Jonnathan Busko
Bangor
LD 2119

Dear Senator Ingwersen, Representative Meyer, and Esteemed Members of the Joint Standing Committee on Health and Human Services,

My name is Jonnathan Busko and I live in Bangor. I'm writing in support of LD 2119, "An Act to Expand Reimbursement for Treatment In Place, Community Paramedicine, and Alternate Destination Transport." I am an emergency and EMS physician and over the last 20 years in Maine I've been the medical director for multiple EMS agencies, been a regional EMS medical director, have served on several Maine EMS committees and councils, and have been an advocate for rural and frontier healthcare. I am also currently leading implementation of an 18 month, $1.9 million grant at Community Care Partnership of Maine to develop a number of healthcare organization / EMS agency collaborations and stand-up several CP programs. I would be testifying in person but I am in Iceland, learning about how they deliver EMS in a similarly rural environment.

Bottom Line Up Front: Choosing to implement LD 2119 will improve Mainer's health, reduce healthcare costs, and improve EMS agencies' financial and operational performance, assuring access to emergency and continuity care in every Maine community.

The US healthcare system payment structure generally discourages healthcare providers for keeping people healthy and pays the most if patients are sick. This is the most expensive and inefficient healthcare incentive program in the developed world and in large part is the reason why the US has some of the worst health outcomes among developed countries despite the highest per capita healthcare expenditures. This is not a fiscally sustainable model, but instead of fixing the perverse fiscal incentives, payers, and particularly traditional Medicare, continue to try to control costs by reducing per case reimbursement while still paying the most for treating people when they are sick and the least for keeping them healthy.

Community paramedicine (CP) has been shown to improve quality and quantity of life at a fraction of the cost of other health care interventions. This is particularly true for the most medically complex patients with the highest use of acute (most expensive) care. Even more importantly, patients experience phenomenal care. To understand this, talk to any of the patients Memorial Ambulance Corps is supporting to age in place in Stonington, the residents whose asthma is under control in Lewiston-Auburn thanks to United Ambulance, or the family members of North East Mobile Health Sevices' patients who were able to choose to die at home in Jackman surrounded by loved ones instead of 90 miles away at a hospice home, far away from where they've spent their whole lives. One of the major barriers to implementing and continuing to provide these services is that they are not routinely reimbursed. This bill will allow more EMS agencies to responsibly implement and sustain these life and health changing services in their communities.

For those patients who do need some acute care, many studies have shown that 15-30% of patients who are transported to emergency departments by ambulances could safely and effectively receive their care at another, less expensive location such as walk-in cares, primary care offices, or even at home via telehealth. The Center for Medicare and Medicaid Innovation's Emergency Triage, Treatment, and Transport (ET3) model payment program was designed to test just that and while, thanks to COVID, the program was stoped early, the data that was collected showed a net savings per patient of over $500 with no change in outcomes. Under current reimbursement models, an ambulance would not be reimbursed for transporting to an alternate location, although thanks to MRS Title 24-A, §4303-F 1-A, at least state regulated healthcare plans reimburse for treatment without transport, as do some ERISA regulated payers. Additionally, Maine EMS would need to allow alternate destination transport.

I would like to suggest 3 amendments to this bill.
1. I would suggest adding an implementation deadline for MaineCare to develop and implement the required deliverables. July 2027 would be a reasonable option.
2. I would suggest broadening the language to include all state regulated healthcare plans.
3. I would suggest directing Maine EMS to explore the feasibility of implement an EMS Rural Health Care Technician (ERHT) licensure level to expand the urgent care scope of practice for those licensees. From 2022-2024, the Critical Access Physician Extender Maine EMS pilot project (aka "the Jackman Project" demonstrated the feasibility and safety of expanding EMS licensees' scope of practice to include urgent care skills such as suturing, removing embedded fishhooks, and taking off ticks when supported by physician medical decision-making. In this program, 165 patients were successfully treated in place with no adverse outcomes, saving Jackman area residents 20,000 miles of driving and approximately 650 hours of travel time. Training programs that would be sufficient for this licensure level have already been built and, upon approval by Maine EMS, could be easily tailored to the specific approved scope of practice.

I appreciate your attention to this important matter. Choosing to implement LD 2119 will improve Mainer's health, reduce healthcare costs, and improve EMS agencies' financial and operational performance, assuring access to emergency and continuity care in every Maine community. Please don't hesitate to reach out to me if there's anything I can do to support your work on this topic.

Be well,

Jonnathan

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