

SB 682 EMS Reimbursement Workgroup

June 14, 2018

3:00 – 4:00

Agenda

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| I. | Welcome & Introductions - (10 min) | Pat Gainer, MIEMSS
Ben Steffen, MHCC |
| II. | Review of SB 682 - (5min) | Megan Renfrew, MHCC |
| III. | New Models of EMS Care (15min) | Pat Gainer & Lisa Myers |
| IV. | Queen Anne's Co. MIH Program-(10min) | Joe Ciotola, MD, Health Officer
Queen Anne's County |
| V. | Options for Medicaid – (5min) | Dennis Schrader, MDH |
| VI. | Options for Medicare – Update on TCOC Agreement – (5-10 min) | Katie Wunderlich, HSCRC |
| VII. | Next Steps | |



SB 682 EMS Reimbursement Workgroup
EMS Reimbursement for New Care Delivery Models
June 14, 2018

Attendees

Patricia Gainer, Ben Steffen, Lisa Myers, Megan Renfrew, Dennis Schrader, Joe Ciotola, Marta Harting, Katie Wunderlich, Jennifer Witten, Maria Prince, Delora Sanchez, Kathleen Loughran, David Cooney, Robert Axelrod, Mary Alice Vanhoy, Andrew Naumann, Rachel Faulkner, Kathy Pettway, John Pelton, Simone Bratton, Mark Fletcher, Tinna Quigley, Anna Sierra, Alan Butsch (phone), Kelly King (phone), Jared Smith (phone), Scott Haas (phone), David Phippen (phone), Sarah Sette (phone), Mike Cole (phone)

Welcome and Introductions

Ms. Gainer, Acting Co-Executive of MIEMSS and Mr. Steffen, Executive Director of MHCC welcomed everyone and gave brief overviews of the MIEMSS and MHCC missions, responsibilities and joint initiatives.

Introductions were made.

Review of SB 682 – Ms. Renfrew

A copy of the Summary of SB 682 was distributed.

Ms. Renfrew summarized SB 682 and said reimbursement for emergency medical services without transportation, emergency medical services with transportation to an alternative destination and mobile integrated health services will be addressed by the work group. The workgroup's charge is to focus on two tasks 1) to develop a plan for Medicaid reimbursement and a process for Medicare reimbursement and 2) to study make recommendations on the desirability and feasibility of reimbursement by various private payers.

New Models of EMS Care – Ms. Gainer and Ms. Myers

A copy of the New Models of EMS Care presentation, MIH Report and Emergency Department Overcrowding Report was distributed. A summary of the current Maryland MIH programs was also distributed.

Ms. Gainer said, prior to the 2018 legislative session, Senators Middleton and Hershey, Dr. Ciotola and Ms. Mizuer chaired a two year Rural Workgroup that focused on unmet healthcare needs in rural

Maryland. One of the recommendations from the Rural Workgroup was to focus on mobile integrated health; which has great potential to assist in meeting the healthcare needs of rural Maryland.

Also, before the 2018 legislative session, MIEMSS submitted two reports to the State Legislature. The first report was on how Mobile Integrated Healthcare (MIH) was developing with suggestions and recommendations for advancing MIH in Maryland; and the second report, working with HSCRC, on Emergency Department Overcrowding. Recommendations from the Emergency Department Overcrowding (ED) report included working with HSCRC, DOH and other state agencies to develop New Models of EMS Care delivery to help provide better healthcare services to communities. This led to the work on SB 682.

Ms. Gainer said that wait times in Maryland Emergency Departments are the worst in the nation. Ms. Gainer gave an overview of the data on Maryland ED wait times. ED overcrowding has a profound effect on EMS from longer waits to offload patients in the ED and diverting EMS patient transports (Yellow Alerts) away from the ED to other EDs. Much of the focus in attempting to provide the most appropriate care is based on what is happening in the ED.

There are patients who call 9-1-1 and are transported by EMS to EDs that have conditions that could be treated in a health care environment other than a hospital ED, such as priority 3 patients. Ms. Myers said that priority 3 patients are those whom EMS has determined have “non-emergent conditions, requiring medical attention, but not on an emergency basis.” Statewide EMS data indicates that most EMS transports to the ED are classified as priority 3. These priority 3 patients are potential candidates for treatment in an environment other than the ED such as an Urgent Care Center. 60% of EMS patients are categorized as priority 3.

Ms. Gainer said that when 9-1-1 is called, EMS is obligated to see the patient. Reimbursement practices for EMS are not aligned with health care initiatives to reduce unnecessary hospital use and provide appropriate care in community settings. Currently, EMS is viewed as a transportation benefit, therefore, if a patient refuses transport, such is frequent with opioid overdose patients, EMS is not reimbursed for any costs including any administered medications such as naloxone.

The hospital ED is a high cost environment for delivery of health care services. There is currently no ability for EMS to be reimbursed for providing services to low-acuity patients at the patient’s home or for obtaining services for patients in other less costly environments. EMS in Maryland is developing new ways to deliver care by reducing unnecessary transports and providing services to patients in less costly settings. These new models include MIH programs that provide in home care, Alternate Destinations, such as urgent care centers for low acuity patients and treat without transport when patients call 9-1-1, receive an intervention but then refuse to be transported to the hospital.

A significant limitation to these new models of EMS care is the lack of reimbursement to EMS if the patient is not transported to a hospital. Tying EMS reimbursement to patient transports severely limits the ability of EMS to implement, or even participate in, these new models of care delivery.

Ms. Myers gave an overview of states and private payers that currently reimburse for EMS for treat without transport to an ED. (A list is included in the presentation)

Mr. Steffen said that it would be valuable to be able to review the volume pick up for states providing Medicaid reimbursement.

Queen Anne’s County (QAC) MICH Program – Joe Ciotola, MD, QAC Health Officer & QAC EMS Medical Director

A copy of the presentation is available on the MIEMSS web site.
QAC MIH Program Cost Reduction Analysis was distributed.

Dr. Ciotola said that QAC Mobile Integrated Community Health (MICH) was the pilot MIH program in Maryland. Development of the program began in 2010 and was approved as a Pilot Protocol and saw their first patient in August 2013.

Dr. Ciotola said the QAC MICH program was designed to enhance the healthcare of the County's most vulnerable citizens (socioeconomic and aging populations). He gave an overview of the QAC MICH program mission and vision, partnerships and current funding sources (totally grant funded).

Dr. Ciotola said participants are required to be QAC residents, be 18+ years of age and has five calls to 9-1-1 within a 6 month period. The only exclusions from the program thus far are refusal to participate. Referrals come from frequent 9-1-1 callers, EMS, ED and QA ER and Shore Regional Health and AAMC post discharge of patients with chronic conditions. QAC MICH receives 15 to 20 referrals per month.

Dr. Ciotola gave an overview of the MICH Team and their responsibilities; he said that monthly patient QA/QI's occur. Dr. Ciotola is the oversight Medical Director for the MICH program.

QAC MICH home visits are performed by EMS and DOH RN. The EMS provider utilizes for evidenced based scales to determine home and personal safety of each patient.

Mobile Wi-Fi is secured through oMG Mobile Gateway by Sierra Wireless (HPPA compliant) using Panasonic Toughbooks. Dr. Ciotola said that the QAC MICH is currently in the process of changing from All Scripts to ImageTrend for the medical record into eMEDS Elite.

Dr. Ciotola reported on the data and demographics of "year by year" increases in home visits, including MICH Team hours spent, age, race, gender, education and employment status, top 10 diagnosis, average medications per patient, linkages to patient services, home safety hazards, 9-1-1 transports, ED utilization and satisfaction survey results. A breakdown by patient insurance was also provided.

Dr. Ciotola said the program faces challenges in data collection, dealing with declinations, patient social isolation and mental health issues, financial stability and medically complex patients.

In the future, Dr. Ciotola says QAC MICH will broaden referral sources, close the loop with primary care physicians, search for financial sustainability and continue to investigate uses for telehealth.

Dr. Ciotola provided a copy of the QAC MICH cost reduction analysis and gave an overview of the reduced patient Emergency Department visits, reduction in hospital readmissions and cost savings as of March 30, 2018 associated with the QAC MICH program.

A discussion on cost savings based on CRISP Data and the cost of the QAC MICH program ensued. Dr. Ciotola said may need to have more than one year's patient data to get a more accurate accounting of the cost saving.

Ms. Gainer and Dr. Ciotola added that although the MIH programs are based on the QAC model and are similar since the EMS provider protocols and provider scope of practice are the same, the programs are not identical. The programs have the flexibility to adjust to the needs of the community they are working in.

Options for Medicaid – Mr. Schrader

Mr. Schrader said there are opportunities for Medicaid savings and potential benefits in areas such as behavioral health, reducing ED hospital visits and population health. He said that DOH and HSCRC is required to submit a report in December 2018 on how the total cost of care will impact Medicaid and determining savings targets and

milestones. The following year, start to measure results for the identified targets. The plan would be to include in the rate setting process in 2020. Mr. Schrader gave an overview of the process moving forward.

Options for Medicare – Ms. Wunderlich

Ms. Wunderlich said Maryland received approval for the total cost of care model which will encourage and require hospitals to reach out and work more proactively with their community based providers starting January 1, 2019. This will promote provider coordination for population health improvement, lower disease burden associated with chronic diseases, reduce costs and reduce abuse utilization. She said there is significant opportunity for hospitals to work with EMS providers to reduce ED utilization and improve patient health and patient outcomes.

Next Steps

Ms. Gainer said the named state agencies will work through July and August on the background items and regroup with all stakeholders in the fall. Ms. Renfrew said that private insurance entities will be contacted individually for input. Mr. Steffen added that the state agencies will also be seeking input from the League of Life and Health Insurers.

Ms. Gainer said all documents from today's meeting will be posted online.