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Testimony Oppose L.D. 1530
An Act to Improve the Sustainability of Emergency Medical Services in Maine
April 22, 2025

Senator Bailey, Representative Mathieson, and Members of the Health Coverage, Insurance, and Financial Services Committee.

My name is Dan Demeritt, the Executive Director of the Maine Association of Health Plans. Insurance coverages offered or administered by our member plans provide access to care and better outcomes for many of the Mainers who receive coverage through an employer plan or the individual market. Our mission as an association is to improve health by promoting affordable, safe, and coordinated health care.

Maine's insurance carriers support initiatives that help our members and all patients get access to evidenced-based care in the appropriate setting. This is especially true in cases of emergency.

We are opposed to L.D. 1530 because it advances community paramedicine coverage and reimbursement beyond the existing recommendations presented to the Legislature earlier this session by the Community Paramedicine Reimbursement Stakeholder Group and because it includes a coverage mandate for Naloxone.

Concerns About Duplicate Claims

L.D. 1602 in the 131st Legislature (P.L. 2023 c. 468) requires that a carrier reimburse an ambulance service provider for any services other than transport if the enrollee refuses transport to a hospital.[1] L.D. 1530 would add many references to nontransporting emergency medical service providers throughout the existing statute.

Adding these references to law is only appropriate if it is made clear that nontransporting providers responding to emergencies are reimbursable under 24-A MRSA §4303-F only if they are billing for services that are not being duplicated by an ambulance provider.

We oppose these references if the intent is that all responding providers can expect reimbursement for duplicative claims for providing similar services in response to the same incident.

We may have more to share with Committee as we learn more about the intent of these references through the scheduled public hearing and in conversations with bill proponents.

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[1] https://legislature.maine.gov/backend/App/services/getDocument.aspx?documentId=103724, P.L. 2023, c.468

Unnecessary Inclusion – 24-A MRSA §4303-F, sub-§1(E): A nontransporting provider reference is not necessary in this section since prior authorization for transports would not apply to a nontransporting service.

Opposed to Mandated Reimbursement of Community Paramedicine

Legislation is not needed for carriers to contract with community paramedicine providers and reimburse them for providing covered services.

MeAHP and representatives from several Maine insurance carriers were among the participants in the Community Paramedicine Reimbursement Stakeholder Group last summer. The findings of that group was presented to the Committee on February 5, 2025.

Recommendation #3 – Focus on Billing. Not Mandated Reimbursement: L.D. 1530 advances well beyond the community paramedicine stakeholder group recommendations by creating a statutory requirement for reimbursement of covered services delivered through community paramedicine (L.D. 1530 -- p.2 line 3).

The stakeholder group explicitly noted that mandated reimbursement should not be a focus for next steps. The recommended approach is for stakeholders to work on standardization of billing, educating providers on joining networks, and reducing barriers to reimbursement.

Home health care is a covered service. It is also noted in the report that more needs to be done to understand the care, cost differences, and interactions between home health care and community paramedicine.

An annotated copy of Recommendation 3 is provided with my testimony.

Section 4 -- Naloxone Coverage Mandate

Maine law already includes a health insurance coverage mandate for abuse-deterrent opioid analgesic drug products that can help prevent opioid abuse. L.D. 1530 would add a new coverage mandate for Naloxone or another opioid overdose-reversing medication.[2]

More than 458,000 state-supplied doses of Naloxone have been distributed to providers since 2019 and is available for Maine EMS providers.[3] Adding a mandate for Naloxone to Maine's insurance code would increase premiums for employers and consumers.

If the committee is interesting in pursuing this bill it should also add an effective date of January 1, 2027, or later to allow plans to work the increased costs into their premium calculations.

We urge a vote of Ought Not to Pass on L.D. 1192 and thank the committee for its consideration.

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[2] https://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-J.html, 24-A §3420-J

[3] https://getmainenaloxone.org/ems/

III. Provide a framework about the differences between home health and community paramedicine from groups currently working on collaboration in this space.
   A. Provide guidance about episodic versus long-term consistent with Title 22 section 2147, which defines episodic care to delineate CP services and home health services.[7]
   B. Do not need to be homebound for CP services.

Recommendation 3: Work with commercial insurers to educate clinicians on joining networks and reducing barriers on reimbursement

Collaborating with commercial insurers will ensure the success of all community paramedicine programs in Maine.

In the presentation by Soliana Goldrich, the Maine EMS Community Paramedicine Coordinator, there were 1,796 unique community paramedicine patients between 2018 and 2022, with 1,042 that have MaineCare. This meant that there were 754 patients who needed CP services but would not be covered through MaineCare; see Appendix C for trends in unique CP patients. It is important to note that some of those 754 individuals might be covered by Medicare or insurance plans not subject to Maine regulations.

Both insurers and providers are concerned about becoming too prescriptive with recommendations. Each patient's needs are unique, and quantifying the maximum number of visits or types of services may not benefit the community, patients, or insurers. It is important to ensure that the focus is on standardization of billing, not mandated reimbursement. It is also important to note that discussions among both insurers and providers must be mindful of antitrust laws.

There was some debate on the recommendations in this section around multi-payor alignment, and we held a vote via Survey Monkey on how to move forward. We ultimately did not reach a consensus, and as such, there is a majority and minority report associated with recommendations three and seven. For this section, the only difference is that the minority report includes specific recommendations under section II, which has been bolded for the ease of the committee. We hope that by including both viewpoints, the committee members better understand the issue's landscape.

Majority Report (Stakeholders from the Health Insurance Carriers (1 vote), Maine Bureau of Insurance, Maine Hospital Association, Maine Medical Association and Maine Osteopathic Association)

I. Issues identified as needing further discussion include establishing a clear understanding

[7] 22 M.R.S. § 2147 (15).

of the difference between community paramedicine and home health care, medical necessity, the affordability of CP compared to alternatives, and if there needs to be prior authorization before a first visit. Carriers raised concerns about mandating coverage, reimbursement rates, and limitations on utilization management tools such as prior authorization.

II. Carriers note that legislation is unnecessary for them to contract with CP providers. Barriers to contracting include needing a clear understanding of the differences in the services rendered by community paramedicine and home health providers, the types of billing codes that would be appropriate, and the structure of the billing entity. Further discussions are needed to better understand these issues and how they could be addressed.

III. As noted in recommendation 2, the most important difference between community paramedicine and home health is that while CP service *may* occur in the home, patients who are not homebound may need care and may not be eligible for home health reimbursement. Knowing where home health and community paramedicine overlap and differ will help commercial insurers understand where coverage needs to be.

IV. Need to determine how different insurance plans interact with these recommendations, including, but not limited to, public, commercial, Medicare Advantage, and commercial (healthcare exchange plans).

V. One question was raised about a potential patient who is given post-discharge instructions on a Friday night and needs CP services on Saturday, but there is no time for prior authorization to be approved before the patient needs the care. If the service is deemed medically necessary, then the Saturday visit would be covered, but if it is not, then the patient who has already used the service could be responsible for payment. It was discussed whether there should be a first visit pass with prior authorization to ensure that patients get timely care. The opinions of the group were mixed.

Minority Report (Stakeholders from the Maine Ambulance Association, Maine EMS Board, Maine EMS Bureau)

I. Issues identified as needing further discussion include establishing a clear understanding of the difference between community paramedicine and home health care, medical necessity, the affordability of CP compared to alternatives, and if there needs to be prior authorization before a first visit. Carriers raised concerns about mandating coverage, reimbursement rates, and limitations on utilization management tools such as prior authorization.

II. Carriers note that legislation is unnecessary for them to contract with CP providers. Barriers to contracting include needing a clear understanding of the differences in the services rendered by community paramedicine and home health providers, the types of billing codes that would be appropriate, and the structure of the billing entity. Further discussions are needed to better understand these issues and how they could be addressed.

A. **To address billing code differences, efforts should be made toward multi-**

payer alignment.

B. **Plan for monitoring progress towards accepting standardized codes and CP services through a report from the Maine Health Data Organization or a similarly suited agency.**

III. As noted in recommendation 2, the most important difference between community paramedicine and home health is that while CP service *may* occur in the home, patients who are not homebound may need care and may not be eligible for home health reimbursement. Knowing where home health and community paramedicine overlap and differ will help commercial insurers understand where coverage needs to be.

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Recommendation 4: Alignment of reimbursement model with the ongoing work of MaineCare

The Office of MaineCare Services (OMS) is currently working on a reimbursement model for community paramedicine and is looking at other states as models. Minnesota allows EMS to bill Medicaid for Mobile Integrated Health- Community Paramedicine services, with the billing going through PCP in partnership with the contracted EMS agency.[8] Currently, CP is not reimbursed through regular EMS codes because those codes generally pertain to emergency care and transportation. Because CP services are delivered in the patient's place of residence and do not involve emergency transportation reimbursement is not covered through regular EMS codes. States like Minnesota and Indiana have started to change the language of statutes to decouple reimbursement and transportation.[9]

MaineCare's work is informed by Maine EMS Community Paramedicine Licensure and scope of practice rules, which is anticipated to be approved in the fall of 2024 or, at the latest, spring of 2025. Final funding decisions and potential implementation of the Maine OMS Model is not expected until 2025.

[8] Minnesota Statute 256B.0625, Subdivision 60, https://www.revisor.mn.gov/statutes/cite/256B.0625

[9] Indiana Department of Homeland Security, Mobile Integrated Health, https://www.in.gov/dhs/ems/mobile-integrated-health/.