

# Coverage and Reimbursement for Emergency Medical Services Care Delivery Models and Uncompensated Services

## Reports required under Senate Bill 682

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## Executive Summary

Senate Bill 682 directed the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and the Maryland Health Care Commission (MHCC) to study and report on the issue of reimbursing three models of EMS care provided through emergency medical service (EMS) providers in Maryland. The three models are:

- (1) EMS treat and release/refer without transport – This model encompasses two scenarios. As a routine part of EMS care, EMS provides services to a 9-1-1 patient at the scene, and the patient ultimately refuses ambulance transport to the hospital emergency department, but no reimbursement is available for services and supplies provided. One EMS jurisdiction in the State is innovating by having EMS providers on the scene assess and identify low acuity patients and offer on-scene treatment provided by a physician or nurse practitioner with the patient’s consent (with no transport). While the physician or nurse practitioner could bill for services, EMS receives no reimbursement under this model.
- (2) EMS transport to an alternative destination – EMS transports 9-1-1- patients with low acuity conditions to an urgent care clinic or similar care environment instead of transporting the low-acuity patient to a hospital emergency department; and
- (3) EMS mobile integrated health (MIH) services – EMS partners with other health care providers, such as nurse practitioners, community health workers, social workers, and physicians to conduct home visits to assess, treat and refer certain 9-1-1 patients to needed services in the community. MIH programs focus on patients who are frequent 9-1-1 callers, frequent users of EMS transport, and/or patients identified by hospitals as being at high risk for hospital readmission.

Currently in Maryland, EMS is not reimbursed by health payers for any of the three models of care.

As discussed herein, the Report includes the following information:

- In Maryland, 9-1-1 call volumes and overcrowded emergency departments have resulted in the development of EMS pilot programs of the three models of care for 9-1-1 patients who can be appropriately treated in settings other than hospital emergency departments.
- Initial results from these pilot programs suggest they could have a significant impact on health system costs, ED overcrowding and wait times, EMS unit turn-around times, and patient satisfaction. In addition, commercial ambulance services in Maryland have also found opportunities to reduce readmissions through home visits with patients identified to be at high risk for readmission to a hospital.
- Public payers (Medicare and Medicaid) and private payers in Maryland reimburse EMS responding to 9-1-1 calls only when patients are transported to emergency departments.
- Long-term viability for these three EMS care models depends on securing reimbursement from payers that would otherwise reimburse EMS transports when patients are transported to emergency departments.

- Due to data collection limitations, the workgroup was unable to estimate the fiscal impact of these three models to public and private payers.

MHCC and MIEMSS make the following recommendations:

### **Vision Statements/Guidelines for Recommendations**

1. The three EMS models of care need long-term sustainable funding solutions to continue and to grow.
2. Reimbursement for the three EMS care models must be financially and practically viable for all system participants, including payers.
3. Reimbursement for the three EMS care models should include all private and public payers to avoid cost-shifting between payer types and to ensure equitable treatment of consumers, regardless of insurance source.
4. EMS reimbursement changes must dovetail with the Total Cost of Care (TCOC) Model.

### **Specific Recommendations**

#### **Medicaid**

5. MIEMSS and Medicaid should develop reasonable cost projections for all three models of EMS care, through increased and enhanced collaboration with EMS jurisdictions, Managed Care Organizations (MCOs), and MIEMSS.
6. Medicaid should include studying the three models of EMS care as it considers developing total cost of care savings initiatives.

#### **Medicare & Health Services Cost Review Commission**

7. The Health Services Cost Review Commission (HSCRC) should expand grant opportunities for the three EMS care delivery models to allow EMS programs to apply for grant funding, in partnership with local hospitals, to fund EMS programs that have the potential to contribute to Medicare savings and reduce unnecessary hospital utilization.
8. HSCRC and the State Innovation Group should consider these models of EMS care in the process of developing proposals for the Centers for Medicare & Medicaid Services (CMS) for new tracks for the Care Redesign program for Medicare funding under the TCOC Model.
9. HSCRC should periodically review opportunities to incorporate the of three EMS care delivery models as potential New Model Programs, which allows for programs where EMS providers may assume financial risk for Medicare beneficiary costs without a hospital partner.
10. Through the TCOC Model, HSCRC should encourage participation by hospitals and other health care providers in the three models of EMS care.
11. HSCRC should continue to identify and consider EMS care delivery financing models that occur outside of Maryland for possible proposals to the Center for Medicare and Medicaid Innovation

(CMMI) at CMS for approval under the TCOC Model, including any future EMS-focused models developed by CMMI.

#### **MIEMSS & MHCC**

12. MIEMSS should develop an Alternative Destination designation process whereby alternative destinations can be approved to receive and treat EMS ambulance transported, low acuity 9-1-1 patients.
13. MIEMSS should compile and analyze data from current pilot EMS new care delivery model programs, including evaluation data comparable among the programs, to provide additional support for the business case for public and private payer support for these programs.
14. MIEMSS should continue to evaluate the percentage of treat and release visits compared to all EMS services.
15. MIEMSS should continue to work with local EMS programs to consider and address any data issues that may impact payers.
16. Working with EMS and payers, MIEMSS and MHCC should create a forum for discussion of changes in delivery of EMS care, results from new initiatives, and payer reimbursement.
17. MHCC and MIEMSS should continue to work with payers as they consider the three models of EMS care described in this report.

#### **Public and Private Payers**

18. Public and private payers should consider implementing creative pilot programs using the three EMS delivery models, including experimenting with payment approaches that have been successfully adopted in other States.

#### **Payers and Hospitals**

19. Hospitals should consider providing additional grants for the three models of EMS care.
20. Payers should consider the three models of EMS care when distributing grant funds.

The Committees, under Insurance Article § 15-1501, could request MHCC to assess the social, medical, and financial impact of establishing a mandate for covering Alternative Destination, and Treat and Release programs.

## Overview

Maryland is known for its innovative health care delivery and financing system, as well as its statewide emergency medical services system.<sup>1</sup> Emergency Medical Services (EMS) providers are a vital part of the State's health care system, ensuring that Maryland residents receive necessary care and safe transportation in emergencies and as to commercial ambulance services, transporting patients to and from health facilities. Maryland's EMS system is stressed by high 9-1-1 call volumes and overcrowded emergency departments (ED).<sup>2</sup> EMS data suggests that almost 60 percent of EMS transports to emergency rooms in response to 9-1-1 calls are for conditions that are potentially non-emergent, meaning that the patient could be adequately treated in a lower cost non-ED care setting.<sup>3</sup>

As a result of these pressures, EMS providers in Maryland have developed and piloted two new care delivery models: (1) Mobile Integrated Health (MIH) Programs and (2) transportation to alternative destinations. MIH programs provide in-home visits from EMS and other providers (often a nurse, social worker, and/or community health worker) to help meet the needs of patients who are frequent 9-1-1 and ED users or individuals recently discharged from hospitals and at risk for readmission). Alternative Destination Programs allow EMS providers, when responding to a 9-1-1 call, to transport patients to non-ED settings like urgent care clinics and behavioral health stabilization centers.

EMS providers are also reporting increased costs associated with certain instances of "treat and release" patient interactions where the patient accepts EMS care, but refuses EMS transport.<sup>4</sup> Treat and release services (including medications and supplies used to care for the patient) are not covered by most insurers in Maryland, which means that EMS receives no reimbursement in these instances, which could be thought of as a form of uncompensated care. The increase in opioid overdoses has spotlighted this problem over the past two years, as 15 EMS jurisdictions have sought grant funding sources to help cover the cost of medications administered to overdose patients who refuse transport.

## Senate Bill 682-Mandated Study

In the 2018 legislative session, the Maryland General Assembly passed Senate Bill 682, which mandated that the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and the Maryland Health

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<sup>1</sup> Maryland has a unique rate setting system for hospitals that includes all payers, both public and private. Maryland's Total Cost of Care Model, which began January 1, 2019, is the newest iteration of this system. This model will bring further reform to the health care system in Maryland.

<http://www.hscrc.state.md.us/Pages/tcocmodel.aspx>. The terms of the TCOC of model agreement between the State of Maryland and the federal Center for Medicare & Medicaid Services is available here:

[https://hscrc.maryland.gov/Documents/Modernization/7-30-18%20Announced%20Terms\\_FINAL.pdf](https://hscrc.maryland.gov/Documents/Modernization/7-30-18%20Announced%20Terms_FINAL.pdf). National Academy of Sciences, Emergency Medical Services at the Crossroads, 2006.

<sup>2</sup>"Joint Chairman's Report on Emergency Room Overcrowding", MIEMSS and HSCRC, December 2017, [http://www.miemss.org/home/Portals/0/Docs/EMS\\_News/MIEMSS\\_Emergency%20Department%20Overcrowding-2017.pdf?ver=2018-06-20-132037-933](http://www.miemss.org/home/Portals/0/Docs/EMS_News/MIEMSS_Emergency%20Department%20Overcrowding-2017.pdf?ver=2018-06-20-132037-933)

<sup>3</sup> 2015-2017 eMEDS data (data collected by EMS personnel and stored by MIEMSS) shows that "priority 3" and "priority 4" transports make up approximately 60 percent of transports each year. Priority 3 transports are non-emergent conditions, requiring medical attention but not on an emergency basis. Priority 4 transports do not require medical attention. The eMEDS data does not include payer information.

<sup>4</sup> This totals approximately 7,500 patients per year according to 2015-2017 eMEDS data which includes patients who accept EMS care and refuse transport to the hospital and those who accept EMS care and then choose to be transported to the hospital by private vehicle.

Care Commission (MHCC) study the issue of reimbursing three models of care provided by emergency medical service (EMS) providers in Maryland:

- (1) treat and release/refer without transport;
- (2) transport to a destination other than a hospital emergency department; and
- (3) mobile integrated health services.

This statute built on recommendations related to mobile integrated health contained in the 2017 report “Transforming Maryland’s Rural Healthcare System: A Regional Approach to Rural Healthcare Delivery”.<sup>5</sup> Under the statute, MIEMSS and MHCC are required to submit reports to the legislature that contain “statewide plan for the reimbursement of [the] services” described above for Medicaid, “a process for obtaining Medicare reimbursement” for these services, and the results of a study (including any recommendations) on “the desirability and feasibility of reimbursement” of these services by commercial health insurers.<sup>6</sup> This document fulfills the reporting requirements under SB 682.

To meet the requirements of SB 682, MHCC and MIEMSS developed a two-pronged approach. Development of the plan for Medicaid and the process for Medicare occurred over the course of seven meetings the MHCC and MIEMSS held with the HSCRC and the Maryland Department of Health (MDH) between June and October 2018. Development of the recommendations for reimbursement for these EMS services to enrollees of health insurers, nonprofit health service plans, and health maintenance organizations was based on individual meetings and discussions between the MHCC / MIEMSS and representatives from commercial health insurers, nonprofit health services plans, and health maintenance organizations. Finally, all stakeholders were brought together for two large work group meetings in the summer and fall of 2018 and one large group meeting in January 2019.

## Description of Maryland Institute of Emergency Medical Services Systems

Maryland Institute for Emergency Medical Services Systems (MIEMSS) is an independent agency of the State of Maryland with statutory responsibility for oversight and coordination of all components of the statewide EMS system. MIEMSS is governed by an 11-member Governor-appointed State EMS Board which promulgates regulations for the operation of the EMS system. Oversight responsibilities include licensing / certifying and disciplining EMS providers, development of standardized medical protocols used by EMS providers, designation of trauma centers and specialty care centers, regulation of commercial ambulance services, operation of the statewide EMS communications system, and conducting initiatives to improve system effectiveness.

## Description of Maryland Health Care Commission

The Maryland Health Care Commission (MHCC) is an independent regulatory agency of the State of Maryland whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public. The Commission’s vision for Maryland is to ensure that informed

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<sup>5</sup> Workgroup on Rural Health Delivery, “Transforming Maryland’s rural healthcare system: A regional approach to rural healthcare delivery; Report of the Workgroup on Rural Health Delivery to the Maryland Health Care Commission As Required by Senate Bill 707”, November 2017, [http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/rural\\_health/Rural%20Health%20Full%20Report%20with%20Appendices\\_2017.pdf](http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/rural_health/Rural%20Health%20Full%20Report%20with%20Appendices_2017.pdf)

<sup>6</sup> Chapter 605, Laws of Maryland 2018.



consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation. MHCC has 15 commissioners who are appointed by the Governor.

## Maryland's Stressed 9-1-1, EMS, and Emergency Department Systems

In Maryland, there is a clear need to implement different response models for certain 9-1-1 calls. In Maryland, 9-1-1 call volume for EMS has grown by 8.6 percent in the past few years.<sup>7</sup> As a result of increased call volume, the number of EMS transports from 9-1-1 calls is also growing.<sup>8</sup> Ambulances that respond to 9-1-1 calls transport patients to hospital EDs where they often encounter long wait times. Maryland's ED wait times far exceed the national average and are frequently among the worst in the country.<sup>9</sup> EMS providers may not leave their patients in the ED until the transfer of patient care to ED personnel is completed.<sup>10</sup> This limits the capacity of public safety EMS to respond to additional calls. As a result, some EMS jurisdictions have implemented alternative response plans to 9-1-1 calls because of a lack of available ambulances to respond immediately to 9-1-1 calls.<sup>11</sup>

As hospitals work to reduce re-admissions in response to changing payment incentives under the Maryland Total Cost of Care Model, ED staff is increasingly responsible for linking the patient to continuing or follow-up care in the community (e.g., primary care provider, behavioral health treatment, substance abuse treatment), in addition to providing the immediate treatment needed by the patient.<sup>12</sup> ED overcrowding, which occurs when the identified need for emergency services outstrips available hospital resources such that there are more ED patients than there are beds available in either the ED or on an inpatient unit, is a common occurrence in Maryland hospitals located in urban and suburban areas. When a hospital ED is overcrowded, that hospital will go on diversion status, so that EMS may not deliver any new patients to that ED during the period of the diversion. This sets off a chain reaction, quickly overcrowding other EDs in the same jurisdiction (if other EDs exist) and extending transport times for EMS and patients. Excessive ED wait times, and ED overcrowding have been a long-standing challenge for the Maryland health care system.<sup>13</sup> CMS collects inpatient and outpatient quality reporting measures across the hospital system, including the median time in minutes from ED arrival to ED

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<sup>7</sup> eMEDS data 2015 – 2017 indicates that EMS call volume grew 8.6 percent from 2015 – 2017. eMEDS call volume data is a unit-based report.

<sup>8</sup> eMEDS data 2015 – 2017 indicates that statewide EMS transports increased by 3.62 percent during the 1025-2017 period. This number does not include patients who accepted EMS treatment but refused EMS transport to a hospital ED.

<sup>9</sup> Joint Chairmen's Report on Emergency Department Overcrowding. MIEMSS & HSCRC, December 2017.

<sup>10</sup> The national standard for ambulance turn-around time (the time from off-loading an EMS patient to a hospital ED stretcher, completing the transfer of care, and EMS return to service) is 30 minutes. Ambulance turn-around time in Maryland exceeds this standard, with one EMS jurisdiction reporting meeting the national standard only about one-third of the time. See "Joint Chairmen's Report on Emergency Department Overcrowding", MIEMSS & HSCRC, December 2017.

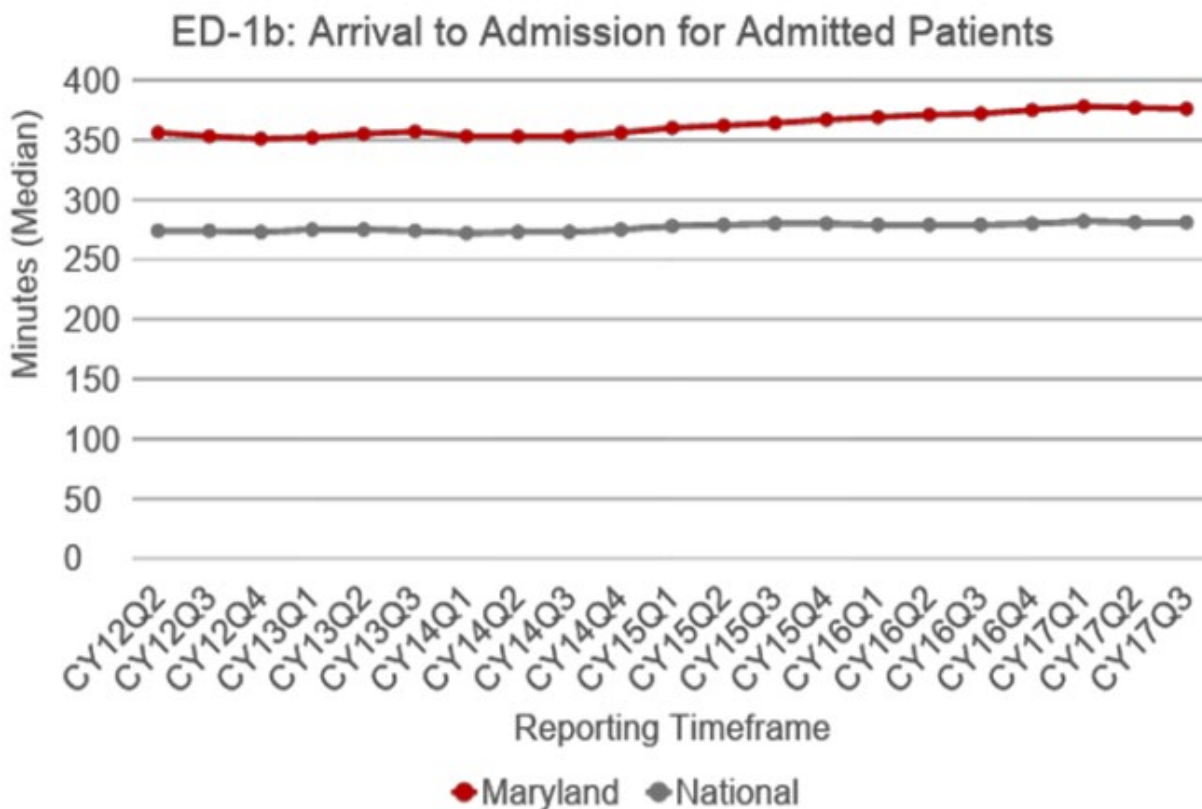
<sup>11</sup> For example, Prince George's County Fire/EMS Department has a "Limited EMS Resource Plan" with two response levels. Level 2 of the Plan goes into effect when 60 percent of all transport units are consumed. During Level 2, the county's dispatch policy changes so that the response to lower acuity calls can be held for up to 45 minutes. See Joint Chairmen's Report on Emergency Department Overcrowding," MIEMSS & HSCRC, December 2017.

<sup>12</sup> See footnote 1.

<sup>13</sup> Joint Chairmen's Report on Emergency Department Overcrowding, 2017. This report considered issues contributing to ED overcrowding, including increases in behavioral health patients seeking treatment in an ED, reimbursement policies, increased patient care requirements in the ED, and staff shortages.

departure for admitted patients. Maryland hospitals perform far worse than the national average on both inpatient and outpatient ED measures; a long-standing problem in Maryland.

**Figure 1: Median time in minutes from ED arrival to admission for admitted patients.**



Source: Health Services Cost Review Commission analysis of CMS’s CQM Emergency Department Throughput Measure, 2018.

Statewide EMS data shows that many 9-1-1 callers could be appropriately treated in health care environments that are less intensive and less costly than hospital emergency departments, such as urgent care centers.<sup>14</sup> About 60 percent of 9-1-1 callers have conditions that are “non-emergent conditions, requiring medical attention, but not on an emergency basis”.<sup>15</sup>

Other 9-1-1 patients can be effectively treated by EMS (sometimes in combination with other care providers) at the location where EMS responds to the call. Also, a small number of 9-1-1 callers, approximately 7,500 per year, accept EMS care, but refuse EMS transport to the ED. EMS is precluded

<sup>14</sup> Ibid.

<sup>15</sup> Patients are categorized into 4 priority categories based on acuity. Priority 1 — Critically ill or injured person requiring immediate attention; unstable patients with life-threatening injury or illness. Priority 2 — Less serious condition yet potentially life-threatening injury or illness, requiring emergency medical attention but not immediately endangering the patient’s life. Priority 3 — Non-emergent condition, requiring medical attention but not on an emergency basis. Priority 4 — Does not require medical attention. Source: Maryland Medical protocols for EMS providers, page 31 II. GENERAL PATIENT CARE (GPC) -> D. INITIAL ASSESSMENT -> 7. Assign Clinical Priority -> (a) through (d). See [http://www.miemss.org/home/Portals/0/Docs/Guidelines\\_Protocols/MD-Medical-Protocols-2018-WEB.pdf?ver=2018-04-11-134820-493](http://www.miemss.org/home/Portals/0/Docs/Guidelines_Protocols/MD-Medical-Protocols-2018-WEB.pdf?ver=2018-04-11-134820-493)

from billing and recouping the cost of the response for these “treat and release” interactions because EMS is only reimbursed for providing transportation to the ED.

In response to the problems that EMS programs see in their communities and in the health care system, they have developed new care delivery models, both in Maryland, and in States around the nation. These new care delivery models (MIH and alternative destination) are discussed in more detail below.

## Overview of Maryland’s EMS System

Maryland’s EMS system is made up of both public EMS programs and commercial EMS services. Public EMS programs are supported through county and local governments, as well as by volunteer ambulance companies, and are responsible for responding to 9-1-1 calls in their respective geographic areas. Commercial EMS services are private sector businesses that provide patient transport between health care facilities (e.g., ICUs; hospitals; nursing homes). By regulation, commercial EMS services are precluded from responding to an emergency incident (9-1-1 calls or disasters) unless requested to do so by a public safety 9-1-1 EMS service.<sup>16</sup>

Public safety EMS services are provided in Maryland through the authority of county or local governments using fire/EMS companies that may be comprised of career-based EMS providers (who are paid to render EMS care) or volunteer-based EMS providers (who provide services at volunteer fire/EMS companies that are non-profit organizations). Many Maryland jurisdictions provide EMS services using a mix of both career-based and volunteer companies and providers.

By statute, MIEMSS regulates and oversees compliance of both the public safety and commercial service components of the EMS system. All EMS providers must meet the same certification and licensing requirements and must render care in compliance with the same approved EMS patient care protocols which are uniform throughout the State. MIEMSS protocols are developed by an expert committee comprised of physicians, nurses, specialists and others to ensure effective care and patient safety. EMS provides treatment under the medical direction of a physician, and each public safety jurisdiction and commercial service has a physician medical director who oversees medical care and quality assurance.

All EMS patient interactions are recorded and saved in the MIEMSS-implemented electronic reporting system, “eMEDS,” which has been in statewide use since 2015.<sup>17</sup> Both components of the EMS system must complete and submit electronic patient care reports for every patient encounter, whether the patient is transported or not. Every public safety jurisdiction in Maryland records and submits patient care data via eMEDS. Commercial EMS services, some of which operate nationally, submit patient care data elements to MIEMSS using electronic media that are compatible with eMEDS data elements. MIEMSS has partnered with CRISP, the State-designated health information exchange, to create unidirectional data linkage from eMEDS to CRISP.<sup>18</sup> This linkage allows hospitals to access pre-hospital care data from eMEDS and EMS personnel to access some clinical information held by CRISP.

Most EMS patients are transported to the closest appropriate hospital ED. For the most critically ill and injured patients, MIEMSS designates certain hospitals as “specialty care centers,” that have the facilities, personnel and equipment needed for rapid and effective patient treatment. By MIEMSS protocol, EMS providers must transport critical patients to these facilities.

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<sup>16</sup> COMAR 30.09.07.04A.

<sup>17</sup> Data from before 2015 is not comparable to data from eMEDS due to differences in system design.

<sup>18</sup> More information about health information exchange and the State’s designation of CRISP is available on the MHCC website: [http://mhcc.maryland.gov/mhcc/pages/hit/hit\\_hie/hit\\_hie.aspx](http://mhcc.maryland.gov/mhcc/pages/hit/hit_hie/hit_hie.aspx)

## EMS Budgets and Costs

### *Overview*

Some costs for public safety EMS services in Maryland are incorporated into annual county/local budgets which provide a portion of the EMS program's annual operating costs. The remainder of the EMS budgets in most jurisdictions is obtained from billing for transportation services rendered to 9-1-1 patients.<sup>19</sup> Typically, EMS programs contract with private billing companies to obtain both patient insurance information from the hospital and to bill for EMS services rendered. At present, EMS providers do not obtain insurance information directly from the patient at the scene of the incident, although the eMEDS patient care report contains the necessary data fields for the EMS provider to obtain and record this information.<sup>20</sup>

Normal operating costs for EMS jurisdictions include personnel salary and benefits, facilities, equipment, and supplies (including pharmaceuticals) provided to patients. Increasing personnel and equipment costs, along with the increase in EMS call volume and EMS transports, have impacted EMS budgets. However, insurers in Maryland (including private insurers as well as Medicaid and Medicare) only reimburse public safety EMS for transportation of a 9-1-1 patient to an ED. EMS is not reimbursed if a 9-1-1 patient is transported to a less costly, but appropriate, care setting or if care is provided at the scene but no transportation is provided to the patient.

To provide some budgetary context, below are brief descriptions of the EMS budgets from four jurisdictions, three of which are conducting pilot projects of the type that are discussed in this report.

### *Baltimore City*

The Baltimore City Fire/EMS budget increased from \$36,456,119 in fiscal year (FY) 2014 to \$46,089,148 in fiscal year 2018, a 26 percent increase in the past five years. The average unit response cost is \$640 per response.

### *Dorchester County*

Dorchester County Emergency Medical Services Division (DCEMS) operating budget has increased from \$2.2 million in FY2014 to \$2.8 million in FY2019, an increase of about 20 percent. The number of unit responses over the same time period increased at roughly the same rate, from 4,932 unit responses in FY2014 to 6,024 in FY18. The average cost per response in FY18 was \$445. DCEMS staffs five 24/7 Advanced Life Support units with a paramedic and an EMT, with a paramedic supervisor staffing a chase unit 24 hours a week.

In FY18, DCEMS collected approximately \$1M for ambulance transports from 139 different payers as well as from 230 patients who paid directly. The chart below describes the top five payers/benefit plans recorded by the third party billing company contracted by DCEMS.

Under the current budget and billing constraints, DCEMS is unable to fund a mobile integrated health program. However, data suggests that a MIH program could be beneficial. Between July 1, 2017 and December 31, 2017, 106 individuals called 9-1-1 three or more times in Dorchester County, resulting in 486 unit responses and 405 transports to local hospitals. These 106 individuals represent 0.3 percent of

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<sup>19</sup> Three EMS jurisdictions do not currently bill for patient care services: Howard County, St. Mary's County and Calvert County.

<sup>20</sup> As a result, insurance information on patients who are treated but not transported is not available in eMEDS at this time.

Dorchester County's population but account for 20 percent of DCEMS's patient encounters and approximately 28 percent of received revenue. A single hospital received 385 of these 405 transports from DCEMS, accounting for 25 percent of all DCEMS transports to that hospital in that time period.

### *Montgomery County*

The Montgomery County Fire/EMS budget decreased from \$237 million in fiscal 2016 to \$218 in fiscal 2019, an eight percent decrease in the past four years. This decrease is a result of a lawsuit against the State of Maryland, *Comptroller of the Treasury v. Wynne*, which resulted in decreased tax revenues in Montgomery County since 2015. This decreased revenue has resulted in county-wide budget decreases, including decreases to Montgomery County Fire and EMS.<sup>21</sup> Montgomery County Fire/EMS average unit response cost is \$500 per response.

### *Prince George's County*

The Prince George's County Fire/EMS Department Budget has increased from \$137.8 million in FY 2014 to \$208.3 million in FY 2019, an increase of 34 percent over five years. Over that period, staffing increased by 182 additional positions which supported the expansion of EMS service delivery since 84 percent of their service delivery is EMS-related. In fiscal year 2017, the Department initially committed two (2) full time equivalent (FTE) positions to its Mobile Integrated Health Program (one of the three models described in the next section), this reflected an approximate cost of \$257,920.00 (annual cost) plus an additional \$210,000 (approximately) in logistical equipment (2 vehicles and Advanced Life support equipment). In fiscal year 2018, the Department committed a third FTE to Mobile Integrated Health, incurring at an additional cost of \$128,960.00 per year.

Average unit response costs are calculated based on the Department's current budget funding divided by the total number of unit responses. In fiscal year 2018, this cost was factored at \$664.00 per response.

## Innovations in EMS Care: Maryland's Pilot Programs

In Maryland, EMS has identified gaps in care for patients that contribute to high 9-1-1 use and program models that EMS can use to fill those gaps. EMS is currently piloting two innovative models of patient care, Mobile Integrated Health Programs and Alternative Destination programs. These pilot programs operate under MIEMSS protocols and oversight and are generally funded through a combination of grants and county/local funds.

### Mobile Integrated Health (MIH) Programs

MIH programs are programs that are built on the EMS infrastructure, but which provide focused care to high-risk patients in non-emergency situations or programs that are based on collaboration between a commercial service and a hospital or insurance company partner. The goal of these programs is to improve patient outcomes while reducing 9-1-1 system utilization, EMS transports, ED use, and/or readmissions. There are currently seven MIH programs operating in Maryland, all of which are currently

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<sup>21</sup> Bosworth, Daniel, "Comptroller of the Treasury v. Wynne: Bridging the Gap Between Strands of Jurisprudence on State Income Taxation", 75 Md. L. Rev. 1092 (2016), <https://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=3722&context=mlr>

within the public safety EMS sector.<sup>22</sup> Each jurisdiction has a slightly different program model, to best meet the needs of its own community. In general, patients are eligible for participation in MIH programs if they are frequent 9-1-1 callers and frequent users of EMS transport; if they are frequent ED users and were referred by ED staff; or if they are being discharged from the hospital and hospital discharge planners are concerned about a potential readmission. These patients usually have chronic somatic or behavioral health conditions that are inadequately managed at the time they enter the MIH program. As of December 2018, MIH programs have served more than 800 high need patients in Maryland.

In MIH programs, EMS providers partner with other health care providers, such as nurse practitioners, community health workers, and social workers. The care team conduct home visits to assess, treat and refer patients to needed services outside the emergency environment, including primary care providers. A summary of the MIH programs operating in the State is included in Appendix A.

The current MIH programs in Maryland are funded predominately through grant funds from hospitals, although some programs have received funding from grant funds from insurers and State agencies, as well as support from local jurisdictions and health offices. Additional detail about each program's sources of support is provided in Appendix A. Because EMS services are currently treated as a transportation benefit by health care payers in the State, EMS programs cannot be reimbursed by Medicare, Medicaid, or private health insurance for MIH programs.

### Alternative Destination Programs

Alternative Destination Programs transport 9-1-1- patients with low acuity conditions to an urgent care clinics or similar care environment, instead of transporting low-acuity patients to a hospital emergency department. Current Maryland EMS data shows that close to 60 percent of current EMS transportation is for individuals with conditions that do not require ED of level care. At this time, this data is not collected by payer, so it is difficult to determine the portion attributed to Medicare, Medicaid, or commercial payers. Directing a subset of these patients from the ED to urgent care centers or other more appropriate settings could have a significant impact on health system costs, ED overcrowding and wait times, EMS unit turn-around times, and patient satisfaction.

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law which requires hospitals to treat and stabilize patients without regard to insurance status and guarantees all patients access to emergency services. Non-hospital providers, like urgent care centers, are not subject to EMTALA and could not be compelled to treat patients under current federal and Maryland law, even if the patients arrived by ambulance.<sup>23</sup> For this reason, as well as issues related to individual financial risk for patients delivered to facilities outside of their insurance network, there are important insurance network and contracting issues that need to be further studied.

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<sup>22</sup> MIH programs have been implemented and are operational in Queen Anne's County, Montgomery County, Prince George's County, and Charles County, Salisbury-Wicomico County, Frederick County, and Baltimore City. For more information about these programs, see Appendix A.

<sup>23</sup> The Maryland Insurance Article provides some limited protections to HMO patients for out-of-network services and another section of the Article protect patients against some balance billing. These protections only apply to health insurance written under the Maryland Insurance Article. See the section of this report on the private insurance market for more discussion of number of lives that are covered under health insurance written under the Maryland Insurance Article. Individuals covered through employer-sponsored self-insured plans would not benefit from these protections unless the employer decided to include in the alternative destination benefit.

MIEMSS has developed a protocol for alternative destination programs that provides clear guidelines to EMS for making decisions about the appropriate destination for a patient.<sup>24</sup> This protocol was designed to ensure patient safety. In addition, patients must consent to transportation to the non-ED destination.

MIEMSS has authorized two alternative destination pilot programs. Montgomery County Fire & Rescue Services partnered with Holy Cross Express Care, an urgent care center. Under this pilot program, EMS can transport patients to an urgent care center that is associated with and located adjacent to Holy Cross Hospital. After a period of implementation with the Holy Cross site, the Montgomery County program may eventually expand to include Kaiser Permanente Urgent Care centers for individuals insured by Kaiser health plans. This program, while approved, was not yet implemented as of November 2018.

Similarly, the Baltimore City Fire Department is working in partnership with the University of Maryland Medical Center (UMMC) to deliver patients from a small catchment area in West Baltimore to UMMC's urgent care center, which is also adjacent to the hospital. The location of the urgent care centers close to the hospital EDs is intentional in these early pilots, to provide additional patient safety protections. The Baltimore City Fire Department is also authorized to transport individuals under the influence of drugs and/or alcohol to the Baltimore City Stabilization Center. This will provide a useful test of the potential for alternative destination programs to respond appropriately to community behavioral and substance abuse needs.

A relatively small number of patients have been served using the alternative destination program in Baltimore City (18 patients as of November 2018). Participating EMS considers the early results promising because of the apparent reduction in time it takes for the EMS crew to go back into service (about 15 minutes turnaround time vs about an hour). This is directly related to how much more quickly urgent care can see a non-urgent patient than would be possible in the ED.

The Baltimore City program is funded through a mix of grants (including a grant from HSCRC) and services which are provided by the University of Maryland Medical Center at no cost (including services provided at the urgent care center for program participants).

The protocol for the Baltimore City Fire Department Alternative Destination Program is provided in Appendix B.

## Treat and Release/Refer

For some 9-1-1 calls, Maryland EMS responds, provides care to the patient, and the patient then refuses ambulance transport to a hospital emergency department. Treat and release is a routine part of EMS's work.

The most common types of treat and release 9-1-1 patients are those with diabetic hypoglycemia, asthma, or unconscious overdose. When EMS responds to a 9-1-1 call, EMS first conducts an assessment of the patient's, level of illness and patient's mental and physiologic status. Non-invasive

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<sup>24</sup> See page 366 of MIEMSS "The Maryland Medical Protocols for Emergency Medical Services Providers, Effective July 1, 2018" [http://www.miemss.org/home/Portals/0/Docs/Guidelines\\_Protocols/MD-Medical-Protocols-2018-WEB.pdf?ver=2018-04-11-134820-493](http://www.miemss.org/home/Portals/0/Docs/Guidelines_Protocols/MD-Medical-Protocols-2018-WEB.pdf?ver=2018-04-11-134820-493)

diagnostic tools are used in this assessment, which may include a physical assessment, heart rate monitoring, blood pressure, pulse, carbon dioxide monitoring, electrocardiography, and blood glucose measurement. Once the assessment is completed and the patient's most likely syndrome is identified based on EMS protocols, the EMS provider begin treatment on the scene. Below are descriptions of the treatment for each of these conditions

Diabetic hypoglycemia: For diabetic hypoglycemia, paramedic treatment involves maintenance of the patient's airway, and either the placement of an IV and the administration dextrose or, if an IV is unobtainable, the intramuscular or intranasal administration of the medication glucagon. Often, following the administration of one of the anti-hypoglycemic medications, the patient regains consciousness within a short period, usually 2 - 5 minutes. The cost of .5 liters of 10% dextrose in water is about \$9.00, while the cost of a single patient dose of glucagon is roughly \$270. The required IV setup for dextrose costs approximately \$15.00.

Asthma: Paramedic treatment of an asthmatic patient consists of an escalating treatment regimen based upon the patient's severity. If the patient's asthma is minor, the paramedic can use the patient's own medication for treatment. However, an asthma patient usually calls 9-1-1 because the patient either doesn't currently have a prescription or is out of their prescribed medication. In this event, the paramedic begins treatment with two fast-acting bronchodilators: albuterol sulfate and ipratropium bromide which are inhaled in a nebulized aerosol. Often, the single dosing of these two medications is sufficient to reverse the patient's symptoms.<sup>25</sup>

Unconscious Overdose: In the case of an unconscious overdoes, the paramedic crew supports the patient's breathing with positive pressure bag-valve mask ventilation, followed by the administration of naloxone via the intravenous or intranasal routes. It is not uncommon for these patients to wake up within minutes. The course of treatment for a patient receiving ventilation support and intravenous naloxone (less than 2mg) is approximately \$30.00 for the oxygen and bag valve mask, \$15.00 for the IV setup and \$50.00 for the naloxone.<sup>26</sup>

While treat and release may be an appropriate choice for some patients whose needs can adequately be treated on scene, EMS has no ability to bill for treatment (including supplies and medications) delivered on site under current reimbursement

### Minor Definitive Care Now: An Innovation in the Treat and Release/Refer Model

MDCN provides low-acuity 9-1-1 callers with the option to receive immediate, on-scene care by an advanced level provider (a nurse practitioner or physician) and a BCFD paramedic. Under this program, BCFD dispatches a normal response to the scene of an emergency call. For appropriate, low-acuity 9-1-1 callers, with patient consent, the MDCN team is contacted and arrives at the scene to participate in the assessment of the ill or injured individual with the emergency providers. A paramedic and nurse practitioner team then completes a thorough evaluation of the patient, renders definitive outpatient care on-scene and arranges follow-up with appropriate providers. A summary of the MDCN Program is at Appendix C.

<sup>25</sup> The combined cost of a dose of albuterol sulfate and ipratropium bromide is about \$2.00, while the required nebulizer and oxygen tubing cost roughly \$5.00.

<sup>26</sup> Patients receiving the intranasal dose would require the oxygen/bag valve mask, the naloxone, a \$9.00 syringe and mucosal atomizer, and may or may not require the IV setup.



models, which only provide insurance payments for EMS when the patient is transported to the hospital. As a result, EMS treatment provided to these patients could be considered as a form of uncompensated care, which is currently born by EMS program budgets.

In the context of broad delivery system reform, there are opportunities for innovation in the treat and release model that both reduce health system costs and improve patient care and outcomes in how this set of services is delivered. MIEMSS has approved, and HSCRC has funded, a pilot program through the Baltimore City Fire Department, in partnership with UMMC, to test a more robust treat and release program, called “Minor Definitive Care Now” (MDCN).

## Funding for MIH, Alternative Destination, and Treat and Release Program Models

In Maryland, the programs described above are currently supported by grant funding, in-kind contributions, tax-supported public safety operational budgets, or a combination of all of these sources. These funding sources, while valuable and essential to program establishment, do not provide the long-term funding mechanism that is needed to sustain the ongoing operations of these programs. Public payers (Medicare and Medicaid) and private insurers do not currently reimburse for services provided by these programs in Maryland.

Other States have also implemented new care delivery models for EMS, some of which have taken steps towards establishing sustainable sources of funding. States with Medicaid Reimbursement for one or more of these models of EMS care include:

- Arizona
- Georgia
- Minnesota
- Nevada
- Pennsylvania
- Washington

A number of these programs are quite new. For example, Pennsylvania’s law, just passed in October 2018, requires commercial insurance companies to reimburse EMS when EMS is dispatched by a county 9-1-1 center and the EMS provider treats the patient but does not transport them to an ED (this statute also applies to Medicaid).

Additionally, Anthem Blue Cross / Blue Shield has implemented reimbursement for EMS-provided treatment that does not result in transportation to a hospital in States where it offers coverage, including their private market, Medicare, and Medicaid plans.

The potential impact of health insurance reimbursing EMS for providing services in a manner other than by transporting the patient to a hospital could be significant. A 2013 study projected that if Medicare alone had the flexibility to reimburse EMS throughout the United States for certain 9-1-1 EMS calls in a manner other than requiring transport to a hospital emergency department, patient continuity of care could be improved and annual Medicare savings could range from \$283 to \$560 million.<sup>27</sup> Changing

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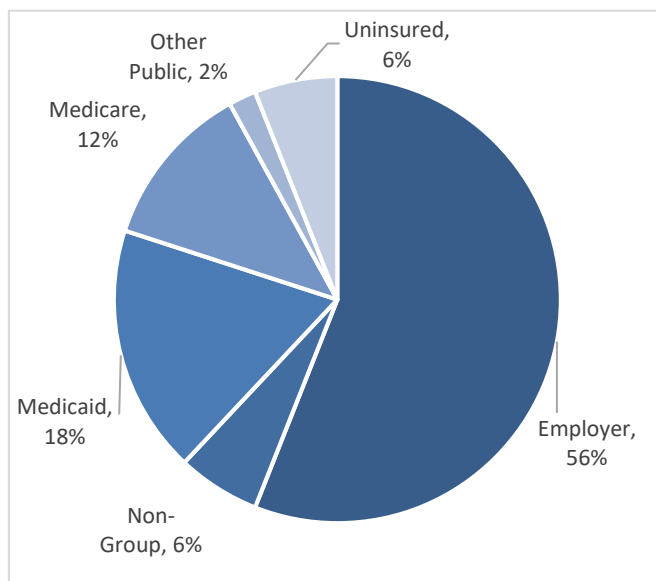
<sup>27</sup> Alpert A, Morganti KG, Margolis GS, Wasserman J, and Kellerman AL. Giving EMS Flexibility in Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings. *Health Affairs* 32:12. December 2013.

Medicaid, Medicare and private payer reimbursement policies for EMS could support the growth of these three EMS service delivery models.

## Health Insurance Coverage and Reimbursement for EMS Services in Maryland

Most of the approximately six million individuals in Maryland have some form of health insurance to help them pay for health care costs. More than half of the Maryland population has employer-sponsored insurance and about thirty percent of the population has insurance from public sources (Medicaid, Medicare, and the Children’s Health Insurance Program). A smaller number of individuals purchase commercial insurance in the individual (or non-group) market. In addition, approximately 360,000 individuals in Maryland were uninsured as of 2017.<sup>28</sup>

Figure 2: Health Insurance Coverage of the Total Maryland Population, 2017



### Medicaid

Medicaid provides health coverage to 1.3 million Marylanders<sup>29</sup> including eligible low-income adults, children, pregnant women, and people with disabilities. Medicaid provides a comprehensive benefit package, which includes coverage for long term care (i.e. nursing home level care). Medicaid is administered by the Maryland Department of Health according to federal requirements and is funded jointly by the State and federal government.

In Maryland, Medicaid uses a statewide managed care<sup>30</sup> program to provide most of its benefits, and 85 percent of those covered by Medicaid are enrolled in managed care plans under the HealthChoice Program. Maryland Medicaid funds Managed Care Organizations (MCO) on a capitated basis to manage the HealthChoice Program.<sup>31</sup> In turn, MCOs contract with a network of providers to provide covered services to their enrollees. Eligible Medicaid participants enroll in a MCO of their choice and select a primary care provider (PCP) to oversee their medical care. MCOs are responsible for providing or arranging for the full range of health care services provide to Medicaid beneficiaries, with a few exceptions.

<sup>28</sup> Source of data referred to in text and used in figure 2: Kaiser Family Foundation State Health Facts, based on data from the United States Census Bureau’s American Community Survey (ACS)

<sup>29</sup> <https://www.medicaid.gov/state-overviews/stateprofile.html?state=maryland>. As part of the Maryland Medicaid program, the Maryland Children’s Health Insurance Program (MCHP) provides access to health insurance coverage for higher income qualifying uninsured children up to age 19 who are included in this count.

<sup>30</sup> Managed Care Programs seek to appropriately control access to and limit utilization of health care services both to limit health care costs and improve quality of care. Managed care arrangements typically rely on primary care physicians to act as gate keepers and manage the care their patients receive.

<sup>31</sup> The term “capitation” means a fixed payment provided to a health provider from a managed care plan for the care of a patient, regardless of the type or number of services actually provided.” <https://khn.org/glossary/#c>

Some Medicaid covered services, including emergency ambulance transport, are “carved out” of the managed care capitation rates and MCO contracts, and are instead paid directly by the State Medicaid agency on a fee-for-service basis. Most behavioral health services, including substance abuse treatment, are also carved out of managed care and paid on a fee-for-service basis. The Maryland Medicaid Program does not cover services at a stabilization center, including the stabilization center being used by the current Baltimore Fire Department alternative destination pilot program.<sup>32</sup>

MCOs in the HealthChoice Program
<ul style="list-style-type: none"><li>• <a href="#">Aetna Better Health</a></li><li>• <a href="#">Amerigroup Community Care</a></li><li>• <a href="#">Jai Medical Systems</a></li><li>• <a href="#">Kaiser Permanente</a></li><li>• <a href="#">Maryland Physicians Care</a></li><li>• <a href="#">MedStar Family Choice</a></li><li>• <a href="#">Priority Partners</a></li><li>• <a href="#">University of Maryland Health Partners</a></li><li>• <a href="#">UnitedHealthcare</a></li></ul>

## Current Medicaid Coverage and Reimbursement for Emergency Medical Transportation

Medicaid pays for emergency medical transportation on a fee-for-service basis. For most Medicaid enrollees, emergency services provided once the enrollee is at a hospital are covered by the MCO.<sup>33</sup> Maryland Medicaid also covers non-emergency medical transportation (NEMT) under certain circumstances.<sup>34</sup>

Maryland Medicaid covers emergency medical transport when an ambulance is dispatched from a 9-1-1 call center, and the ambulance transports a participant from the site of the incident to the hospital. Emergency medical transports are paid for on a flat fee-for-service basis for all Medicaid participants,

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<sup>32</sup> <https://health.baltimorecity.gov/baltimore-city-stabilization-center>

<sup>33</sup> In the Maryland Medicaid program, similar to commercial insurance products, the costs associated with emergency care delivered by the hospital ED are reimbursed separately and apart from the costs of EMS care and ambulance transportation. Delivery of hospital emergency services to HealthChoice participants are included in the MCOs’ capitation rates. The MCOs are responsible for reimbursing hospitals and physicians for emergency services, if that care was medically necessary, from the capitation rate that the MCO received from the state Medicaid agency. The MCO may determine that care provided to a Medicaid enrollee in an emergency department for a condition that was non-emergent was medical unnecessary, because that care could have been delivered in a more appropriate setting. To the extent emergency services are determined medically unnecessary, MCOs are only responsible for paying the Emergency Medical Treatment and Labor Act (“EMTALA”) fee and ancillary charges. All other costs (e.g., facility fees) are denied. The Medicaid Program follows this same policy for FFS participants. Commercial insurance programs also make medical necessity determinations before paying claims; this is not unique to Medicaid.

<sup>34</sup> Medicaid-funded transportation is also available to Medicaid participants for non-emergency medically necessary appointments if the participant lacks access to all transportation resources, or is unable to utilize other public transportation and has no other means of transportation to covered medical appointments. NEMT services paid for by Medicaid is provided through the local counties who are responsible for contracting with local transportation vendor(s), including may include commercial – but not public safety – ambulance services. Additional NEMT services include trips to and from scheduled medical services (e.g. doctors’ visits) as well as return trips from hospital, emergency rooms, return trips from hospital stays, and medically necessary inter-hospital transports when discharged. The Medicaid Program provides all modes of transportation as appropriate, including but not limited to ambulance, wheelchair van, sedan/van, taxi, public transportation and aero medical transport.

even if they are enrolled in HealthChoice. The transport fee is outside the MCO capitation rates and the Department reimburses EMS providers directly.

Maryland Medicaid pays EMS \$100 per transport using a single billing code, CPT A0427 (Ambulance service, advanced life support, emergency transport, level 1), regardless of the costs to EMS for the care and transport provided to the 9-1-1 patient. The reimbursement amount to EMS is the same, regardless whether the care provided is at the advanced life support (ALS) or basic life support (BLS)<sup>35</sup> level. Services, medications, and supplies provided by EMS at a scene or during transport are not eligible for separate reimbursement outside the \$100 transport fee. Medicaid does not reimburse for mileage. To be eligible for reimbursement, EMS must have been dispatched by a 9-1-1 call center, the ambulance must transport the patient to a hospital ED, and meet other requirements.<sup>36</sup>

Maryland Medicaid does not reimburse Treat and Release services provided by EMS.

## **Modifying Medicaid Reimbursement**

Currently, the three models of EMS care described in SB 682 (mobile integrated health services; emergency medical services without transportation; and emergency medical services with transportation to an alternative destination) are not eligible for reimbursement by the Maryland Medicaid Program. As described below, changing reimbursement to cover these models would require MDH to seek authority from CMS and may also require engagement with the MCOs through the annual rate setting process and development of new regulations and approval from the Department of Budget and Management for changes with fiscal impacts to the State budget. Maryland Medicaid uses a specific process, summarized below, for modifications to Maryland Medicaid reimbursement.

- MDH must apply to the CMS for the approval of a state plan amendment (SPA). The Medicaid and CHIP State plan is the agreement between Maryland and the CMS describing the groups of individuals covered under the Maryland Medicaid program, services provided, methodologies for providers to be reimbursed, and the administrative activities underway in the State. To amend the State Plan, Maryland must develop a SPA that describes any material changes to State law, organization, policy and/or state operations of the Medicaid program. CMS determines if the SPA meets the requirements of federal laws and regulations. Approval of the SPA is required to ensure availability of Medicaid Federal Financial Participation, i.e., the federal matching dollars used in the Maryland Medicaid program.<sup>37</sup>

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<sup>35</sup> Advanced Life Support (ALS) refers to care provided by licensed, advanced level EMS providers, e.g., paramedics. ALS is provided to a patient who is more critical who requires medications or advanced interventions in the prehospital phase of care. Basic Life Support (BLS) refers to care provided by certified Emergency Medical Technicians to less severe patients who require monitoring and support, but no advanced interventions.

<sup>36</sup> Among other requirements, Maryland Medicaid reimbursement for emergency medical transportation is limited to public entities or volunteer fire, rescue or EMS companies that also must routinely bill all third-party payers for services.

<sup>37</sup> As of 2016, Medicaid made up about 17 percent of the State budget or almost 3 billion dollars a year, second only to K-12 education as a budget priority. State funds spent on Medicaid in Maryland are generally matched, dollar for dollar, by federal funds (i.e., Maryland has a 50 percent Federal Medical Assistance Percentage).

- Prior to submitting a SPA to CMS for approval, the State must complete a required internal review and obtain necessary approvals, including from the Department of Budget & Management regarding any budgetary impact.<sup>38</sup>
- Any potential changes or adjustments in covered services that would need to be included in the managed care rate must be included in the MCO capitation rate setting and negotiation process. This process, which occurs annually to plan for future rate years, requires engagement with the MCOs as key partners in the managed care program.
- Depending on the type of change to Medicaid programs and operations, Maryland Medicaid might need to modify existing or create new regulations.<sup>39</sup>
- Past experience indicates that, generally, the process for implementing a new service/program takes a year or longer.

## Factors to Consider Regarding Medicaid Reimbursement Changes

Although there is an identified process in place that could be used to modify Maryland Medicaid to reimburse for the three models of EMS care, the decision to do so is complex and requires careful consideration. Among the factors for consideration are the following.

- The fiscal impact to Medicaid of reimbursing EMS for the three models of care is difficult to quantify. For the Treat and Release model, there is no reliable data currently available to quantify the current number of Medicaid patients whom EMS treats and project future costs of modifying Medicaid reimbursement to EMS. For the Alternative Destination model, although it appears that reimbursing EMS for the transport fee to an alternative destination would likely be neutral to Medicaid, the cost that would be attributed to the MCO for treatment at an alternative destination is presently unknown. Currently, when an MCO subsequently determines an ED patient to have non-emergent conditions, the MCO does not pay for the hospital facility charge. As a result, while transport to an alternative destination where there is no hospital facility charge appears to have the potential to reduce costs, that potential cannot be confirmed, as the alternative destinations to which EMS patients would be transported have yet to be identified. Finally, for the MIH model, there is little available data with which to quantify the number of patients who could be eligible for inclusion. Reasonable cost projection models could be developed through increased and enhanced collaboration among Medicaid, MIEMSS, the MCOs and EMS jurisdictions.
- The issue of third party liability needs to be considered. Third party liability is the legal obligation of payers to pay all or part of the expenditures for care that is provided to a Medicaid enrollee. It is common for Medicaid enrollees to have one or more additional sources of coverage for health care services. Federal law requires that all other third party resources must

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<sup>38</sup> §42 CFR 430.12

<sup>39</sup> This may also require amendments to [COMAR Sec. 10.09.65.20](#). MCO Payment for Self-Referred, Emergency, and Physician Service, COMAR [Sec. 10.09.65.14](#). Referral to Behavioral Health ASO and [COMAR Sec. 10.09.77](#) Urgent Care Centers specific to license requirements, covered services and services and payment as well as provisions of EMTALA as discussed in proposed permanent regulations [COMAR 10.24.19](#) State Health Plan for Facilities and Services: Freestanding Medical Facilities.

meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. If a Medicaid-covered service is not reimbursed by third party insurance, Medicaid is obligated to pay for the service.<sup>40</sup> If Medicaid reimburses EMS for the three models of care before other payers decide to do so, costs for these services would be shifted to Medicaid. Requiring reimbursement from both public and private payers to EMS for the three models of care would avoid such cost-shifting.

- Maryland policy-makers are considering future application of hospital cost and total cost-of-care savings initiatives to Medicaid, similar to Maryland's Medicare initiatives under the Total Cost of Care models<sup>41</sup>. MDH and the HSCRC have been directed to analyze the potential for setting Medicaid-specific targets to meet specified performance metrics that could result in significant savings to Medicaid comparable to those achieved for Medicare. These targets will help inform consideration of future changes to Medicaid reimbursement.
- Beyond the issue of reimbursement for the three models of EMS care, Medicaid's current reimbursement per EMS transport has been \$100 for many years. There is concern that these reimbursement rates do not adequately cover the costs of EMS care to Medicaid enrollees.

## Medicare

### Overview

Medicare is a national program administered by CMS. Reimbursement policies are set at the national level. Through the Total Cost of Care (TCOC) Model the State of Maryland has a unique agreement with CMS that allows the State to set hospital payment rates at the state level. HSCRC has a number of care transformation tools available under the TCOC model that will help the State more effectively manage total costs of care, improve population health and increase quality of care in Maryland. It is important to note that Maryland rate setting authority for Medicare only applies to hospital inpatient and outpatient services and does not extend to non-hospital Medicare Part B services.

### Current Medicare Reimbursement for EMS

Current Medicare reimbursement to EMS providers is paid through Medicare Part B funding, but is only provided if there is a coinciding Medicare Part A, or hospital claim. There is no current structure for EMS to receive Medicare reimbursement for care delivered at the scene or for transport to an alternate destination. While Maryland has authority from CMS to set state rates for Part A claims, Part B claims are currently subject to national Medicare payment policies.

### Strategies for Future Medicare Funding for EMS

This section describes the potential tools under the Total Cost of Care Model that HSCRC can offer to foster better alignment between the hospital and EMS system in a way that benefits patients. These tools include population health improvement grants, the Care Redesign Programs and potential "New Model" programs.

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<sup>40</sup> [COMAR 10.09.65.18](#) - Maryland Medicaid Managed Care Program: Managed Care Organizations, Third Party Liability.

<sup>41</sup> The Budget Reconciliation & Financing Act, 2018. Senate Bill 187 / House Bill 161.

### *Population Health Improvement Grants*

The HSCRC has grant making authority and may issue grants, funded through hospital rates, to hospitals on both a competitive and non-competitive basis. HSCRC's population health improvement grants offer valuable start-up and capacity building funds to test care transformation interventions and prove the viability of new ideas. These funds help to incentivize hospitals' participation in new initiatives that can improve quality of care, lower total costs and focus on population health. While grants help the system build capacity and experiment with new care strategies, the grant funds are finite and time-limited. Grant funded programs must develop sustainable funding pathways for long term health system development and improvements.

The HSCRC is currently reducing past Care Transformation grants, as was the intention when the grants were provided to hospitals. Re-purposing this spend down to provide grants for EMS and other care transformation initiatives designed to reduce unnecessary hospital utilization provides a revenue-neutral approach to funding a new grant process. Any grant proposal would be limited to availability of funds in the rate setting system, need to be executed by a hospital, be awarded on a competitive basis, and require the review and approval of the HSCRC's seven member Commission.

In order to better understand which alternative EMS funding mechanisms are scalable to a Care Redesign Program (CRP) Track, a competitive grant process could be deployed to further build out capacity and demonstrate savings to the system. The competitive grant could serve as a pathway to a future CRP track that could provide long-term financial sustainability.

A grant development process is as follows. HSCRC staff must make a recommendation to Commissioners on total funding and duration of a grant program which Commissioners may accept, modify, or reject. Subsequently, the HSCRC will then develop a Request for Applications (RFA) outlining general requirements for participation and submissions, to which hospitals may respond. HSCRC staff will build a review committee of staff and stakeholders to review proposals, identify awardees and determine total award amounts. Applicants will be selected based on a matrix of criteria that is scored by the evaluation committee and aggregated to determine the awardees.

Generating the initial program proposal is a three month process, at a minimum, that allows for staff time to write the recommendation, present a draft recommendation to Commissioners, accept comment letters and address stakeholder feedback, and then present a final recommendation for vote. With past competitive grants, the HSCRC allowed applicants one month to complete submissions. Subsequently, another three month process follows to allow for staff time to write a recommendation on awardees and funding amounts, present a draft to Commissioners, accept comment letters, address stakeholder feedback, and present a final recommendation for vote. Therefore, the full grant making process will take a minimum of 9-10 months.

#### **West Baltimore Paramedicine Program: Non-Competitive Grant Development**

In FY 2018, the HSCRC issued a \$2 million grant to the West Baltimore Collaborative to support the three models of EMS care in West Baltimore. The grant funded care management interventions and coordination for people residing in West Baltimore and utilizing EMS services for routine health care and support. The program is in its first year, although it has already diverted or prevented unnecessary hospital care via anecdotal reports.

In order to evaluate the effectiveness of the program, a quarterly or semi-annual reporting and monitoring tool must be developed. The Commission ultimately would reserve the right to terminate or rescind an award at any time for material lack of performance or for not meeting the letter or intent of an application.

### *Care Redesign Programs Overview*

The HSCRC Care Redesign Program began in 2017 and serves to encourage greater provider alignment and functions as an additional tool for care transformation efforts that require a waiver from the federal government.<sup>42</sup> Under the Care Redesign Program (CRP), the HSCRC may create voluntary, hospital-led care redesign tracks on an annual basis. Additionally, the HSCRC may modify or remove tracks based on stakeholder, State, or federal input. Hospitals sign one Participation Agreement with the State and federal government which allows them to participate in multiple CRP tracks. Hospitals participating in the CRP identify care partners to collaborate with on patient care improvements, total costs and improved health outcomes. The program structure allows for hospitals to share resources with care partners and provide incentives based on performance within the track.

The State has the ability to add or amend an existing track during an annual review period with the Centers for Medicare & Medicaid Innovation (CMMI). In order to propose a new track, stakeholder engagement and modeling must be completed before the proposal is submitted to CMMI. To the extent the three models discussed in this report change Medicare reimbursement, federal waivers will be required. A potential new track could allow a hospital to share financial resources with EMS providers for care and transport that does not result in hospital utilization, unlike current Medicare Part B reimbursement which requires transport to a hospital. A number of programs and EMS interventions have been catalogued by the EMS Reimbursement (SB682) Steering Committee, those that partner with hospitals could be contenders for CRP Track development. If no federal waiver is needed, hospitals and EMS can work together to implement these programs without developing a Care Redesign program track.

### *Care Redesign Program Track Development*

The HSCRC partners closely with hospital and non-hospital stakeholders when creating new CRP tracks; in this case, staff anticipates this process to coincide with grant development. All CRP programs are hospital-sponsored.

For consideration of new tracks, the State must develop a track template to submit to CMS by the end of June and work over the summer with CMS to further refine the track template before approval. Hospitals will use the developed track template to create their implementation protocols, which will be due at the end of October.<sup>43</sup> Track templates generally require the following components:

1. List of allowable interventions
2. Methodology for calculating savings and incentive payment pool
3. Description of care partner responsibilities
4. Description of eligibility for payment incentives

Hospital implementation protocols are reviewed and approved or rejected by CMS by the end of the calendar year. Performance periods are anticipated to operate on a calendar-year basis under the TCOC

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<sup>42</sup> <https://hscrc.maryland.gov/Pages/CareRedesign.aspx>

<sup>43</sup> This is based on dates in the 2019 Care Redesign Calendar and may change on an annual basis based on HSCRC and CMS input. These dates also assume a 12-month performance period on a calendar-year basis.



Model. Hospitals will report on activities on a quarterly basis and must meet various requirements outlined in their Participation Agreement.

Developing a successful CRP track requires strong interest from stakeholders and must have a clear link to the goals of the TCOC Model to improve quality, develop population health and control the growth of total costs. Identifying the target population and savings opportunities under the CRP track provide a stronger justification to CMS that the track under consideration is valuable to Maryland and the TCOC Model objectives. Ultimately, CMS must approve a new CRP track and without complete and thorough development the proposal may be rejected.

Additionally, in order for a CRP track to be feasible, hospitals must have a clear picture of the opportunities available to them through participation in a given track and a willingness to invest resources necessary for participation. In existing CRP tracks, hospitals reported initial slow or delayed implementation activities in the first six to twelve months as they worked to engage care partners and operationalize the program. However, some hospital activities increased at a faster pace if they were tied to previously existing initiatives that the CRP track could leverage. Implementing grants to build capacity and supports to participants helps to mitigate any issue of slow implementation and build on past reform experiences.

#### *New Model Programs under Total Cost of Care Contract*

Under the TCOC Contract, the HSCRC may create New Model Programs to assist in meeting the goals of the Model. Developing a New Model Program requires an amendment to the Total Cost of Care Contract. In addition, the HSCRC and CMS must develop a new Participation Agreement that outlines the requirements of the program. While developing these items, the State must also develop a track template to submit to CMS that would likely have many of the same requirements as CRP track templates. New Model Programs are currently being developed so that non-hospital providers may serve as conveners. These providers must take downside risk for total spending per capita and undergo care transformation efforts to support the TCOC Model. Staff anticipates that the first New Model Programs will be available to non-hospital conveners by 2021.

At this time, HSCRC staff does not recommend New Model Programs as a solution for EMS reimbursement modernization for a number of reasons. The longer timeframe to develop and implement a New Model Program aside, staff are also acutely aware that the three EMS program models intimately interact with hospital global budgets. Savings and performance reducing unnecessary utilization required of a New Model Program would accrue to hospitals global budgets. Additionally, it is not clear that EMS providers, even one of the three program models described in this report, have enough control over patient outcomes to be held accountable for demonstrating savings and performance on total cost of care. New Model Program conveners are required to assume financial risk, both upside and downside, for Medicare total costs of care. Close interactions between hospitals and care partners are already possible underneath the Care Redesign Program, which obviates the need for a New Model Program for EMS reimbursement modernization.

## Private Market Insurance

### Overview

Many Maryland residents are covered through private market health insurance plans, including employer based insurance plans and individual market plans. Approximately, “2.86 million Maryland

residents under the age of 65 had health insurance through a commercial health benefit plan” in 2018.<sup>44</sup> The Maryland Insurance Administration (MIA) has the primary regulatory authority over health insurance in Maryland.<sup>45</sup> However, regulatory authority over the private insurance market is divided between the federal government and state government.

Approximately 67 percent (1.9 million) of the individuals insured through the private health insurance market are insured through self-insured plans (including the Federal Employee Health Benefit Plan). Self-insured plans include plans that are protected from state regulation under the Employee Retirement Income Security Act (ERISA) of 1974, which exempts certain self-insured products from state insurance oversight. Other self-insured products that are not ERISA protected include non-HMO health benefit plans offered by the State of Maryland, non-profit employers, and many local governments. Both types of self-insured employer-sponsored health plans are exempt from state insurance mandates, although the employer may, at its sole discretion, include a type of coverage which is subject to a particular mandate.

Twenty-five percent of the private insurance market (725,000 individuals) is insured through fully insured group health plans, and almost 9 percent of the market (214,000 individuals) is insured through fully-insured individual plans. The State has some authority to regulate these fully-insured health insurance products.

## **Current Reimbursement Rules**

Private insurers in Maryland generally provide reimbursement for ambulance services as a transportation benefit, reimbursing for transport to an emergency department. A small number of claims for treat and release at the scene are reimbursed in Maryland on an annual basis, but further study is required to fully understand the policies that support these claims.<sup>46</sup> Some insurers in the state have supported some of pilot programs in MIH and alternative destinations through grants.

In general, covered benefits in the private insurance market are determined by the insurers based on actuarial analysis and business decisions, including negotiations with the plan sponsor in group plans.

Insurers may provide different levels of reimbursement to providers they have contracted with who are “in-network” and other providers. Network status impacts patients, who may have different levels of financial responsibility if their provider is in-network or out-of-network. The issues of network adequacy and billing will be important areas of consideration as MIEMSS and MHCC continue to work with private payers on this topic.

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<sup>44</sup> Source: 2018 Report on The Number of Insured and Self-Insured Lives MSAR # 7797, Maryland Insurance Administration, December 1, 2018.  
<http://www.mdinsurance.state.md.us/Consumer/Appeals%20and%20Grievances%20Reports/2018-Report-on-the-Number-of-Insured-and-Self-Insured-Lives-MSAR7797.pdf>

<sup>45</sup> More information about the Maryland Insurance Administration is available at  
<http://www.mdinsurance.state.md.us/Pages/default.aspx>.

<sup>46</sup> The Maryland Medical Care Data Base for 2015/2016 shows approximately 100 paid claims for Treat and Release (code A0998) total, paid by 3 insurers.

## Considerations for Aligning Commercial Insurance Reimbursement with EMS Programs.

Changes to private market insurance coverage and reimbursement policies could be achieved either through voluntary changes on the part of insurance companies or through coverage mandates put in place through legislation. A number of considerations impact either approach.

Over the course of this study, MIEMSS and MHCC met with a number of insurers to discuss the topics covered in this report. Insurers demonstrated a strong interest in more data to better understand the impact of the programs covered under this report on individuals covered under their plans and the cost savings achieved through these programs. Because many of the pilot programs in the State are very new, the data that would allow insurers to understand the business impact of supporting reimbursement for these programs continues to be limited. Continued development and sharing of data as these pilot programs continue is key to encouraging voluntary insurer participation in reimbursement for these programs.

Alternatively, a legislative mandate could achieve a uniform change in payment policy for fully-insured large group and ACA-grandfathered small group and individual plans. However, a state insurance mandate is an incomplete solution because it affects only a subset of the private insured market. “As of 2018, the MIA regulates and Maryland state law applies to commercial health benefits plans for approximately 18.3 percent of the population under the age of 65, and for approximately 32.9 percent of all covered lives” in the private health insurance market.<sup>47</sup> Including coverage for the three EMS innovative models through a health insurance mandate would affect only about 30 percent of the private market, although a number government firms and some private employers could voluntarily adopt the new mandate.

Non-grandfathered individual and small group market plans are subject to regulation under the federal Affordable Care Act (ACA). The ACA requires that these plans have an essential health benefits (EHB) package and the ACA describes a broad set of benefits that must be included in the EHB for these plans. In a December 2011 bulletin, the Department of Health and Human Services (HHS) provided guidance on the types of health benefits plans each state could consider when determining a benchmark EHB plan for its residents. Each state had the opportunity to update its benchmark plan effective for 2017.<sup>48</sup> The State may update its benchmark plan for FY 2021 given recent regulatory changes by the Centers for Consumer Information and Insurance Oversight (CCIIO), a component of CMS. It is important to note that ACA requires states to fund the cost of any new mandates that are not included in the state-specific EHB for policies purchased in the non-grandfathered individual or small group markets.

As mentioned above, the State does not have regulatory authority over private employer self-insured group plans or the large government plans including the Federal Employee Health Benefits Plan (FEHBP). Decisions to offer an expanded EMS benefit in these markets would be at the discretion of the individual plan sponsor.

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<sup>47</sup> Source: 2018 Report on The Number of Insured and Self-Insured Lives MSAR # 7797, Maryland Insurance Administration, December 1, 2018.

<http://www.mdinsurance.state.md.us/Consumer/Appeals%20and%20Grievances%20Reports/2018-Report-on-the-Number-of-Insured-and-Self-Insured-Lives-MSAR7797.pdf> .

<sup>48</sup> Maryland has chosen the small group CareFirst BlueChoice HMO HSA-HRA \$1,500 plan as its 2017 benchmark plan.

Health Insurance mandates are often fiercely debated because while they may benefit certain individuals, they have the potential to raise premiums for all individuals covered by impacted insurance products, depending on the cost impact of adding the mandated coverage. MHCC has repeatedly stated that while the impact of any one mandate is modest, the cumulative impact mandates on the cost of insurance coverage can be significant.<sup>49</sup>

Under Insurance Article § 15-1501, the MHCC must annually assess the impact of proposed mandated health insurance services that failed to pass during the preceding legislative session or that were submitted to MHCC by a legislator before July 1 of each year. The assessment reports are due to the General Assembly annually by December 31. Applying this requirement to the question of expanded EMS coverage could be a basis for gathering solid information on such a mandate. The same data that would be used for an assessment report could be used by insurers to support their voluntary participation in expanded EMS programs.

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<sup>49</sup> See Annual Mandate Report: Coverage for Fertility Preservation for Iatrogenic Infertility, November 16, 2017 at [http://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/NovaRest\\_Evaluation\\_of\\_%20Proposed\\_Mandated\\_Services\\_Iatrogenic\\_Infertility\\_FINAL\\_11-20-17.pdf](http://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/NovaRest_Evaluation_of_%20Proposed_Mandated_Services_Iatrogenic_Infertility_FINAL_11-20-17.pdf).

Annual Mandate Report: Coverage for Lymphedema Diagnosis, Evaluation, and Treatment, December 15, 2016 at [http://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2017/LGSRPT\\_Lymphedema\\_rpt\\_20170101.pdf](http://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2017/LGSRPT_Lymphedema_rpt_20170101.pdf),

Annual Mandate Report: Coverage for Digital Tomosynthesis, December 15, 2016 at [http://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2017/LGSRPT\\_DigitalTomosynthesis\\_rpt\\_20170101.pdf](http://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2017/LGSRPT_DigitalTomosynthesis_rpt_20170101.pdf).

## Recommendations

### Vision Statements/Guidelines for Recommendations

1. The three EMS models of care need long-term sustainable funding solutions to continue and to grow.
2. Reimbursement for the three EMS care models must be financially and practically viable for all system participants, including payers.
3. Reimbursement for the three EMS care models should include all private and public payers to avoid cost-shifting between payer types and to ensure equitable treatment of consumers, regardless of insurance source.
4. EMS reimbursement changes must dovetail with Total Cost of Care Model.

### Specific Recommendations

#### Medicaid

5. MIEMSS and Medicaid should develop reasonable cost projection models for all three of the three models of EMS care, through increased and enhanced collaboration with EMS jurisdictions, MCOs, and MIEMSS.
21. Medicaid should include studying the three models of EMS care as it considers developing total cost of care savings initiatives.

#### Medicare & HSCRC

6. HSCRC should expand grant opportunities for three EMS care delivery models to allow EMS programs to apply for grant funding, in partnership with local hospitals, to fund EMS programs that have the potential to contribute to Medicare savings and reduce unnecessary hospital utilization.
7. HSCRC and the State Innovation Group should consider these models of EMS care in the process of developing proposals for CMS for new tracks for the Care Redesign program for Medicare funding under the TCOC model.
8. HSCRC should periodically review opportunities to incorporate the of three EMS care delivery models as potential New Model Programs, which allows for programs where EMS providers may assume financial risk for Medicare beneficiary costs without a hospital partner.
9. Through the TCOC Model, HSCRC should encourage participation by hospitals and other health care providers in the three models of EMS care.
10. HSCRC should continue to identify and consider EMS care delivery financing models that occur outside of Maryland for possible proposals to CMMI at CMS for approval under the TCOC Model, including any future EMS-focused models developed by CMMI.

## **MIEMSS & MHCC**

11. MIEMSS should develop an Alternative Destination designation process whereby alternative destinations can be approved to receive and treat EMS ambulance transported, low acuity 9-1-1 patients.
12. MIEMSS should compile and analyze data from current pilot EMS new care delivery model programs, including evaluation data comparable among the programs, to provide additional support for the business case for public and private payer support for these programs.
13. MIEMSS should continue to evaluate the percentage of treat and release visits compared to all EMS services.
14. MIEMSS should continue to work with local EMS programs to consider and address any data issues that may impact payers.
15. Working with EMS and payers, MIEMSS and MHCC should create a forum for discussion of changes in delivery of EMS care, results from new initiatives, and payer reimbursement.
16. MHCC and MIEMSS should continue to work with payers as they consider the three models of EMS care described in this report.

## **Public and Private Payers**

17. Public and private payers should consider implementing creative pilot programs using the three EMS delivery models, including experimenting with payment approaches that have been successfully adopted in other States.

## **Payers and Hospitals**

18. Hospitals should consider providing additional grants [and/or in kind support] for the three models of EMS care.
19. Payers should consider the three models of EMS care when distributing grant funds.

The Committees, under Insurance Article § 15-1501, could request MHCC to assess the social, medical, and financial impact of establishing a mandate for covering Alternative Destination, and Treat and Release programs.

## Appendix A: Summary of Maryland Innovations in EMS Care.

[https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/EMSReimburs/EMS\\_Cover\\_Reimburse\\_Appendix\\_A.pdf](https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/EMSReimburs/EMS_Cover_Reimburse_Appendix_A.pdf)

## Appendix B: Baltimore City Alternative Destination Pilot Program Protocol

[https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/EMSReimburs/EMS\\_Cover\\_Reimburse\\_Appendix\\_B.pdf](https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/EMSReimburs/EMS_Cover_Reimburse_Appendix_B.pdf)

## Appendix C: Summary of Minor Definitive Care Now Program, an enhanced Treat and Release program model

[https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/EMSReimburs/EMS\\_Cover\\_Reimburse\\_Appendix\\_C.pdf](https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/EMSReimburs/EMS_Cover_Reimburse_Appendix_C.pdf)