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Blue Ribbon Commission To Study Emergency Medical Services in the State

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Office of Policy and Legal Analysis

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Blue Ribbon Commission To Study
Emergency Medical Services in the State

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Executive Summary

The Blue Ribbon Commission To Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Public Law 2021, chapter 749 (Appendix A).[1] Pursuant to the public law, the commission consisted of the following 17 members: two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature; two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents; one member who represents a statewide association of emergency medical services providers; one member who represents a private, for-profit ambulance service; one member who represents a statewide association of municipalities; four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature; one member who represents a tribal emergency medical service; one member who represents a volunteer emergency medical service; one member who represents a county government; one member who represents a statewide association of hospitals; the Commissioner of Health and Human Services or the commissioner's designee; and the Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

A list of commission members may be found in Appendix B.

The duties of the commission are set forth in Public Law 2021, chapter 749 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

Over the course of six meetings, the commission developed the following findings and recommendations:

Funding

Finding A-1: Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to support transporting EMS services in the State.

[1] Public Law 2021, chapter 749 also amends the Maine Emergency Medical Services Act of 1982 by including a legislative finding that emergency medical services provided by an ambulance service are essential services.

Recommendation A-1: The Legislature should fund the delivery of EMS in Maine by appropriating $70 million per year for the next five years from the General Fund to support existing transporting EMS services, with such appropriation amount to be reduced to the maximum extent possible through the utilization of public and private Medicaid match programs.

Recommendation A-2: The Legislature should initially allocate $25 million of that $70 million appropriation to specifically target transporting EMS services at immediate risk of failing and leaving their service area without access to adequate EMS.

Recommendation A-3: The Legislature should further fund the delivery of EMS in Maine by appropriating $6 million per year for the next five years from the General Fund for non-transporting emergency medical services.

Workforce Development, Education and Training

Recommendation B-1: The Legislature should explore options for providing staff of non-municipal, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.

Recommendation B-2: The Legislature should fully fund the Length of Service Award Program.

Recommendation B-3: The Legislature should direct Maine EMS, the Maine Community College System, and University of Maine System to convene a stakeholder work group to explore EMS career pathways and educational opportunities in the State.

Community Paramedicine

Recommendation C-1: To facilitate the growth of community paramedicine programs in Maine, the Legislature should explore options for addressing a potential disparity created by the statutory definition and licensure requirements of home health care providers and community paramedic requirements.

Continued Study of Emergency Medical Services in the State

Recommendation D-1: During the 131st Legislature, the Legislature should reestablish the Blue Ribbon Commission To Study Emergency Medical Services in the State.

I. Introduction

The Blue Ribbon Commission To Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Public Law 2021, chapter 749 (Appendix A).[2] Pursuant to the public law, the commission consisted of the following 17 members:

- Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;
- Two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents;
- One member who represents a statewide association of emergency medical services providers;
- One member who represents a private, for-profit ambulance service;
- One member who represents a statewide association of municipalities;
- Four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature;
- One member who represents a tribal emergency medical service;
- One member who represents a volunteer emergency medical service;
- One member who represents a county government;
- One member who represents a statewide association of hospitals;
- The Commissioner of Health and Human Services or the commissioner's designee; and
- The Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

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The duties of the commission are set forth in Public Law 2021, chapter 749 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate

[2] Public Law 2021, chapter 749 also amends the Maine Emergency Medical Services Act of 1982 by including a legislative finding that emergency medical services provided by an ambulance service are essential services.

with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

The commission was directed to submit a report, with findings and recommendations, including suggested legislation, to the joint standing committee of the Legislature having jurisdiction over public safety matters.

II. Commission Process

The commission was authorized to hold a maximum of six meetings, which were held on the following dates: September 1st, September 15th, October 6th, October 25th, November 14th, and December 5th. Meetings were conducted using a hybrid format, through which commission members could choose to attend each meeting in person or remotely. Members of the public were afforded an opportunity to attend each meeting in person or view a livestream or archived video recording of each meeting through the Legislature's website. Meeting materials, including meeting agendas and background materials can be found at https://legislature.maine.gov/emergency-medical-services-study.

At the first meeting[3] of the commission on September 1st, members gave extended introductions, including information about their background and involvement in or experience with EMS in Maine, the organization or interests they are representing on the commission and any additional information that members felt relevant to share with the commission. Commission staff reviewed the commission's authorizing legislation, Public Law 2021, chapter 749, including the commission's duties, process and timeline for the commission's work. In addition, commission member and Director of Maine Emergency Medical Services (Maine EMS) Sam Hurley provided an overview of EMS in Maine and Dia Gainor, Executive Director of the National Association of State EMS Officials (NASEMSO) provided an overview of EMS nationally. The meeting concluded with commission member discussion regarding the charge and duties of the commission, commission goals and desired outcomes.

The second meeting[4] of the commission took place on September 15th and began with an overview of historical funding requests by Maine EMS and the Department of Public Safety provided by Commissioner of Public Safety Michael Sauschuck. The commission also received an overview on the cost of the provision of services by commission member Joe Kellner. The commission further discussed EMS funding across the State and, at the chairs' request, commission members Carrie Kipfer, Joe Kellner, Chris Baker, Scott Dow and Katelyn Damon provided specific funding information on their respective agencies or organizations. Butch

[3] The archived video of the first meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86335&startDate=2022-09-01T12:30:00-04:00
[4] The archived video of the second meeting is available at the following link: https://legislature.maine.gov/audio/#127?event=86439&startDate=2022-09-15T13:00:00-04:00

Russell, President and CEO of North East Mobile Health, provided EMS funding information as well from his organization's perspective.

The third meeting[5] of the commission took place on October 6th and began with an overview on EMS workforce development and training programs provided by Eric Wellman, Emergency Medical Services Project Director at the Maine Community College System and Dennis Russell, Dean, Education Department Manager and Community Paramedicine Manager at United Training Center. The commission next received a presentation on the EMS workforce provided by Glenn Mills, Deputy Director of the Department of Labor's Center for Workforce Research and Information and a presentation on community paramedicine in Maine provided by Karen Pearson, Policy Associate at the Catherine Cutler Institute at the University of Southern Maine. The final presentation of the day was an update on the Maine EMS Strategic Planning Process provided by SafeTech Solutions consultant John Becknell. At the end of the third meeting, commission members discussed the process by which future commission discussion could be narrowed to focus on potential findings and recommendations. To prepare for that discussion at the next meeting, the chairs requested that commission members suggest potential findings and recommendations prior to the next meeting, to be compiled by staff.

The fourth meeting[6] was held on October 25th and began with a presentation by the consulting firm Sellers Dorsey on behalf of the Maine Ambulance Association regarding the potential implementation of an ambulance Medicaid supplemental payment program in Maine. The commission next heard from member Chris Baker regarding the operation of and challenges unique to a joint fire and ambulance service from his perspective serving with the joint fire/EMS in Old Town. Following these presentations, the discussion turned to the potential findings and recommendations to be included in the commission's final report. Prior to the meeting, the commission had received a document prepared by staff compiling what members had identified as potential findings and recommendations and which served as a framework for this discussion. Members opted to begin the discussion by addressing the EMS funding shortfall and potential solutions. Member Joe Kellner provided the commission with a brief presentation that both sought to identify the amount of that shortfall and provide a number of options for addressing it through State funding. Following additional discussion, the members present unanimously voted to recognize that there exists a funding shortfall in the EMS industry in Maine of roughly $70 million per year and that the shortfall should be addressed through the provision of State funding in that same amount annually over a 5-year period. Although members largely agreed that reporting and accountability mechanisms needed to be built into any such distribution of State dollars, there remained a difference of opinion over whether the funds should be distributed directly, through a Maine EMS-administered grant program or through some other method. Further discussion of the specific method of distributing these funds was accordingly deferred until the next meeting.

[5] The archived video of the third meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86506&startDate=2022-10-06T13:00:00-04:00

[6] The archived video of the fourth meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86527&startDate=2022-10-25T13:00:00-04:00

The fifth meeting[7] was held on November 14th, during which the commission continued its consideration of suggested findings and recommendations and voted on which findings and recommendations to include in the final report. Staff was assigned to draft a preliminary report including those findings and recommendations receiving a majority of votes from the members present and voting at the November 14th meeting, and information regarding the substantive discussions around those findings and recommendations.

The sixth and final meeting[8] was held on December 5th, during which the commission reviewed the draft report and provided suggestions and clarifications on its substance, including re-voting one recommendation to include an additional, substantive component. The findings and recommendations, and underlying votes, of the commission are described in detail in Part IV of this report. Members who were absent at the time of the votes were given the opportunity to submit their votes and those votes are reflected accordingly. Those who were not in attendance and did not subsequently submit a vote are reflected as absent.

III. Background Information

A. Overview of EMS in Maine

The Maine Emergency Medical Services program in Maine was initially established as the result of the federal Highway Safety Act of 1966, which provided that each state must formulate an emergency medical services program or lose a percentage of its national highway funds allocated for highway construction. Previously, funeral directors had been the primary providers of ambulance services. As funeral directors were ceasing to provide this service, citizens began to create volunteer ambulance services in their place. With the new federal law, the first state-sponsored EMS medical training was developed and by 1970, the Department for Licensure of Ambulance Services, Vehicles and Personnel had been created and began to initiate licensing. Over the next few years, federal grants were awarded to fund various city and regional EMS structures and in 1982, the Maine Legislature enacted the Maine Emergency Medical Services Act of 1982, establishing the basis for the current State EMS laws.

Today, EMS in Maine is comprised of three basic entities: the Bureau of Emergency Medical Services (Maine EMS), which is based within the Department of Public Safety; the Board of Emergency Medical Services (Board), which has statutory authority for EMS system oversight; and the EMS system itself, which is the collection of clinicians, first responders, dispatch centers, resources and medical directors throughout the State.

Maine EMS provides regulatory oversight of a variety of entities. These regulated entities include emergency medical dispatchers (EMD) and EMD centers; EMS ambulance operators, emergency medical responders (EMRs), emergency medical technicians (EMTs), advanced EMTs (AEMTs) and paramedics; non-transporting, transporting and air medical services and

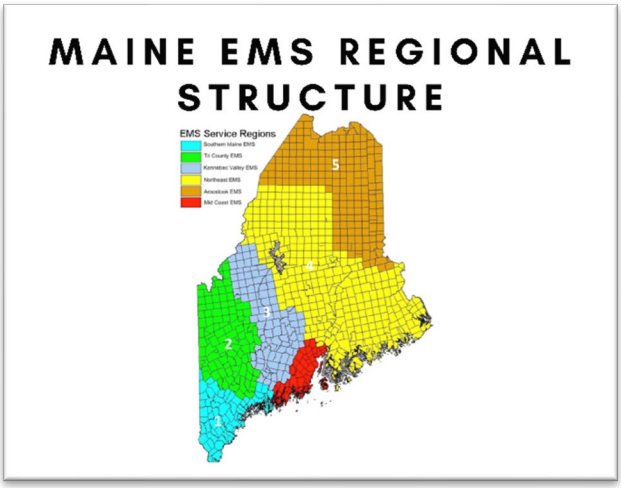
[7] The archived video of the fifth meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86572&startDate=2022-11-14T13:00:00-05:00
[8] The archived video of the sixth meeting is available at the following link: https://legislature.maine.gov/audio/#126?event=86678&startDate=2022-12-05T13:00:00-05:00

emergency vehicles (ambulances, response vehicles and air ambulances); and EMS training centers, which include instructors and coordinators and initial and continuing education courses.

As of January 2021, Maine has over 276 licensed services responsible for delivering emergency medical services throughout the State, including:

- 173 fire departments;
- 41 nonprofit, community-based EMS services;
- 35 independent municipal EMS services;
- 11 private EMS services;
- 11 hospital-based EMS services;
- 3 college-based EMS services;
- 2 tribal EMS services; and
- 1 air medical service.[9]

The State is divided into six EMS regions, each with a regional council, office and medical director. The regional EMS offices are each independent not-for-profit 501(c)(3) corporations that contract with Maine EMS to coordinate the EMS system in their respective region. Those six regions are shown in the chart on the left.[10]

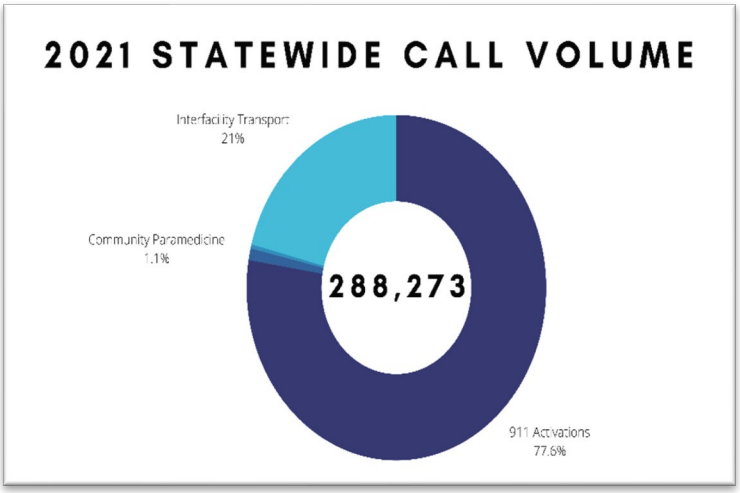


The delivery of emergency medical services, however, is exclusively provided at the local level. Accordingly, how the delivery of EMS is organized and financed varies significantly from community to community. Some communities rely on municipal fire departments or dedicated EMS departments, while others may contract with private, non-profit community-based, or hospital-based EMS services. Each service model has its own challenges and advantages but regardless of the type of service and service mix, in each community EMS provides coordinated response and emergency medical care involving multiple people and agencies and has to be ready at all times to respond a call. All of these components as a whole constitute what we think of as "EMS" in Maine.

[9] *See* https://www.maine.gov/ems/whatisems.
[10] *See* Maine EMS September 1st presentation materials, which can be found at https://legislature.maine.gov/doc/8817.

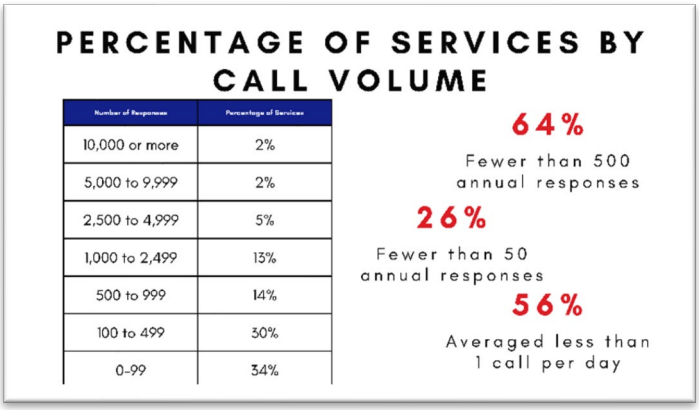
B. Costs of EMS and Reimbursements

Funding of EMS is complicated, partly because each EMS service has different service mixes as previously noted, but also because of varying call volumes, geographic areas and service structures. Statewide, EMS is funded primarily through insurance reimbursement – both public and private. Public Medicare and Medicaid reimbursement is the largest funding source, although reimbursement may also be provided through hospitals or medical facilities, commercial insurers, and self-pay patients.[11] Reimbursement, and especially Medicare and Medicaid reimbursement is particularly complex.



To understand EMS costs and reimbursements, it can be helpful to start first with an understanding call volume. In 2021, there were approximately 288,273 calls for EMS. As shown in the chart on the right,[12] 911 activations accounted for 77.6% of those transports. Interfacility transport (IFT), which is the transport of a person from one medical facility to another medical facility, accounted for 21% of those transports. Community paramedicine, which represents an expanded role for EMS providers to assist with both public health and primary healthcare to underserved populations without the duplication of services, accounted for 1.1% of those transports.

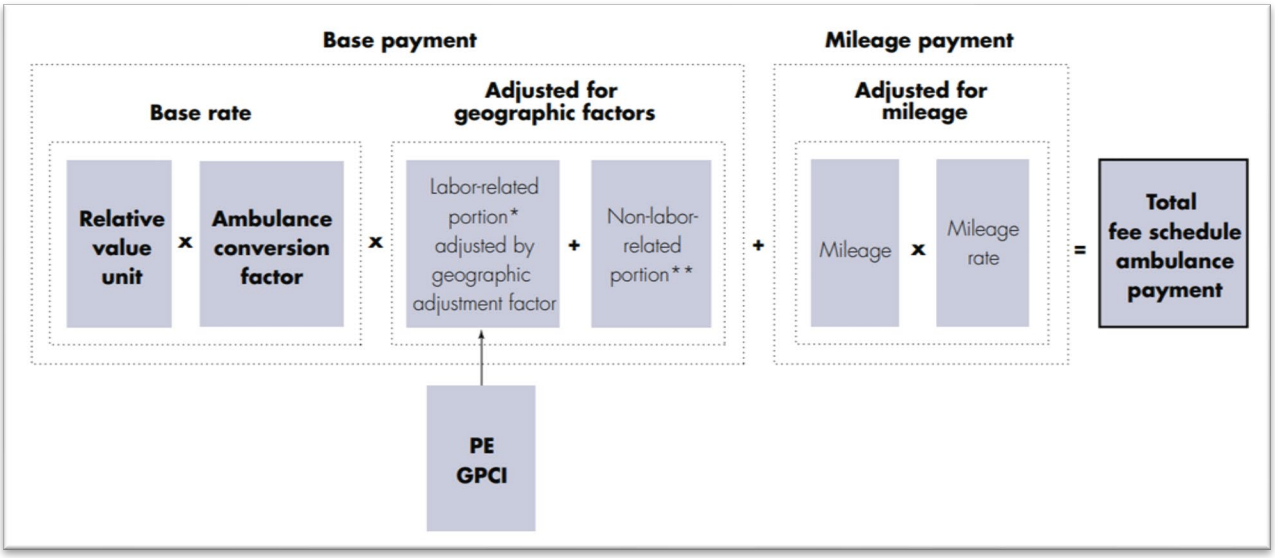
Most EMS services in Maine do not respond to a large call volume. The chart to the left shows the percentage of services by call volume.[13] Even EMS services that have a low volume of calls, however, must have the staff and equipment necessary to be able to provide a continuous, 24/7 ambulance response and services must be geographically dispersed so as to be able to respond to those calls in a timely manner. This is what is commonly referred to as the "cost of readiness." By using call volume as an indicator of "cost-per-call," a service with a low call volume will necessarily have a higher cost-per-call because all of the overhead costs to run an EMS service are spread amongst fewer calls.



[11] The commission estimates that only approximate 18-20% of funding comes from private reimbursement, although that percentage can be expected to vary from region to region and service to service.
[12] *See id.*
[13] *See id.*

There is limited data on the cost of providing ambulance services, which is contributing to low reimbursement rates. It can also be difficult to calculate the exact cost of EMS where, for example, a municipality has a joint fire/EMS department. The commission did receive information from members regarding EMS budgets from a variety of different service types, including services representing a large city service, a joint fire/EMS department, a small/rural service, a volunteer service and a regional service. In addition, commission member Joe Kellner presented on the cost of EMS and provided an illustrative sample ambulance budget.[14] For each service, a number of factors contribute to the cost of providing ambulance services, including, but not limited to: general budget items, such as salaries and wages, supplies, dispatch and billing, equipment, repairs and maintenance and fuel costs; population density; call volume and volume of transports; types of services provided; grants and fundraising; and staffing and level of staff training and use of volunteers. Of course, underlying all of these costs, is the "cost of readiness," as previously described.

Reimbursement through Medicare and Medicaid is based on the ambulance fee schedule, which has two components: a base payment, which contains seven distinct levels of ground transport ambulance service representing varying levels of service intensity, and a mileage payment. There are also add-on payments tied to the mode of ambulance transportation and/or geographic location, which include rural and super rural add-ons as determined by zip code. Rates are updated annually by the ambulance inflation factor, which is an amount equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) reduced by the 10-year moving average of multi-factor productivity. The update for 2021 was 0.2 percent. Ambulance add-on payments, which will expire at the end of 2022, include: 2% for urban, 3% for rural and 22.6% for super-rural. MaineCare pays at average Medicare rates based on the lowest geographic practice cost index (GPCI).[15] This equation can also be mapped out as follows.



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[14] *See* September 15 meeting materials, which can be found at https://legislature.maine.gov/ems-study-meeting-9152022.
[15] *See id.*
[16] *See id.*

It is vitally important to consider, however, that a call which does not result in transport does not result in payment, further exacerbating the gap between the cost of delivering EMS and the reimbursement received. Using the data that is available and by making a few assumptions,[17] the difference between the cost-per-call and reimbursement-per-call can be estimated as follows.

Call Volume	**300**	**600**	**900**	**1200**	**1500**	**1800**	**2100**
Cost per Call	$2,522.06	$ 1,301.37	$ 894.47	$ 1,177.20	$ 958.99	$ 813.51	$ 709.60
Reimbursement per Call	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99
Loss per Transport	$ 2,030	$ 809	$ 402	$ 685	$ 467	$ 322	$ 218
Total Gap	$609,020.97	$485,625.81	$362,230.65	$822,253.61	$700,496.45	$578,739.29	$456,982.13

Thus, although the cost per call is much greater for a service with a low call volume, the reimbursement per call remains the same, and even for those services with the greatest call volume, the reimbursement is still not sufficient to cover the costs. This is because the reimbursement through Medicare and Medicaid is antiquated and woefully inadequate, made worse in a state as rural and geographically diverse as Maine.

C. Subsidies

The difference between an EMS service's cost-per-call and reimbursement must be made up through subsidies. Current subsidies take many forms and no EMS services in the State use the exact same model. Subsidies that are utilized include taxpayer support, municipal contributions, commercial payers, philanthropy and grants. One of the biggest subsidies underwriting EMS, however, is volunteer and underpaid labor.

EMS in Maine has been highly dependent on and values the role of volunteerism and service in the creation of locally-developed EMS services. While recognizing that volunteerism will always have a role in EMS, it is admittedly not a reliable solution to the central challenges to the long-term sustainability of the EMS system. Declining volunteerism coupled with a dependence on an underpaid workforce that hampers recruitment and retention has necessarily required greater reliance on other subsidies, thereby increasing costs to local municipalities and taxpayers. Declining volunteerism has also helped to reveal the true cost of EMS, which comes as a shock to many communities now struggling to provide those services locally.

Absent a subsidy, transporting EMS services cannot break even in the State, regardless of service mix, and all transporting EMS services are currently operating at a loss. As demonstrated in the previous chart, to break even, a high-efficiency (1,800 transports per year) service would need a subsidy of approximately $322 per transport; for a more rural, low-volume service (300 transports per year), a subsidy of $2,030 per transport is needed. Relying on current subsidies without additional State assistance is insufficient to meet the existing need for transporting EMS

[17] *See id.*

services and, as the commission heard throughout its work, all EMS services in Maine are currently operating at a loss.

D. EMS Workforce, Education and Training

As mentioned above, one of the largest subsidizations of EMS services in Maine is a volunteer and underpaid workforce. Volunteerism, however, is declining and struggles with EMS employee recruitment and retention have exacerbated problems for a workforce that is already stretched too thin. A primary contributor to these recruitment and retention issues is the generally inadequate compensation and benefits offered to many EMS employees. As noted by the Maine Department of Labor (MDOL), the average annual salary for an EMT in Maine varies, depending on location, from $29,225 to $35,542, while the annual average salary for a paramedic varies from $38,836 to $53,244. Due to the significant funding problems that all EMS services face in Maine, the compensation, benefits and working conditions generally offered to EMS employees are often insufficient to recruit and retain the workforce needed to effectively and efficiently deliver EMS across the State. Per a 2021 MDOL survey, EMS services generally reported difficulties hiring EMTs, AEMTs and paramedics and consequently have had to rely on per diem staffing and volunteer positions to fulfill their workforce needs.

At the same time that EMS services are reporting such significant staffing issues, the commission also received information suggesting an increasing recent demand for EMS educational and training programs in the State. There are multiple EMS training centers in Maine provided through regional EMS offices, private ambulance services and the Maine Community College System, which offer education and training opportunities for EMRs, EMTs, AEMTs and paramedics. Additionally, the MDOL has also partnered with other State agencies and the University of Maine System to offer continued healthcare training and career advancement opportunities for EMS staff through the Healthcare Training for ME program. Funding for many of these programs for both participants and educators remains an outstanding need and it was noted to the commission that the retention of individuals completing those programs in the traditional EMS field has been problematic.

All of these factors are contributing to bringing EMS in Maine to a breaking point. Legislative action will be necessary to ensure the short-term and long-term future of EMS in the State. Accordingly, the commission makes the following findings and recommendations.

IV. Findings and Recommendations

A. Funding

From the very first meeting of the commission, members expressed grave concern that EMS in the State is not only at the edge of a cliff but that in many areas of the State, particularly rural areas, EMS is already over that cliff. The primary issue facing EMS is a lack of funding. As established by the Legislature pursuant to Public Law 2021, chapter 749, which also authorized this commission, emergency medical services provided by an ambulance service are essential

services.[18] Funding is necessary and vital to delivering those essential services. That funding comes down to two key components: the cost of providing services – including the cost of readiness – and the funds necessary to cover those costs, currently fulfilled through Medicare and Medicaid and private insurance reimbursement and other subsidies.

The federal Centers for Medicare and Medicaid Services is currently conducting a cost study on ground ambulance services. This study is anticipated to more accurately identify how much it costs to actually deliver EMS and to result in a corresponding increase in reimbursement rates. That cost study will take time, however, and it is unlikely that any of those reimbursement rate increases will be implemented within the next five years.

In the meantime, it is critical that the State support EMS in Maine to avoid EMS service closures and to ensure that, when Mainers call for EMS, there are services able to respond wherever they are needed in a timely manner. Accordingly, the commission makes the following findings and recommendations relating to the funding of EMS in Maine.

Finding A-1: Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to support transporting EMS services in the State.[19]

While it is apparent to those involved in EMS that current funding is woefully inadequate, it is harder to determine exactly what the actual need is to ensure that EMS services have the funding necessary to provide their critical services. The commission recognized from the beginning of its work that funding this need is crucial to ensuring the survival of EMS services in Maine.

As noted previously in this report, there is limited data on the cost of providing ambulance services. Additionally, even with examining the actual cost data available, that data is necessarily deficient because it relies on the provision of EMS through volunteerism, low wages and donated labor. Without subsidies and with reimbursement rates only covering 60-80% of the cost of service, it is clear that the shortfall between cost of service and revenue is greater than $70 million.

Nevertheless, a majority of commission members recognize the importance and immediate need of funding transporting services in a way that will make a meaningful difference. Those members accordingly determined that, at a minimum, there is a need for $70 million in funding each year for the next five years – in addition to current subsidies – to support transporting EMS services in Maine.

[18] *See* Appendix A.

[19] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, McGinnis, Morris and Kellner. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

To determine the amount of this need, the commission utilized the calculation of loss per transport as explained in a presentation by commission member Joe Kellner.[20] Essentially, this calculation begins with a base rate, suggested at what is deemed to be a high-efficiency EMS service with about an 1,800 call volume annually. At that annual call volume, it is estimated that such a service will lose approximately $325 per transport, including all types of transport, such as 911 calls, interfacility transport, etc. Not all EMS services operate with that level of call volume, however, and in fact many services in Maine are rural services with a much lower annual call volume. Accordingly, the commission included a "rural adjustment" utilizing the USDA zip-code-based rurality scores to determine a multiplier. Thus, for each EMS service, the commission was able to roughly determine the amount of need per call necessary to better support that service.

The commission used this calculation method to determine that the total need throughout the State for transporting EMS services is $70 million per year, which can be broken down, depending on the chosen disbursement method, either by transporting service, by service mix or using some other methodology. This total number is essentially the minimum amount necessary to support transporting EMS services in Maine over the next five years until increased Medicare and Medicaid reimbursement rates are expected to be available.

Recommendation A-1: The Legislature should fund the delivery of EMS in Maine by appropriating $70 million per year for the next five years from the General Fund to support existing transporting EMS services, with such appropriation amount to be reduced to the maximum extent possible through the utilization of public and private Medicaid match programs.[21]

A majority of commission members recommend that the Legislature fund this identified need over a five-year period, with the funding limited to those EMS services that are currently operating in the State – or their successor organizations, if for example, services seek to regionalize or otherwise improve their efficiency – rather than be used to provide funding to new services. The commission, also emphasizes and recommends that this amount be offset through the use of federal funds. In particular, the Legislature should pursue the use of the Medicaid Supplemental Payment Program for non-municipal ambulance services and Certified Public Expenditure (CPE) programs for municipal services to maximize Medicaid matching.

For non-municipal ambulance services (for-profit, non-profit and volunteer services), federal Medicaid law allows states to establish a program under which a state collects an assessment from those services and uses that money as that state's share for federal Medicaid matching funds, thus increasing Medicaid rates by making supplemental payments to those services. Similar assessment programs have been used to benefit hospital and nursing home industries here in Maine and nationally. To establish such an assessment program, the Legislature should direct the Maine Department of Health and Human Services to collect the assessment from each

[20] *See* Maine Ambulance Association EMS Funding Proposal presentation from the October 25th Meeting, which can be found as Appendix C and at https://legislature.maine.gov/doc/9181.

[21] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Kellner, McGinnis and Morris. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

non-municipal ambulance service (for-profit, non-profit and volunteer service) and, with the funds generated from the assessment, match available federal Medicaid dollars. MaineCare would then make the corresponding supplemental Medicaid payments to these non-municipal ambulance services. Draft legislation provided by consultant Sellers Dorsey, which presented to the commission at its October 25th meeting, is included as Appendix D. Sellers Dorsey estimates that the net gain – the increase in supplemental payments minus the assessment paid – to each service will vary but, for the industry as a whole, the supplemental payments should be at least two times the amount of the assessments paid by all such services, which will help offset the funds needed from the State to meet the identified need.

For municipal EMS services, the commission recommends the use of CPE programs to help offset the identified need. A CPE program is a Medicaid financing approach by which a governmental entity, including a governmental service such as a municipal EMS service, incurs an expenditure eligible for federal financial participation (FFP) under the state's approved Medicaid State plan. The governmental entity is required to certify that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the State then claims FFP.[22] To maximize the use of the federal funds available under a CPE program, the Legislature should direct the Department of Health and Human Services to include such a program in its Medicaid State plan and to provide the support, resources and education necessary for municipal EMS services to most effectively take advantage of the program.

Recommendation A-2: The Legislature should initially allocate $25 million of the recommended $70 million appropriation to specifically target transporting EMS services at immediate risk of failing and leaving their service area without access to adequate EMS.[23]

The commission consistently recognized that there are two components to funding EMS needs in the State: (1) immediate crisis funding for EMS services at the highest risk of failing and (2) long-term funding for the sustainability of the future of EMS in the State. Accordingly, a majority of commission members recommend that of the $70 million in funding identified in the prior recommendation, during the first two years in which that funding is available, $25 million in each year should be immediately set aside in a non-lapsing fund to be targeted specifically to those EMS services at immediate risk of failing and leaving residents of those service areas without adequate EMS.

When a person calls 911, the person expects that an EMS service will provide an immediate response and be able to provide the necessary medical care and transport, if required, to the patient. There are EMS services in this State, however, that are in danger of failing due to a lack of funding, not only from low reimbursement rates but from difficulty in finding volunteers and a high workforce turnover. These services need immediate assistance and, without that assistance, their service areas will no longer have necessary EMS coverage. By specifically targeting this

[22] *See* https://www.macpac.gov/subtopic/non-federal-financing/#:~:text=A%20CPE%20is%20a%20statutorily,Act%3B%2042%20CFR%20433.51).

[23] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Kellner, Morris and McGinnis. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

funding initially to those services with the greatest need, the residents of those areas will not lose access to EMS and the immediate influx in funding will allow those services to better plan for long-term sustainability.

Recommendation A-3: The Legislature should further fund the delivery of EMS in Maine by appropriating $6 million per year for the next five years from the General Fund for non-transporting emergency medical services.[24]

In addition to the 171 transporting EMS services in the State, there are 103 non-transporting EMS services. A non-transporting EMS service is defined as any organization, person or persons who hold themselves out as providers of emergency medical treatment and who do not routinely provide transportation to ill or injured persons, and who routinely offer or provide services to the general public beyond the boundaries of a single recreational site, business, school or other facility. Non-transporting services generally respond to a location of a medical emergency to provide immediate medical care but do not provide patient transport. Examples may include fire apparatus, response cars or other non-transport vehicles.

The commission identified that non-transporting EMS services are also in need of funds. Accordingly, a majority of commission members recommend that the Legislature fund $6 million per year over the next five years for non-transporting EMS services. This infusion of funding will help non-transporting EMS services with their immediate need, thereby allowing them to put plans in place for their long-term sustainability following the five-year period.

B. Workforce Development, Education and Training

The commission dedicated a substantial portion of its time discussing and identifying potential solutions to EMS workforce issues, which are significantly impacting the delivery of EMS in Maine, leading to delayed emergency response times and to an overworked and overstressed workforce.

Recommendation B-1: The Legislature should explore options for providing staff of non-municipal, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.[25]

As previously noted, a primary contributor to the EMS employee recruitment and retention issues faced by EMS services across the State are the insufficient compensation and benefits offered to EMS employees. Although the provision of supplemental funding for EMS services

[24] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Morris, McGinnis and Kellner. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

[25] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Doane, Damon, McGinnis, Morris and Kellner. Commission member Hurley abstained from the vote and commission members Mason, Theriault and Letourneau were absent. Commission member Dow voted in opposition to this recommendation because, although he has no concerns with access to the Maine State Retirement System, he is concerned that he, as most municipal employees, have the same coverage as most other services, which is a group plan, and that municipal services will begin to lose people, and that this will just be shifting the problem around, not solving it.

proposed in the prior recommendations will allow for enhancement of employee compensation and benefits during the period in which that funding is available, the commission recognized that there are other mechanisms that might be employed to address those same concerns. One such mechanism, which was supported by a majority of commission members at the fifth meeting, is for the Legislature to explore options for providing staff of non-governmental, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.

Many of the 272 licensed EMS services in Maine are governmental services and are therefore able to provide staff with access to the Maine State Retirement System. Staff of non-governmental EMS services may be offered access to a retirement benefits package through their employer although the benefits offered to such individuals varies across Maine. Offering access to State retirement benefits and State healthcare benefits to employees of licensed non-governmental, nonprofit EMS services may serve to boost employee recruitment and retention for those services, which fill a critical need for the delivery of EMS in many areas of the State. The commission is committed to supporting the Legislature as it explores this recommendation, recognizing that facilitating this change will require the consideration of a myriad of factors and, potentially, the expenditure of State funds.

Recommendation B-2: The Legislature should fully fund the Length of Service Award Program (5 MRSA §3372).[26]

The Length of Service Award Program (LOSAP), 5 MRSA §3372, was enacted in 2015 to provide paid length of service awards to eligible volunteers. Under the program, an "eligible volunteer" is an active part-time or on-call member of a fire department or a volunteer firefighter or a licensed EMS person or ambulance operator who provides on-call, part-time or volunteer emergency medical response under the direction of a fire department chief or for an ambulance service or a non-transporting EMS. The LOSAP rewards these eligible volunteers for the service to their communities with contributions to a retirement program. Participants are generally eligible for such benefits at the earlier of attaining sixty-five years of age or 20 years of service credit.

The LOSAP can accept funding from the federal government, the State or a municipality; however, when it was established in 2015, no State funds were provided and since that time, there have only been three one-time funding initiatives enacted totaling $2 million.[27] At this time, there is no dedicated funding source for the LOSAP and it is unclear what the anticipated needs of the program currently are or are anticipated to be beyond the $2 million already appropriated. Commission members, however, believe that the benefits that can be provided through the LOSAP represent another important mechanism by which EMS staff recruitment and retention rates can be improved. Consequently, a majority of commission members at the fifth

[26] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, McGinnis, Morris and Kellner. Commission member Hurley abstained from the vote and commission members Mason, Theriault and Letourneau were absent.

[27] *See* Public Law 2021, Chapter 444, which provided a one-time General Fund appropriation of $500,000 in Fiscal Year 21-22; Public Law 2021, Chapter 721, which provided a one-time General Fund appropriation of $500,000 in Fiscal Year 22-23; Public Law 2021, Chapter 635, Section A-16), which provided a one-time General Fund appropriation of $1,000,000 in FY 22-23.

meeting support the Legislature funding the LOSAP at a level necessary to meet that program's current and anticipated future needs, with consideration given to the establishment of a dedicated funding source.

Recommendation B-3: The Legislature should direct Maine EMS, the Maine Community College System, and University of Maine System to convene a stakeholder work group to explore EMS career pathways and educational opportunities in the State.[28]

Although, as the commission heard, there exist a number of public and private educational and training programs for EMS providers in Maine that have seen an increasing demand for services, the retention of the individuals completing those programs in the traditional EMS field has been problematic. To ensure that the educational and training options available in the State are best designed and coordinated to enhance the recruitment and retention of EMS service employees in the traditional EMS field and where the staffing demands of EMS services are the greatest, a majority of commission members at the fifth meeting stated their support for the Legislature directing the convening of a stakeholder workgroup to explore EMS career pathways and educational opportunities in the State.

To ensure that a broad spectrum of experiences and backgrounds are present on the workgroup, it should include representatives of Maine EMS, the Maine Community College System, the University of Maine System, other public and private entities that provide EMS educational or training programs in the State and other individuals with relevant backgrounds and experiences in EMS education and training and in the delivery of EMS generally. To facilitate consideration of any findings or recommendations that may arise out of this workgroup, the Legislature should consider requiring the submission of a report by the workgroup outlining the activities of the workgroup and any recommendations proposed by its members, including proposed legislation where appropriate.

C. Community Paramedicine

As the commission heard during their October 6th meeting, community paramedicine is an evolving model of healthcare delivery in both rural and urban areas as EMS services look to reduce the use of EMS for non-emergency 911 calls, the overcrowding of emergency departments and healthcare costs. Community paramedicine is an important part of the EMS system in the State and has been proven to be impactful and to reduce healthcare costs. The commission supports opportunities to expand community paramedicine programs, including exploring reimbursement models and revenue streams that would support these programs.[29] There is no single model of community paramedicine – rather programs are based on community needs and services. Community paramedicine pilot projects were authorized by the 125th Maine Legislature and expanded during the 128th Maine Legislature. There have been additional

[28] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, McGinnis, Morris, Kellner and Hurley. Commission members Mason, Theriault, and Letourneau were absent.

[29] Commission member and Director of Maine EMS, Sam Hurley, noted that this is an issue that Maine EMS is currently working to address through facilitating modifications to the State's MaineCare plan to allow reimbursement for community paramedicine services.

studies, including the Lincoln County Community Paramedicine Data Collection Initiative in 2019 and, in 2022, Maine EMS contracted with the Catherine Cutler Institute to expand this pilot study and evaluate programs in Maine. The commission believes in the importance of community paramedicine but identified a potential disparity in statutory and licensing requirements and accordingly makes the following finding and recommendation.

Recommendation C-1: To facilitate the growth of community paramedicine programs in Maine, the Legislature should explore options for addressing a potential disparity created by the statutory definition and licensure requirements of home health care providers and community paramedic requirements.[30]

One of the challenges with growing community paramedicine programs is the potential overlap between community paramedics and other home health care professionals. The commission identified a potential disparity in the statutory definition and licensure requirements of home health care providers and community paramedic requirements that jeopardizes the community paramedic programs that the Legislature should address.

Title 22, section 2143 of the Maine Revised Statutes prohibits a home health care provider from providing home health services without a license. A home health care provider is defined as "any business entity or subdivision thereof, whether public or private, proprietary or not for profit, that is engaged in providing acute, restorative, rehabilitative, maintenance, preventive or health promotion services through professional nursing or another therapeutic service, such as physical therapy, home health aides, nurse assistants, medical social work, nutritionist services or personal care services, either directly or through contractual agreement, in a client's place of residence."[31] This term does not apply to any sole practitioner providing private duty nursing services or other restorative, rehabilitative, maintenance, preventive or health promotion services in a client's place of residence or to municipal entities providing health promotion services in a client's place of residence.[32] It also does not apply to a federally qualified health center or a rural health clinic as defined in 42 United States Code, Section 1395x, subsection (aa) (1993) that is delivering case management services or health education in a client's place of residence.[33] Beginning October 1, 1991, "home health care provider" includes any business entity or subdivision thereof, whether public or private, proprietary or nonprofit, that is engaged in providing speech pathology services."[34]

Community paramedicine, on the other hand, is established as "the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing episodic patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically

[30] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Doane, Damon, Kipfer, McGinnis, Morris, and Kellner. Commission member Letourneau abstained from the vote and commission members Mason and Theriault were absent. Commission member Dow voted in opposition to this recommendation, with the question of why community paramedics are not currently in the home health sector and that that would solve many of the problems.
[31] 22 MRSA §2142(3).
[32] *Id.*
[33] *Id.*
[34] *Id.*

requested or directed by a physician" and operates under the rules established by the Maine EMS Board.[35]

These overlapping concepts have created confusion over the licensure requirements for community paramedics and the licensure requirements for home health care providers and a majority of commission members believes that there needs to be clearer delineation between the requirements applicable to these two categories of regulated entities.

Accordingly, a majority of commission members recommend that the Legislature further explore this potential disparity with the goal of better delineating in statutory definitions and licensure requirements, the differences between the two roles, which will, in turn, grow and further enable community paramedicine programs in the State. Members of the commission noted that community paramedic programs do not have, and should not need, home health service licenses, as they are licensed separately under the rules established by the Maine EMS Board. Some members did caution, however, about potential unintended consequences of simply exempting community paramedics from home health service licensure requirements.

D. Continued Study of Emergency Medical Services in the State

Through six meetings, the commission heard from its members, stakeholders and others about EMS in Maine and many of the challenges to the funding, support and delivery of EMS services and regarding how all aspects of EMS, including workforce development, training, compensation, retention costs, reimbursement rates, organization and local and state support, contribute to the system. Although many of these aspects are touched on in the commission's findings and recommendations, there remain many aspects of that system and identified issues the commission was not able to fully explore or examine in its limited time.

In addition, as recognized in the commission's duties, the commission's work was conducted parallel to the strategic planning work undertaken by Maine EMS. Maine EMS contracted with a consultant, SafeTech Solutions, to engage in strategic planning process of Maine EMS and the EMS Board to put forward a vision and plan for the future of Maine EMS and to make recommendations on its short-term and long-term sustainability. The commission heard from the consultant, John Becknell, during its October 25th meeting, however, the work of the strategic planning process was not completed by the time the commission held its final meetings and voted on findings and recommendations. Accordingly, a majority of commission members make the following recommendation.

Recommendation D-1: During the 131st Legislature, the Legislature should reestablish the Blue Ribbon Commission To Study Emergency Medical Services in the State.[36]

A majority of commission members do not feel that the commission's work is complete and recognizes that there are still outstanding issues that need to be addressed to ensure the short-

[35] *See* 32 MRSA §84(4).

[36] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Kellner, Morris and McGinnis. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

term and long-term sustainability of EMS in Maine. This can best be accomplished by continuing to bring together legislators, experts and EMS providers to collaborate and advise the Legislature on the best paths forward. This need is particularly acute as the Maine EMS strategic planning process concludes and makes its recommendations to Maine EMS, the EMS Board, the Department of Public Safety and ultimately the Legislature.

From the beginning of its work, the Legislature and the commission recognized the need for the strategic planning process to inform the work of the commission and vice-versa. The commission believes that reestablishing this commission in the 131st Legislature will allow that communication to continue. A reestablished commission would be better positioned to evaluate the strategic planning recommendations as well as progress made on EMS as identified in this report. The commission discussed that the State needs to build a better, more supportive structure, but that this commission was not at a place to make specific recommendations. However, it is anticipated that the strategic plan will include recommendations on the structure of Maine EMS and the delivery of EMS in the State. Commission members noted how important it is that everyone who is involved in EMS have a voice in the structure of the delivery of services and that those voices be heard by policy- and decisionmakers. A reestablished commission will be better positioned to evaluate recommendations regarding system structure and sustainability. It is critical that the State continue to support the structure, at the state and local level, and the delivery of EMS in the State and continuing the work of this commission as proposed above will help to fulfill that important purpose.

V. Conclusion

The commission's work and publication of its report comes at a time when EMS in the State is in crisis. EMS services in Maine are at the edge of a cliff, or over it, and changes must occur to ensure that when someone calls with a medical emergency, EMS services are able and ready to assist. This requires, first and foremost, increased funding for the delivery of EMS. Current subsidies, especially volunteerism, are declining and revealing the true cost of EMS, and the State must step in to ensure that EMS does not disappear in parts of this State.

Of course, this work does not end with the commission's report and the commission hopes that the findings and recommendations contained in this report demonstrate not only the dire need within the EMS system but also the first steps towards ensuring both the short-term and long-term sustainability of the system. Members of the commission look forward to working with the 131st Legislature to refine the details of these recommendations and maintain focus on this critically important issue and Maine's EMS workforce.

Finally, the commission would like to thank all of its members and presenters for generously offering their time, expertise and advice on the complicated issues involved in funding and supporting EMS in the State. Their knowledge and perspectives were invaluable in developing the findings and recommendations of the commission. Additionally, the EMS system in Maine would not exist without EMS providers and the commission would like thank all of them who dedicate their time – often overburdened and underpaid – to serving their communities and the State.

APPENDIX A

Authorizing Legislation: Public Law 2021, c. 749

LAW WITHOUT GOVERNOR'S SIGNATURE

MAY 8, 2022

CHAPTER

749

PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-TWO

H.P. 1474 - L.D. 1988

An Act To Establish That the Provision of Emergency Medical Services by an Ambulance Service Is an Essential Service and To Establish the Blue Ribbon Commission To Study Emergency Medical Services in the State

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this legislation needs to take effect before the expiration of the 90-day period in order to provide sufficient time for the study established in this legislation to be completed; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 32 MRSA §81-A, first ¶, as enacted by PL 1985, c. 730, §§3 and 16, is amended to read:

It is the purpose of this chapter to promote and provide for a comprehensive and effective emergency medical services system to ensure optimum patient care. The Legislature finds that emergency medical services provided by an ambulance service are essential services. The Legislature finds that the provision of medical assistance in an emergency is a matter of vital concern affecting the health, safety and welfare of the public.

Sec. 2. Establishment of Blue Ribbon Commission To Study Emergency Medical Services in the State.

1. Blue ribbon commission established. The Blue Ribbon Commission To Study Emergency Medical Services in the State, referred to in this section as "the commission," is established.

2. Commission membership. Notwithstanding Joint Rule 353, the commission consists of 17 members:

A. Seven members appointed by the President of the Senate as follows:

(1) Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;

(2) Two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents;

(3) One member who represents a statewide association of emergency medical services providers;

(4) One member who represents a private, for-profit ambulance service; and

(5) One member who represents a statewide association of municipalities;

B. Eight members appointed by the Speaker of the House as follows:

(1) Four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature;

(2) One member who represents a tribal emergency medical service;

(3) One member who represents a volunteer emergency medical service;

(4) One member who represents a county government; and

(5) One member who represents a statewide association of hospitals;

C. The Commissioner of Health and Human Services or the commissioner's designee; and

D. The Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

3. Chairs. The first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

4. Appointments; convening of commission. Notwithstanding Joint Rule 353, all appointments must be made no later than 15 days following the effective date of this Act. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. Within 15 days after appointment of all members, the chairs shall call and convene the first meeting of the commission, which must be no later than 30 days following the appointment of all members.

5. Duties; meetings. The commission shall examine and make recommendations on the structure, support and delivery of emergency medical services in the State. The commission shall maintain communication and coordinate with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission may look at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support. The commission is authorized to hold a maximum of 6 meetings.

6. Staff assistance. The Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

7. Report. Notwithstanding Joint Rule 353, no later than December 7, 2022, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the joint standing committee of the Legislature having jurisdiction over public safety matters.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership List: Blue Ribbon Commission To Study Emergency Medical Services in the State

Blue Ribbon Commission To Study Emergency Medical Services in the State

Public Law 2021, Ch. 749

Membership List

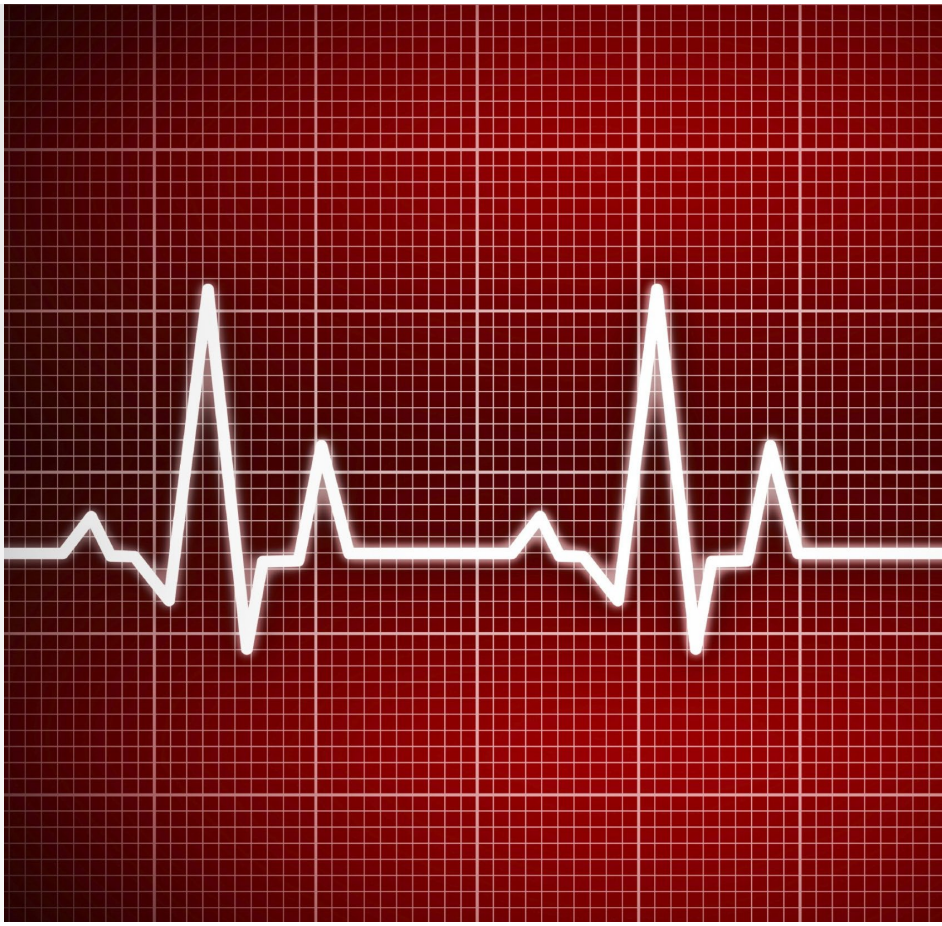
Name	Representation
Senator Chip Curry (Chair)	Member of the Senate
Representative Rachel Talbot Ross (Chair)	Member of the House of Representatives
Senator Bradlee Farrin	Member of the Senate
Representative Suzanne Salisbury	Member of the House of Representatives
Representative Richard Mason	Member of the House of Representatives
Representative Tim Theriault	Member of the House of Representatives
Christopher Baker	Member who is employed or volunteers in the field of emergency medical services and represents a community of 10,000 residents or more
Scott Dow	Member who is employed or volunteers in the field of emergency medical services and represents a community of fewer than 10,000 residents
Kevin McGinnis	Member representing a statewide association of emergency medical services providers
Richard Petrie	Member representing a private, for-profit ambulance service
Melissa Dow-Doane	Member representing a statewide association of municipalities
Brad Morris	Member representing a tribal emergency medical service
Katelyn Damon	Member representing a volunteer emergency medical service
Carrie Kipfer	Member representing a county government
Joe Kellner	Member representing a statewide association of hospitals
Dr. Lisa Letourneau	Commissioner of Health and Human Services or the commissioner's designee
Sam Hurley	Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee

APPENDIX C

Joe Kellner October 25th PowerPoint Presentation

EMS Funding Proposal

MAINE AMBULANCE ASSOCIATION



Disclosures

This analysis, proposal, and evaluation is a work product of the MAA. This has not been presented to the Blue-Ribbon Commission.

MAINE AMBULANCE ASSOCIATION

Funding Background

- Absent a subsidy, it is our analysis that ambulance services cannot break even in the State of Maine, regardless of service mix
  - This was demonstrated to BRC, work product can be shared
- For a high-efficiency[1] service, in order to break even, a subsidy of approximately $322 per annual transport is needed
- For a more rural, low-volume service[2], a subsidy of $2,030 per annual transport is needed

- 1 – 1,800 Transports per Year
- 2 - 300 Transports per year

Gap by Volume

Volume	300	600	900	1200	1500	1800	2100
Cost per Call	$ 2,522.06	$ 1,301.37	$ 894.47	$ 1,177.20	$ 958.99	$ 813.51	$ 709.60
Reimbursement per Call	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99
Loss per Transport	$ 2,030	$ 809	$ 402	$ 685	$ 467	$ 322	$ 218
Total Gap	$ 609,020.97	$ 485,625.81	$ 362,230.65	$ 822,253.61	$ 700,496.45	$ 578,739.29	$ 456,982.13

Proposal

Step 1: Establish a basis

- This evaluation establishes the basis at $325.00 per transport
- All transports are in scope (911, IFT, etc.)

Step 2: Establish a rural modifier

- Utilize USDA Zip Code-based rurality scores (Not Rural, 1, 2, 3, 4)
- Determine the multiplier:

USDA Rural Score (primary base of operation, or do per call)	Multiplier
0	0
1	0.2
2	0.4
3	0.6
4	1

Step 3: Consider an efficiency add-on

- Utilize USDA Zip Code-based rurality scores (Not Rural, 1, 2, 3, 4)
- Determine the multiplier:

Political Subdivisions Served	Multiplier
0-1	0
2-10	0.25
10+	0.5

- *Recommendation is to delay*

Sample Calculation

	Basis	Rurality Score	Rurality Multiplier	Rurality Add On	Total
Super Rural Service	$325	4	1	$325	$650

	Basis	Rurality Score	Rurality Multiplier	Rurality Add On	Total
Moderately Rural Service	$325	2	0.4	$130	$455

	Basis	Rurality Score	Rurality Multiplier	Rurality Add On	Total
Non-Rural Service	$325	Not Rural	0	0	$325

Total funding request

Transport Type	Total
911 Response (Scene)	$51,255,555.00
Community Paramedicine	$325.00
Intercept	$83,525.00
Interfacility Transport	$12,746,305.00
Medical Transport	$3,454,230.00
Mutual Aid	$201,760.00
NULL	$5,200.00
PIFT (Paramedic Interfacility Transfer)	$1,110,265.00
Public Assistance/Other Not Listed	$26,390.00
Specialty Care Transport	$363,675.00
Standby	$12,740.00
Grand Total	$69,259,970.00

Top 10 Services

Service	Total Transports
United Ambulance Service	13861
Northeast Mobile Health Services	11859
Delta Ambulance	12355
Northern Light Medical Transport	11297
Portland Fire Department	8694
Stewarts Ambulance	7447
Bangor Fire Department	6011
NorthStar	5038
Augusta Fire Department	4090
Redington Fairview EMS	3910

Potential Disbursement Methodologies

- Bail-out lump sum payment to services (require utilization on workforce)
- EMS Clinician Bonuses
- Grant Directed Spending
  - Money is available in amounts proportionate and in line with the presented methodology
  - Board sets priorities (suggest workforce for several years)
  - Simple application process
  - Fiscal note for grant staff
  - Money rolls over

Appendix

Adjusting the Number

- Adjustment of Rural Multiplier
- Adjustment of Basis
- Selectivity on Transport Types

Sample Adjustment

- If Rural multipliers are changed to:

USDA Rural Score (primary base of operation, or do per call)	Multiplier
0	0
1	2
2	3
3	4
4	5

- And the basis is cut in half …

The Top 10 Services Change

New

Services	Total Runs
Northeast Mobile Health Services	11859
United Ambulance Service	13861
Delta Ambulance	12355
Presque Isle Fire Department	2341
Northern Light Medical Transport	11297
Caribou Fire - Ambulance	1915
NorthStar	5038
Portland Fire Department	8694
Stewarts Ambulance	7447
WCEMSA dba Downeast EMS	1314

Old

Service	Total Transports
United Ambulance Service	13861
Northeast Mobile Health Services	11859
Delta Ambulance	12355
Northern Light Medical Transport	11297
Portland Fire Department	8694
Stewarts Ambulance	7447
Bangor Fire Department	6011
NorthStar	5038
Augusta Fire Department	4090
Redington Fairview EMS	3910

Grand Total $47,912,150

APPENDIX D

Maine Ambulance Association Assessment Draft Language

An Act To Promote Access to Ambulance Services

STATE OF MAINE

_____

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

_____

H.P. XYZ - L.D. XYZ

An Act To Promote Access to Ambulance Services

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA c. 424 is enacted to read:

CHAPTER 424

Ambulance Assessment

§2150-H. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. **Ambulance Service Provider.** "Ambulance Service Provider" means any person, persons or organization which holds itself out to be a provider of transportation of ill or injured persons or which routinely provides transportation for ill or injured persons and is licensed under Title 32, chapter 2-B; provided that the following shall not be considered an ambulance service for purposes of this chapter:(i) the Maine Army National Guard, Maine Air National Guard and the United States Armed Forces ; (ii) a municipal fire, police department, or any other governmental entity that provides Emergency Ambulance Services; (iii) an entity that exclusively provides air ambulance services; and any organization that is required to pay any other tax under Title 36, Part 4.
2. **Department.** "Department" refers to the Department of Health and Human Services.
3. **Fee.** "Fee" refers to the ambulance service assessment fee authorized by this Chapter.
4. **Emergency Ambulance Services**. For purposes of this chapter "Emergency Ambulance Services" means any services delivered by an Ambulance Service Provider other than air ambulance services.
5. **Net Operating Revenue**. "Net operating revenue" means gross revenue collected by Ambulance Service Providers for the delivery of Emergency Ambulance Services less any deducted amounts for bad debts, charity care, and payer discounts.

131st Maine Legislature
An Act To Promote Access to Ambulance Services
L.D. XYZ

§2150-I. Ambulance Service Assessment Fee

1. The Department shall charge every Ambulance Service Provider a uniform ambulance assessment Fee. The Fee shall be assessed on each Ambulance Service Provider's Net Operating Revenue at a rate determined annually by the Department. The rate shall be calculated such that the assessment generates the state share necessary to fund the payments described in §2150-J. of this Chapter, provided however that the Fee shall not exceed the maximum limit allowable under 42 C.F.R. 433.68(f). The Department shall establish each Ambulance Service Provider's Fee amount using the best data available as determined by the Department in consultation with the Maine Ambulance Association and shall update each Ambulance Service Provider's Fee amount on a periodic basis, but at least annually as updated information becomes available. All Emergency Ambulance Services, regardless of payor, shall be subject to the Fee including, but not limited to, Emergency Ambulance Services provided by Ambulance Service Providers under fee-for-service and managed care arrangements. An Ambulance Service Provider's liability for the Fee shall, in the case of a transfer of ownership, be assumed by the successor in interest to the Ambulance Service Provider.
2. The Department shall charge the Fee only if the Department has received approval from the Centers for Medicare and Medicaid Services necessary to authorize the Medicaid payments to Ambulance Service Providers in accordance with §2150-J.
3. The funds generated from the Fee shall be deposited into the Ambulance Fee Fund established in §2150-J of this Chapter and shall only be used in accordance with that section. Funds generated from the Fee do not revert to the state general fund and shall be available for expenditure in subsequent fiscal years.

§2150-J. Ambulance Fee Fund

1. **Fund created.** The ambulance Fee fund, referred to in this chapter as "the fund," is established as a separate nonlapsible fund in the Department.
2. **Source of funds.** Amounts credited to the fund shall be expended, without further appropriation, for Medicaid payments to Ambulance Service Providers. There shall be credited to the fund:
    A. All revenues generated from the Fee collected under 22 MRSA §2150-I;
    B. an amount equal to any federal financial participation revenues claimed and received by the state for eligible expenditures made from the fund;
    C. any revenue from appropriations or other money authorized by the Maine Legislature and specifically designated to be credited to the fund; and
    D. interest earned on any money in the fund.
3. **Federal financial participation.** Federal financial participation shall be sought in a manner that achieves the maximum amount of federal revenue such that the assessment amount equals the state share of the qualifying Medicaid Ambulance Service Provider payments related to this section. The expenditures from the fund shall be made by the Department in a manner consistent with the requirements and conditions of federal financial participation under 42 U.S.C. 1396b(w) and 42 C.F.R. 433.68 and shall be made only under federally approved payment methods and consistent with federal funding requirements and all federal payment limits as determined by the secretary of health and human services.

4. **Use of funds.** Amounts in the fund shall be expended exclusively for Medicaid payments to Ambulance Service Providers and must be used to supplement, not supplant, general fund appropriations to support Emergency Ambulance Service reimbursements as of the effective date of this chapter. Amounts in the fund shall not be used to replace payment commitments between the Ambulance Service Providers and the state. The Medicaid payment amounts established and distributed by the Department under this section shall increase the total Medicaid payment for Emergency Ambulance Services up to the average commercial rate to the extent permitted by the amount of funds generated from the Fee. Such payments shall be made to Ambulance Service Providers at least on a quarterly basis.
5. If the Centers for Medicare and Medicaid Services does not authorize or withdraws approval of the Medicaid payments made to Ambulance Service Providers in accordance with this section, all monies in the fund shall be returned to Ambulance Service Providers. If the Department no longer collects the Fee, all monies in the fund shall be returned to Ambulance Service Providers.

Sec. 2. Stakeholder engagement. During rulemaking the Department shall consult with stakeholders, including the Maine Ambulance Association, in the development and implementation of the payments.

Sec. 3. Required submittals. The Department shall submit to the Centers for Medicare and Medicaid Services any and all Medicaid state plan amendments, waiver requests, preprints and/or other documents required to implement or continue the implementation of 22 MRSA c. 424 no later than six (6) months of the passage of this act.

Sec. 4. Additional Medicaid financing mechanisms. The Department shall implement voluntary programs to increase funding to governmental ambulance service providers, including, but not limited to intragovernmental transfer or certified public expenditure programs, as permissible under §1903(w)(6) of the Social Security Act and codified at 42 CFR 433.51.