SB 682 EMS Reimbursement Workgroup

EMS Reimbursement for New Care Delivery Models

November 14, 2018

Attendees in person

Patricia Gainer, Ben Steffen, Lisa Myers, Megan Renfrew, Joe Ciotola, Jeff Willats, Rich Schenning, David Phippen, Chris Truitt, Matt Celentano, Tinna Quigley, Mark Fletcher, Jessica Thomas, Marc Flotchin, Tricia Roddy, Jamie Baltrotsky, Ashley Robinson, Robyn Elliott, Greg Buehla, Justin Kinsey, Delora Sanchez, Alyssa Brown, Lisa Myers, Sarah Sette, Andrew Naumann, Christina Castro, Matthew Levy, Barbara Goff

Attendees by phone & "gotomeeting"

Aaron Seabach, Alan Butsch, Mike Cole, Deb Rivkin, Erin Dorrien, Maria Prince, Mary Alice Vanhoy, Jim Matz, John Filer, Lara Wilson, Donna Kauffman

Welcome and Introductions

Ms. Gainer, Acting Executive Director of MIEMSS and Ms. Megan Renfrew, Chief of Government Affairs and Special Projects at MHCC welcomed everyone.

Coverage and Reimbursement for Emergency Medical Services:
(New Care Delivery Models and Uncompensated Services)
A paper copy of the presentation was distributed. The PowerPoint presentation will be emailed to the workgroup and posted on the MIEMSS website after the meeting.

Ms. Renfrew said that the presentation is a high level look at coverage and reimbursement for emergency medical services and that the draft report will have more detail. She asked for written feedback from the workgroup.

Ms. Gainer said that the new models currently being implemented in Maryland include Mobile Integrated Health (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. Maryland currently has seven MIH programs; Baltimore City has a slight variation on Mobile Integrated Health; partnering with the University of Maryland Medical Center to identify patients who are about to be discharged from the hospital who need assistance transitioning to back to their home, assuring medications and any durable health equipment are in place to assist in reducing the number of hospital re-admissions. There are two jurisdictions, Baltimore City and Montgomery County, that have been approved to transport patients to alternate destinations. Treat and release is not new to EMS, but with the opioid crisis, is happening more frequently at a significant increase in cost to EMS with no means to recover these costs.

When 9-1-1 is called, EMS is obligated to respond to treat the patient. Currently, EMS is viewed by Medicare and Medicaid as a transportation benefit, therefore, if a patient accepts treatment but refuses transport (treat & release), EMS is not reimbursed for any costs including any administered medications such as naloxone.

Emergency Department (ED) overcrowding, a long standing problem in Maryland, has had a profound effect on EMS, including longer EMS wait times to offload patients in the ED and diversion of EMS patient transports away from the ED to other ED's.

Statewide EMS data shows that many 911 patients have conditions that do not necessarily need to be treated in an emergency department and could be treated in less costly environments.

Currently, MIH and Alternate Destination programs in Maryland are funded by grants (which are time limited), in-kind service donations and jurisdictional budgets through county / local taxes, or a combination of the three.

Reimbursement practices for EMS are not aligned with current health care initiatives in Maryland that are intended to reduce unnecessary hospital use and provide appropriate care in community settings. Maryland is transitioning to a total cost of care approach; EMS initiatives to treat patients n less costly environments needs to be a part of this effort.

Ms. Renfrew said, as discussed at the last meeting, the workgroup deliverables under SB682 are to develop a plan for Medicaid reimbursement and a process for Medicare reimbursement and to study and make recommendations on the desirability and feasibility of reimbursement by various private payers for emergency medical services without transportation, emergency medical services with transportation to an alternative destination and mobile integrated health services. She said that the state agency partners worked on Medicaid and Medicare over the summer and also met with individual stakeholders (including MHA and some private insurers) over the summer. After the conclusion of the three EMS Reimbursement Workgroup meetings, the draft report will be presented to the EMS Board and the MHCC Commissioners at the December 2018 meetings.

Medicaid Reimbursement

Ms. Roddy said general discussions have focused on making sure that any changes make sense in terms of health system delivery reform by (1) improving quality of care delivered and (2) identifying health cost savings. She said there are some concerns in approaching a Medicaid only model; complications exist in this when building a model only around Medicaid. Unlike the EDs, where there is an uncompensated care approach to hospitals in Maryland, the alternative delivery sites and other forms of delivering care do not have the same framework for billing uncompensated care. EMS providers would be required to check on Medicaid enrollment status of the patient before transporting to an alternate destination. She added that many Medicaid enrollees have third party coverage, e.g., Medicare for primary hospital services or a commercial carrier for primary care. If it is a non-covered service under Medicare or the commercial carrier, there would be some cost shifting to Medicaid. 85% of Medicaid enrollees are in enrolled in managed care organizations who are directly responsible for providing services to enrollees outside of transportation. EMS would need to determine alternate destinations within the patient's network. Therefore, the general thought is that it would be more appropriate to approach these new models of care under an all payer basis.

Ms. Renfrew said discussions have included increasing the flat rate of EMS transports to cover the cost of EMS treat with no transport uncompensated care. Unfortunately, there is not enough data to determine budgetary impact at this time.

Alternative Destinations

Ms. Renfrew said this would allow EMS to transport to an urgent care clinic or behavior health facility. This would require developing a network of urgent care centers and requiring MCOs to include those in their networks. It would also require that EMS check for insurance information at the scene. EMTALA only applies to hospital emergency departments; therefore, urgent care centers can deny treatment.

Chief Fletcher said that the Baltimore City Fire Department's (BCFD) Alternative Destination program began on August 1, 2018, in a small catchment area surrounding the University of Maryland. Due to funding, the program is running only one day per week. Eighteen (18) patients have been transported safely to the urgent care clinic with no follow-up transports to the emergency department. EMS turnaround times were approximately 15 minutes as opposed to the 40+minute turnaround at emergency departments. Baltimore City is one of the busiest EMS systems per capita in the country, unit availability to respond to 911 calls is imperative. BCFD developed an inclusion and exclusion criteria for transport to an alternate destination. It is required that a patient consent to the program; if a patient does not consent, he/she is transported to the emergency department. A follow-up quality assurance is completed on each patient transported to the urgent care center. BCFD is currently assessing expanding the catchment area.

Ms. Renfrew said, as indicated by Ms. Roddy, there is merit in an all payer versus a Medicaid only approach as there are concerns regarding denial of services at an alternate destination, possible increases in uncompensated care and third party liability.

Medicare

Ms. Renfrew introduced Ms. Jackson-Faul, who attended via conference call.

Population Health Improvement Grants- Ms. Renfrew said that HSCRC provides grants, funded through hospital rates, to hospitals for new initiatives. (The BCFD program is currently funded by this grant.) Funding availability is limited. EMS must partner with a hospital to apply; grants are awarded on a competitive basis subject to HSCRC approval. Ms. Jackson-Faul said the grant process would take six to nine month until grant funds were distributed.

Care Redesign Program (CRP) and New Model Programs- Ms. Renfrew said that CRP is focused on Medicare savings; HSCRC can create new care redesign tracks each year with CMS approval. CRP tracks take time to develop; population health grants can be a potential funding bridge. There are current no new tracks expected until 2021. HSCRC is not recommending the New Model of Care approach for EMS care models due to insufficient control over patient outcomes.

Ms. Renfrew added that there is an existing system for raising and thinking through New Models care redesign with stakeholders through the State Innovation Group convened through MHA. This should be considered moving forward.

Private Market Insurance

Ms. Renfrew noted that some of the private insurers are currently providing grants for Alternative Destination and Mobile Integrated Healthcare pilots.

Ms. Renfrew said that legislative mandates only apply to fully-insured large group and ACA-grandfathered small group and individual insurance plans. The state does not have regulatory authority over large group self-insured plans. Ms. Renfrew and Mr. Steffen gave an overview of the differences in

private payer insurance plan regulation. Legislative mandates adding additional coverage to private payer insurance plans raises premiums.

Ms. Rivkin reiterated that EMS companies and urgent care centers need to be included in private payer networks and that EMS transporting to alternate destinations will need to know the patient provider network to ensure compensated care.

The Medicare Advantage Plan inclusion was discussed.

Ms. Renfrew said that EMS mobile integrated health and alternative destination programs will need to interact and coordinate with other delivery reform programs.

Ms. Gainer said that the jurisdictions that have added mobile integrated health and alternative destination programs are on the cutting edge of what is happening within EMS in Maryland. The state is attempting to find a way forward to assist these and other innovations happen. It is extremely important for EMS to participate in CRISP. MIEMSS has developed a blanket contract with CRISP that is available to all EMS jurisdictions. There are currently three counties that have signed up to have their data uploaded into CRISP. EMS jurisdictions need to let their leadership and legal support teams know what is needed for participation in CRISP.

Working Concepts

Ms. Gainer said a lot of time and effort has been put into these issues with stakeholders understanding the potential value in these new models of care. She said it was important to find ways to sustain and grow these models.
Ms. Gainer said that these new reimbursement models for EMS need to make financial sense and be practical to implement for everyone. All payers should be reimbursing for these new models; achieving this will take some time. It is unclear where the initial impact of these model will be; therefore, EMS reimbursement will need to dovetail with all other health care initiatives. The HSCRC population health grants will assist with sustaining these new EMS models until system adjustments can be made.

Chief Fletcher said successful programs around the country have established best practices for what paramedics are doing in the prehospital setting. Paying more for transportation, as opposed to reimbursing for the care and treatment provided, does not enhance the healthcare system. He said that it was important to focus on incentivizing change to move EMS into the healthcare arena.

MIEMSS and MHCC will release the draft report for comment.