Collection
5. Quality Data Reporting
Allows for Conditions of Participation

Conditions of Coverage/Conditions of Participation

- Set a federal standard for how providers operate and interact with beneficiaries

Sample provisions

- Organizational/Administration
- Administrative and Medical Records
- Compliance with Other Laws
- Personnel
- Safety
- Patient Rights

State and local requirements will remain primary
Allows for Provider Payment Review Board

- Independent Panel as established under Section 1878 of the SSA
- Avenue for certified Medicare providers to dispute CMS final approval regarding reasonable cost reimbursement
- Covers all providers who cost report
- Also covers HMOs and competitive medical plans that participate in the Medicare program
- There are a few nonprovider entities that file periodic cost reports that are excluded from the protections under PPRB (*$1000 or >)
Accreditation or Survey Process

• Accreditation Organization or State-sponsored
• Site review
• Certify minimum operational and administrative procedures
• Similar to CAAS but not as extensive
Provider Status Change WILL NOT…. 

1. Impact any Third Party or Medicaid Reimbursements
2. Require you to participate in CP programs or the equivalent
3. Allow for Paramedics or EMTs to bill for services to Medicare Part B
4. Change the current billing requirements and reimbursement for ambulance agencies under Medicare Part B
Hospital-based Ambulance Providers

Centers for Medicare & Medicaid Services 2015 Part B Data File
Safety Net Providers

1. Mirror Disproportionate Share Hospital (DSH) eligibility criteria
2. EMS DS = 15% or greater un- and underinsured and provide emergency response services through a 9-1-1 system or equivalent
3. Give ability to the states to request a State Plan Amendment or waiver under Section 1115(a)(2) to allow for additional payment.
Contact Information

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