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CMS Releases ET3 Pilot Model

On February 14, 2019, the *Centers for Medicare & Medicaid Services* (CMS) announced a new voluntary *Emergency Triage, Treat, and Transport* (ET3) payment pilot model, granting ambulance teams greater flexibility when addressing 911 initiated emergency calls for Medicare *fee-for-service* (FFS) beneficiaries.[1] The number of costly *emergency department* (ED) visits has been gradually increasing for decades, causing healthcare spending concerns;[2] in 2015, there were approximately 136.9 million ED visits, 15.6% of which visits were by those aged 65 and older.[3] As a response to the high ED utilization, most private insurance plans and select Medicaid programs discourage costly ED use through methods such as imposing higher copays or refusing to pay if the condition does not meet the definition of an "*emergency*."[4] However, under current policies, Medicare only pays for emergency ground ambulance services to hospitals, critical access hospitals, skilled nursing facilities, and dialysis centers, with no incentive for transporting non-emergent patients to lower cost care.[5] Due to this payment constraint, ambulances are funneling patients to high cost settings, i.e., hospital EDs, even when a less expensive, more appropriate alternative may be available, effectively increasing Medicare (and overall healthcare) expenditures.[6] This *Health Capital Topics* article will discuss the various aspects of the ET3 model, as well as the implications for the *emergency medical services* (EMS) system and other healthcare organizations.

The ET3 model aims to limit the incentive for emergency ambulance teams to transport Medicare FFS beneficiaries only to covered Medicare facilities, e.g., hospital EDs, by making it possible for the participating ambulance suppliers and providers to partner with qualified healthcare practitioners, i.e., individuals qualified by education, training, etc. to perform a healthcare service within their scope of practice,[7] and be reimbursed for that treatment through two new types of ambulance payments.[8] In addition to the traditional hospital ED transport payment, the ambulance team would also receive payment for transporting beneficiaries to alternative destination sites (e.g., primary care physician offices or urgent care clinics) and for treatment with a qualified healthcare practitioner in place (for services either rendered on the scene or through telehealth services).[9] In addition to allowing payment to these alternative destinations/treatments, the model will enable participating ambulance suppliers and providers to earn up to a 5% positive payment adjustment based on the achievement of certain quality measures in later years.[10] Although there is limited information regarding the quality component, the quality measurements strategy intends to minimize new reporting requirements to reduce participant burden.[11] However, both qualified healthcare practitioners and alternative site destinations will receive their usual Medicare payment for services provided.[12]

Additionally, this model seeks to develop triage lines for low-acuity 911 calls wherein the dispatch system would screen patients based on their needs.[13] Either an ambulance ride would be initiated, to triage the individual through ET3 interventions based on their condition, or the individual would stay on the phone, and be transferred to discuss their health concerns with a healthcare professional via a medical triage line.[14] Of note, a beneficiary is still able to override a first responder's decision and choose to be brought to an ED.[15] While the ET3 system is limited to Medicare FFS beneficiaries, CMS encourages a multi-payor alignment strategy, supporting model participants in their partnerships with additional payors to provide similar interventions to all patients (and not just Medicare beneficiaries) within the locality.[16] CMS intends to issue 40 two-year cooperative agreements, available to local governments or other relevant entities, in the participating geographic areas in order to establish medical triage lines; this would allow 911 dispatch to evaluate whether a patient's condition is appropriate for a medical triage line instead of an ambulance transport.[17]

Through the ET3 model's aim of engaging healthcare providers across the continuum of care to meet beneficiaries' needs, overall spending is projected to decrease, as a result of avoiding unnecessary transports and additional downstream costs. A whitepaper released by the U.S. Departments of *Health and Human Services* (HHS) and Transportation reported that Medicare could save approximately $560 million per year by transporting patients to physician offices, rather than always transferring individuals to a hospital ED.[18] In addition, avoided hospitalizations from unnecessary ED transports may provide further savings and quality improvements.[19] CMS estimates that up to 19% of FFS beneficiaries could be treated at the alternative destinations, allowing beneficiaries to decrease their out-of-pocket costs, rather than paying for expensive ED visits.[20] Beneficiaries choosing these alternative destinations will be able to

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avoid hours spent waiting in the ED, avoid the costs associated with unnecessary hospitalization, and mitigate exposure to hospital acquired conditions.[21]

CMS Administrator, Seema Verma, believes that "*[t]his model will help make how we pay for care more patient-centric by supporting care in more appropriate settings while saving emergency medical services providers precious time and resources to respond to more serious cases*." CMS estimates that average treatment time per patient would be reduced by 45 minutes through the utilization of this model, saving first responders approximately 50 million minutes per year.[22] As a result, this system will enable EMS to more quickly respond to higher acuity cases, e.g., heart attacks, as a few minutes may make a significant difference in patient outcomes.[23]

General healthcare and EMS industry leaders, including leaders those of the *American Medical Association* (AMA) and the *National Association of EMS Physicians* (NAEMSP), are in strong support of the ET3 model.[24] EMS leaders are especially supportive, due to the model's potential to increase patient quality and optimize outcomes; however, they recognize that the EMS system will need to forge new relationships and change the structure of their current relationships, in order for the program to be successful.[25] EMS leaders in participating areas will need to effectively locate alternative treatment destinations to which they will direct patients, as well as establish effective triage systems.[26] Currently, many EMS jurisdictions do not allow ambulances to transport from an uncontrolled environment to anywhere except an approved ED.[27] State and local EMS authorities will need to alter protocol and policy in order to allow providers to transport to alternative destinations or provide non-transport services in order to guard against liability.[28] In addition, leaders will need to inform *emergency medical technicians* (EMTs) on the new protocol and methods on how to appropriately *triage, treat, and transport* patients to alternative destinations in order to ensure success of the system.[29]

The ET3 model reflects the ongoing push toward value-based care. Because the model does not seem to carry any downside financial risk, participation may increase in areas across the U.S., expanding the overall impact of the model. However, because the model is voluntary, local governments and other entities that have authority over the EMS system,[30] particularly those without strong infrastructures, may choose to not participate, limiting the overall assessment of this model in different areas. Regardless, with the implementation of the ET3 model, especially with the inclusion of the multi-payor strategy, hospitals may experience decreased ED revenues, but gain more efficiency. With fewer low-acuity patients, more hospital beds will be available for high-acuity patients, offering faster treatment and improved outcomes. In addition, there may be decreased ED wait times, which will likely increase patient satisfaction and reduce the number of those left without being seen in the ED. Other alternative destination organizations may also benefit from the ET3 model, as they would receive a greater influx of patients and higher utilization of their services. Ultimately, healthcare costs will likely decrease as a result of reducing of unnecessary ED visits, providing benefits to healthcare organizations, e.g., the ability to more efficiently utilize resources.

The ET3 pilot is expected to run from January 1, 2020 to December 31, 2024, with staggered performance start dates in order to maximize participation in different U.S. localities.[31] This model aims to improve healthcare quality and lower cost by reducing avoidable transports to the ED, and, consequently, unnecessary hospitalizations. However, despite the focus on FFS Medicare beneficiaries, this model may serve to change the U.S. healthcare delivery system through multi-payor participation, ultimately reducing healthcare expenditures across the board.

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