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LD 1258

An Act To Implement the Recommendations of the Stakeholder Group Convened by the Emergency Medical Services' Board Related to Reimbursement Rates for Ambulance Services by Health Insurance Carriers and To Improve Participation of Ambulance Service Providers in Carrier Networks

Information for Work Session – May 4, 2021

Senator Sanborn, Representative Tepler, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services.

We know your agenda for the work session is very full and wanted to provide this information in writing to follow up on questions, issues, and concerns raised at the public hearing.

The Stakeholder group that met as directed by LD 2105 (129th Legislature) to work on contracting and reimbursement for ambulance services provided a unanimous report to the Committee and we appreciate the Committee's bill. Our consensus goal is to provide incentives and reduce barriers to EMS services being in network with carriers and to eliminate surprise billing.

It is important that all six parts of the recommendations (including those referred to Health & Human Services) are implemented to help address the current and ongoing crisis in emergency medical services. As drafted, LD 1258 fairly represents the stakeholder recommendations, and each Section builds on the proceeding. Carving out provisions or changing the language is not consistent with the recommendations, threatens the success of the overall effort, and will not achieve the original objectives of LD 2105. It needs to be the mutual goal of providers and carriers to establish in-network agreements. We hope this committee also supports the companion legislation in HHS to increase MaineCare rates for rural and super rural services.

Section 1. We believe that with an emergency preamble as suggested by Maine EMS Director Sam Hurley, the proposed timetable with a December 2023 date is achievable for setting up the new rate system. This addition also sends an important message about the Committee's recognition of the critical nature of the work to be done to respond to the crisis in EMS.

Section 2. An IDR process may be necessary as EMS agencies and insurance carriers may choose to remain out of network despite the incentives to participate in network. For example, an EMS agency and insurance carrier may be able to successfully negotiate a network agreement while the same EMS agency and another insurance carrier may not be able to achieve such an agreement.

Section 3.1

- The in-network and out of network rates provide reasonable incentive for network participation.
- Adding a differing effective date for the legislation and backdating the effective date would be inconsistent with LD2105. Further the provisions the Standard Offer Agreement are not yet developed.
- The intent of the Stakeholder group was to improve reimbursement for rural, and super rural low volume providers. There is substantial data reported by the GAO that low volume rural providers are negatively impacted by standard Medicare reimbursement. The carriers and MaineCare should follow the CMS reimbursement model for the add on payments including point of pick up which his federally defined and updated annually. All of the EMS services are already billing with the point of pick up determining rural and super rural designation.
- We acknowledge the commentary from Maine EMS and the Maine Municipal Association, which highlight the current capacity crisis for EMS across the state. The Stakeholder group recommended a maximum increase in charges of 5% per year for EMS services with lower rates. In fairness to the recommendations of the stakeholder group, MAA feels this provision should be maintained, recognizing that this would not exclude carriers and providers from negotiating higher rates.
- Concerns from both the providers and insurance carriers over this section can be addressed through establishing an agreed upon cost reporting template to support a change in rates (e.g. CMS or HRSA cost templates).

Section 3.2

The difficulty of managing and negotiating multiple carrier network agreements is a significant barrier to EMS provider participation within those networks. While it will take some time to develop, it needs the momentum noted above to accomplish this in a timely manner.

Section 4. There are several ways to accomplish efficiency assessment (CON or otherwise) without the need to build a complicated review system. This provision develops transparency and clarity when a completely new entity is proposed either in a community already served by another EMS agency or as the result of the closure or reconfiguration of existing EMS services. It is not envisioned or intended to review changes in existing EMS licensure by an existing EMS agency, which may have been a source of confusion for Maine EMS and DPS.

One such method that may be seen as “softer” than a COG was developed by the National Rural Health Association and published last year by the Rural Health Action Network in Maine is the Informed Community Self Determination process which has been used successfully in a variety of settings in Maine most recently with the Towns of Rockport, Camden, Hope, Lincolnville, along with Penobscot Bay Medical Center. This project worked with municipal leaders, hospital physician leadership, the local fire departments, and the existing contract EMS provider to identify options, costs, and determine appropriate and desired levels of service. It resulted in an agreement to retain one EMS agency while improving services with two first responder agencies rather than resulting in two or three agencies serving the same area. This is a transparent process to match the desired clinical level of service with the costs which include subsidies by communities. The process has previously been successfully used in St. George and Franklin County/ NorthStar. It is an iterative community level stakeholder engagement process and results can be then shared with the EMS Board. This process can also potentially support voluntary regionalization as evidenced by the Franklin County project.

Section 5. As noted in the report CMS has established a requirement and template mandating EMS cost reporting with a multi-year implementation which was interrupted by COVID. The federal "No Surprises Act" has also established a committee to review cost and performance data for ground EMS on a federal level. There are relatively straight forward cost reporting matrices developed by U.S. Health and Human Services.

The LD 2105 stakeholder group arrived at a "multiple of Medicare" reimbursement as a proxy for cost of service. Going forward beyond December 31, 2023, transparent cost data is needed to support the standard offer contract aligning costs and charges. The data set for these costs are both limited in elements and numbers of contributors. The confidentiality of the data will need to be protected. One potential repository is the DHHS Maine Care Cost Reporting unit or the Maine Health Data Organization.

Section 6. The momentum to clearly understand the various drivers of costs, quality, performance, and innovation developed by the Stakeholder Work Group needs to be maintained to ensure a stable EMS system serving the populace of Maine. While we are supportive of resources needed by Maine EMS we do not think a fiscal note attached to the bill to provide new staffing is necessary.

Amidst the many bills you have before you in these closing weeks, it is important to note that this bill and the companion bill in HHS are important steps but still represent a partial solution. Other issues such as workforce development, recruitment, retention, and rural systems of care will continue to be priority issues.

In closing we would like to make two final points:

1. We would recommend an Interim Report on contracting progress and the new systems for needs assessment and data collection be provided to the committee by Feb 1, 2022.
2. If a fiscal note cannot be overcome, it will be necessary to continue the current structure instead of having it expire on October 31, 2021. Absent this, there will be no clear path on reimbursement for ambulance services.

Attached is a copy of the NY Times article *Rural Ambulance Crews Have Run Out of Money and Volunteers* which illustrates the dire situation by the lack of adequate funding.

https://www.nytimes.com/2021/04/25/us/rural-ambulance-coronavirus.html?smid=em-share

Tom Judge (MAA representative on the LD 2105 Work Group) and Jay Bradshaw (and perhaps others) will be "in the room" at the work session and available to assist with additional questions.

Thank you.

Rural Ambulance Crews Have Run Out of Money and Volunteers

Strained by pandemic-era budget cuts, stress and a lack of revenue, at least 10 ambulance companies in Wyoming are in danger of shuttering — some imminently.

By Ali Watkins

Published April 25, 2021 Updated April 27, 2021

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WORLAND, Wyo. — For three years, Luke Sypherd has run the small volunteer ambulance crew that services Washakie County, Wyo., caring for the county's 7,800 residents and, when necessary, transporting them 162 miles north to the nearest major trauma center, in Billings, Mont.

In May, though, the volunteer Washakie County Ambulance Service will be no more.

"It's just steadily going downhill," Mr. Sypherd said. The work is hard, demanding and almost entirely volunteer-based, and the meager revenue from bringing patients in small cities like Worland to medical centers was steeply eroded during much of 2020 when all but the sickest coronavirus patients avoided hospitals.

Washakie County's conundrum is reflective of a troubling trend in Wyoming and states like it: The ambulance crews that service much of rural America have run out of money and volunteers, a crisis exacerbated by the demands of the pandemic and a neglected, patchwork 911 system. The problem transcends geography: In rural, upstate New York, crews are struggling to pay bills. In Wisconsin, older volunteers are retiring, and no one is taking their place.

The situation is particularly acute in Wyoming, where nearly half of the population lives in territory so empty it is still considered the frontier. At least 10 localities in the state are in danger of losing ambulance service, some imminently, according to an analysis reviewed by The New York Times.

Many of the disappearing ambulances are staffed by volunteers, and some are for-profit ambulance providers that say they are losing money. Still others are local contractors hired by municipalities that, strained by the budget crisis of the pandemic, can no longer afford to pay them. Thousands of Wyoming residents could soon be in a position where there is no one nearby to answer a call for help.

"Nobody can figure out a solution," said Andy Gienapp, the recent administrator for emergency medical services at the Wyoming Department of Health. "Communities are faced with confronting the very real crisis of, 'We don't know how we're going to do this tomorrow, because nobody's doing it for free.'"

'Nobody wants to pay for it'

About 230 miles southwest of Washakie County, Ron Gatti is preparing to close up Sweetwater Medics, a small ambulance provider in Sweetwater County, where 42,000 people are spread across 10,000 square miles. Facing a budget crisis, the county is expected to end its contract with Mr. Gatti's ambulance service in June.

The situation is a direct result of the pandemic, Mr. Gatti and county officials said. Rock Springs, the town that Sweetwater Medics serves, was looking for budget cuts; the ambulance contract was one of them. Mr. Gatti's company proposed transitioning to a public, tax-supported service, funded by the county, he said, but the money was not there.

"Everybody wants it and nobody wants to pay for it," said Jeff Smith, a commissioner in Sweetwater County.

Instead, after June 30, the regional hospital will have to respond on its own to emergency calls.

Sweetwater County is expected to end its contract with Ron Gatti's ambulance service, Sweetwater Medics, in June. Kim Raff for The New York Times

Mr. Sypherd, who is also president of the Wyoming E.M.S. Association, keeps a list in his head of ambulance companies, large and small, in imminent danger of closing. There is Sweetwater Medics, which could be gone by autumn. Sublette County's service was recently saved after voters approved a small tax increase, which will fund a new hospital and the affiliated ambulance. Albin, near Cheyenne, no longer has enough volunteers to fill its crew.

"The ambulance at Albin is fiscally healthy. There's just nobody to give it to," said Carrie Deselms, who helps direct the program.

Fremont County, home to the state's Wind River Indian Reservation, is set to lose its only ambulance service, American Medical Response, a national for-profit company that merged recently with the company that has handled the county's ambulance service since 2016.

Now, American Medical Response says its profit margins cannot justify remaining there. The company has informed county officials that it will not rebid when its contract runs out this summer.

"The call volume in Fremont County plummeted, making it impossible to cover increasing operational costs without a subsidy" said Randy Lyman, the Northwest regional president for Global Medical Response, the parent company of American Medical Response. "The revenue alone simply wasn't sufficient."

An unsustainable model, strained further

There is a misconception, fueled by stories of astronomical bills and post facto charges, that ambulance service is a sustainable — even lucrative — business model. The truth, medical professionals say, is that those bills are rarely paid in full, by Medicare, private insurance or otherwise. Even in New York City, which operates ambulance services alongside its Fire Department, ambulances do not make enough money on their own to survive.

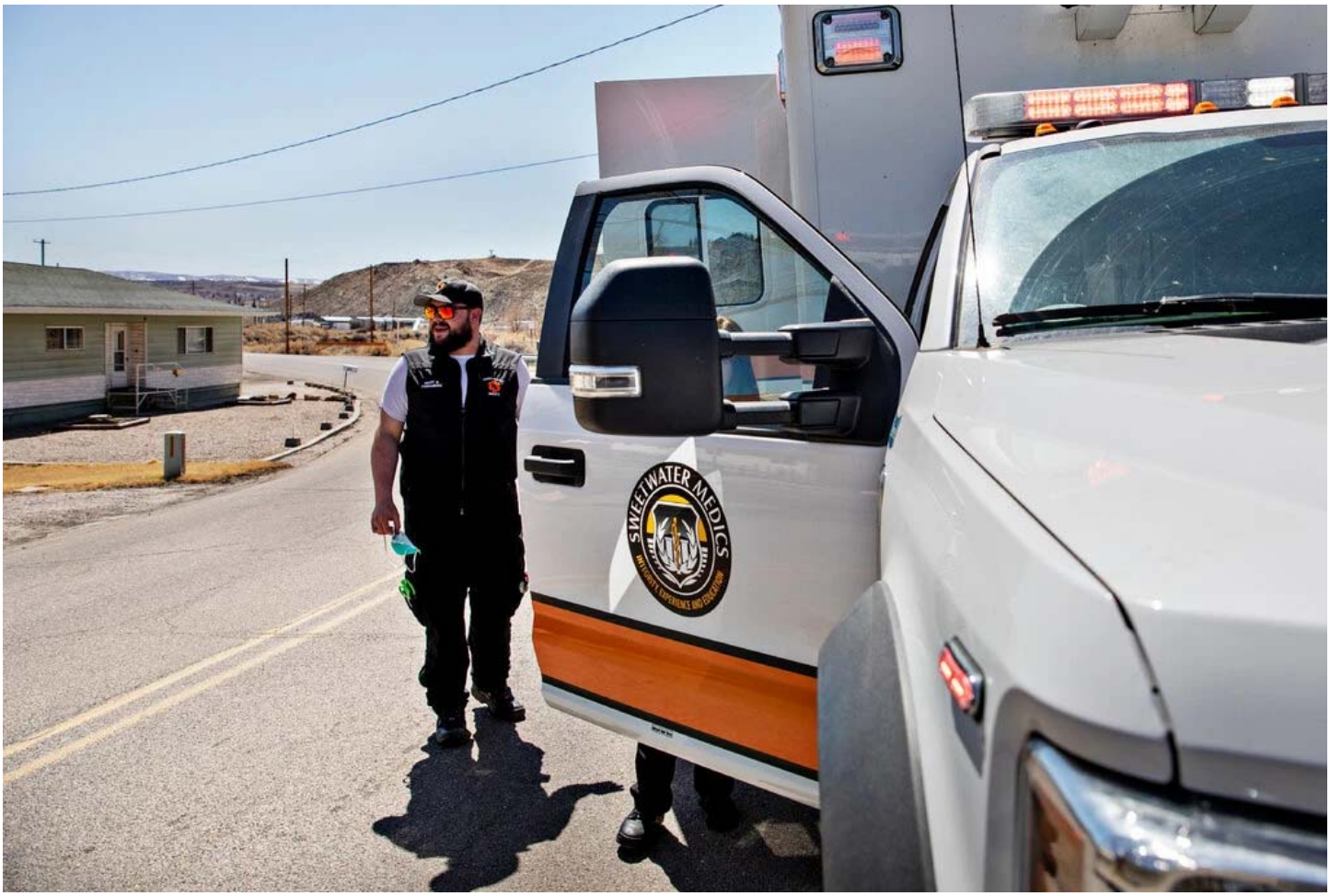
- With school districts making their own rules, children with special needs miss out.
- Australia prioritizes Olympic-bound athletes for vaccines.
- Their father was dying, so two brothers in India went on a desperate hunt for oxygen.

Is this helpful?

“Revenue does not come close to covering the full cost of operating E.M.S.,” said Frank Dwyer, a Fire Department spokesman.

For years, paramedics and emergency technicians have warned that these unreliable revenue streams put the country’s emergency medical systems in danger of collapse. The current crisis in rural service, experts say, was almost certain to arrive at some point, but the pandemic expedited it.

“It is a universal issue,” said Tristan North, a senior vice president with the American Ambulance Association, which represents crews in rural and urban areas. “If you have a pretty steady volume, then you can get some efficiencies of scale and have a better idea as far as budgeting, whereas in a rural area, it’s far less predictable because you have a smaller population.”



Without Sweetwater Medics, county residents will have no E.M.S. services available when they call 911. Kim Raff for The New York Times

Critical to an ambulance’s survival is its ability to transport patients to hospitals, which allows it to bill for a transport. That limited revenue stream dried up during the pandemic, according to workers across the country, when crews were discouraged from transporting all but the sickest of patients.

Instead of transporting patients to hospitals, crews were being directed to provide care on scene, Mr. Gienapp, of the Wyoming health department, said. “E.M.S. doesn’t get paid for any of that,” he said.

At the same time, many of the standard sorts of medical emergencies that helped keep ambulances afloat disappeared, either because people were moving around less, or were fearful of going to a hospital and exposing themselves to the coronavirus.

“There is not sufficient E.M.S. volume in this entire service area to make this a profitable, break-even venture,” Mr. Gatti, of Rock Springs, said. “This is an essential service that doesn’t pay for itself.”

In dense urban areas like New York or Los Angeles, there are enough people and everyday maladies that an ambulance service can come closer to sustaining itself, and enough of a tax base that cities can support it. But in places like Wyoming, the least populous state and one notoriously averse to tax increases, each missed transport in 2020 was critically lost revenue.

Unlike fire and police departments, many states do not consider ambulances to be “essential services.” Only a handful of states require local governments to provide them.

For most of the country, access to an ambulance is a lottery. Some municipalities provide them as a public service, funded by taxpayers, while some contract with for-profit ambulance companies. Most rely on the willingness of volunteer companies, like Mr. Sypherd’s in Washakie County, which are buoyed by a patchwork system of public and private funding streams.

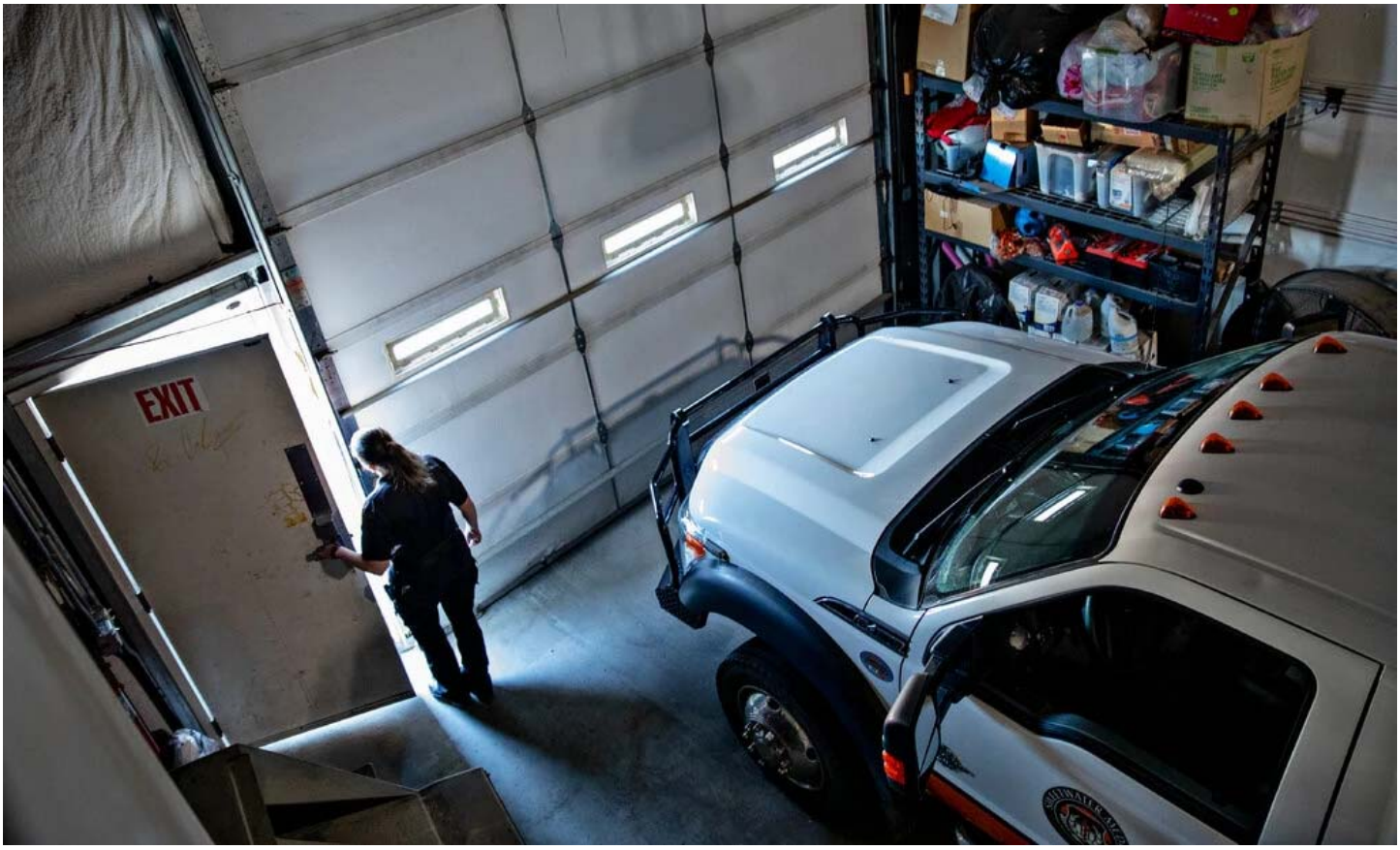
But across the country, E.M.S. professionals say fewer and fewer people are willing to volunteer for the job, a phenomenon accelerated by the stress of the pandemic. Many municipalities expect volunteers to take time away from work, something few people can now afford to do.

“The donated labor is not there anymore,” Mr. Gienapp said.

Same job, new patch

On May 1, Mr. Sypherd will put on a new uniform.

For more than a year, he had known Washakie County’s system was unsustainable. In an effort to ensure an ambulance remained in Worland, Mr. Sypherd reached out to Cody Regional Health, a hospital system based near Yellowstone National Park, and began exploring whether the agency would take over his ambulance company.



Ms. Bartlett in the ambulance bay at the Sweetwater Medics station in Rock Springs. Kim Raff for The New York Times

It is a trend that is gaining traction in rural states like Wyoming: In the absence of volunteer ambulance crews or sustainable funding from local governments, some struggling ambulance services are accepting takeovers from local hospitals and health care systems.

The system is not ideal, experts acknowledge, and it could leave large swaths of rural America disconcertingly far from ambulance service. Still, faced with the alternative, many crews like Mr. Sypherd's are grudgingly accepting the help. In May, Washakie County Ambulance Service will become a Cody Regional Health ambulance company, and will keep many of Mr. Sypherd's original crew on staff.

"It's the right thing to do," said Phillip Franklin, the director of Cody Regional Health's ambulance program.

So far, Mr. Franklin and his team have taken over two struggling ambulance companies in northwest Wyoming, and they are trying to help others with their workload.

The reality, he says, is that without help from systems like Cody's, many of the ambulances in rural Wyoming will fail.

"Someone is always going to have to subsidize rural America," he said.

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A version of this article appears in print on , Section A, Page 12 of the New York edition with the headline: Out of Money and Volunteers, Rural Ambulances Drift to a Dead End