MAINE AMBULANCE ASSOCIATION

PO Box 202
Waterville, ME 04903
(207) 209-3944
info@maineambulance.org

Testimony of the Maine Ambulance Association Before the Maine Committee on Health and Human Services in Support of LD 2119

An Act to Expand Reimbursement for Treatment in Place, Community Paramedicine and Alternate Destination Transport

February 11, 2026

Senator Ingwersen, Representative Meyer and other Members of the Committee,

My name is Butch Russell and I am here today on behalf of the Maine Ambulance Association. We support the intent of LD 2119 and appreciate the Legislature's recognition that EMS must evolve alongside Maine's changing healthcare system.

First, we support reimbursement for **community paramedicine**. In Maine, there are already active efforts underway with the Office of Maine EMS to establish appropriate pathways, standards, and payment structures for these services.

Second, we support payment for **treatment in place**. EMS clinicians regularly assess and treat patients on scene when transport is not clinically necessary. Payment for treatment in place recognizes the value of that care and supports appropriate clinical decision-making.

The largest and most forward-looking issue in this bill, however, is **transport to alternate destinations**.

Today, EMS in Maine has very limited ability to transport patients anywhere other than a hospital emergency department, even when another destination may be more appropriate. As hospitals close or reduce services, EMS is increasingly required to transport patients long distances, placing growing strain on the EMS system.

National research and long-term planning efforts identify alternate destination transport as a future pathway for EMS. The federal ET3 model demonstrated both the potential and the complexity of this approach. The lesson from ET3 is that alternate destinations cannot be implemented overnight—they require careful planning, clear clinical standards, destination readiness, and sustainable reimbursement. For that reason, we believe LD 2119 should be viewed as a **starting point**, allowing Maine EMS and the EMS Commission to study, design, and phase in alternate destination pathways in a way that is safe, deliberate, and appropriate for Maine.

On behalf of the Maine Ambulance Association, we look forward to working with the Committee to ensure LD 2119 helps build the future of EMS in Maine responsibly.

Sincerely,
Butch Russell
Executive Director, Maine Ambulance Association

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Overview of the Emergency Triage, Treat, and Transport (ET3) Model

The Emergency Triage, Treat, and Transport (ET3) model was a federal demonstration project developed by the Centers for Medicare & Medicaid Services (CMS) Innovation Center to test alternative approaches to paying for emergency medical services. The model was designed to address a long-standing limitation in ambulance reimbursement policy: under traditional Medicare rules, ambulance services are generally paid only when they transport a patient to a hospital emergency department or a small set of other approved facilities.

ET3 was intended to explore whether EMS could safely and effectively provide care through additional pathways—while being reimbursed appropriately—without relying solely on transport to the emergency department as the default outcome of every 911 response.

Policy Context and Rationale

Historically, Medicare and many other payors have treated EMS primarily as a transportation benefit rather than a mobile healthcare service. This structure created a system in which ambulance providers were reimbursed for miles driven and destinations reached, rather than for clinical assessment, treatment, or navigation to the most appropriate level of care.

CMS developed ET3 in response to several system pressures:

- Growing emergency department overcrowding
- Increasing numbers of low-acuity 911 calls
- Rising healthcare costs
- Recognition that EMS clinicians routinely assess and treat patients whose needs do not require emergency department care

ET3 sought to test whether aligning payment with clinical care and decision-making could improve patient experience, reduce unnecessary emergency department utilization, and support more efficient use of healthcare resources.

Core Components of the ET3 Model

ET3 introduced two primary alternative payment pathways for participating ambulance providers:

Treatment in Place

Under ET3, ambulance services could be reimbursed for treating a patient on scene without transporting them to a hospital, provided certain conditions were met. This typically required:

- Clinical assessment by EMS
- Involvement of a qualified healthcare practitioner, often through telehealth
- Documentation demonstrating medical necessity and appropriateness

The intent was to recognize and pay for care that EMS already provides when patients can be safely managed without transport.

Transport to Alternate Destinations

ET3 also allowed ambulance providers to be reimbursed for transporting patients to approved alternate destinations instead of a hospital emergency department. These destinations could include:

- Urgent care centers
- Primary care offices
- Federally Qualified Health Centers
- Behavioral health or substance use treatment facilities

Participation required ambulance services to establish relationships with receiving facilities willing and able to accept patients directly from EMS, and to follow defined clinical protocols.

Patients retained the right to choose transport to an emergency department if they preferred.

Participation and Implementation

ET3 was structured as a voluntary model. Ambulance providers, telehealth partners, and alternate destination sites had to apply and be accepted into the program. While a meaningful number of EMS agencies initially enrolled, actual use of ET3 payment pathways was more limited than CMS anticipated.

Implementation varied significantly by region, reflecting differences in:

- Availability of alternate destination facilities
- Local healthcare infrastructure
- Telehealth capacity
- EMS medical oversight models
- State and local regulatory environments

In many areas—particularly rural communities—alternate destination options were limited or nonexistent, reducing the practical applicability of the model.

Early Termination of the ET3 Model

ET3 was originally designed as a five-year demonstration. However, CMS ended the model early, concluding operations in 2023.

CMS cited lower-than-expected participation and utilization as the primary reasons for early termination. Importantly, CMS did not identify patient safety issues as the cause of the program's

conclusion. Instead, the model did not generate sufficient volume of treatment-in-place or alternate destination encounters to support broader conclusions within the expected timeframe.

Several factors contributed to this outcome:

- Significant operational complexity for EMS agencies
- Difficulty establishing and maintaining alternate destination networks
- Challenges contracting for telehealth support
- Uncertainty around long-term payment sustainability
- Disruption caused by the COVID-19 public health emergency

Key Lessons Learned from ET3

Although ET3 ended early, it is widely regarded as an important learning experience rather than a failed concept. Several key lessons emerged:

System Readiness Is Critical

ET3 demonstrated that alternate destination transport and treatment in place require more than payment authorization. Successful implementation depends on:

- Available and willing receiving facilities
- Clear clinical eligibility criteria
- Reliable communication and handoff processes
- Consistent medical oversight

Without these elements, utilization remains limited.

Alternate Destinations Require Infrastructure

Many communities lacked suitable alternate destinations that could accept EMS patients directly. This was particularly true in rural areas, where healthcare options are already constrained. ET3 highlighted the need to intentionally build destination networks rather than assume they exist.

Payment Must Reflect True Costs

ET3 reinforced that nominal or uncertain reimbursement does not support sustained participation. EMS agencies must be paid at least the cost of providing care, including staffing, readiness, documentation, and medical oversight.

Phased and Localized Implementation Matters

A national, one-size-fits-all approach proved difficult. ET3 showed that alternate destination models are best developed incrementally, tailored to local healthcare environments, and scaled only after foundational elements are in place.

Relevance to Future EMS Policy

ET3 has had a lasting influence on how policymakers and EMS leaders think about the future of emergency medical services. Its concepts align closely with broader national efforts, such as EMS Agenda 2050, which envisions EMS as an integrated component of the healthcare continuum rather than solely a transport function.

The consensus emerging from ET3 is not that alternate destination transport or treatment in place should be abandoned, but that they must be:

- Carefully planned
- Clinically grounded
- Operationally feasible
- Financially sustainable

ET3 is now commonly referenced as a case study demonstrating that system design must precede system change.

Conclusion

The ET3 model represented a significant step toward modernizing EMS reimbursement and care pathways. While it ended earlier than planned, it provided valuable insights into the complexities of implementing alternative EMS care models.

ET3 showed that EMS can safely assess, treat, and navigate patients to appropriate levels of care—but also made clear that achieving this at scale requires deliberate planning, coordination, and investment.

As states and healthcare systems consider similar approaches, ET3 serves as an important reminder that alternate destination transport is not an overnight reform, but a long-term system transformation.