State of Maryland
Maryland Institute *for* Emergency Medical Services Systems

Wes W. Moore
Governor

Clay B. Stamp
Chairman EMS Board

Theodore R. Delbridge, MD, MPH
Executive Director

State EMS Board
Virtual
May 12, 2026
Minutes

Board Members Present: William J. Frohna, MD (presiding officer); Stephan Cox; Scott Haas; Jeffrey Hobbs; Tom Scalea, MD; James Scheulen; Meg Sullivan, MD; Yonnia Waggoner; Dany Westerband, MD; Trisha Wolford

Board Members Absent: Clay B. Stamp;

OAG: Mr. Malizio; Ms. Pierson; Ms. McAllister

RACSTC: Dr. Snedeker

MSPAC: Major Tagliaferri

MIEMSS: Dr. Delbridge; Dr. Mr. Abramovitz; Dr. Barajas, DNP; Mr. Bechtel; Mr. Bilger; Ms. Butler; Mr. Cantera; Ms. Chervon; Mr. Ebling; Mr. Edwards; Ms. Gainer; Ms. Geisel; Mr. Huggins; Mr. Legore; Mr. Linthicum; Mr. Kitis; Mr. Miele; Mr. Robertson; Mr. Sidik; Dr. Thompson, PhD; Mr. Tiemersma; Mr. Tracey; Dr. Wooster, PhD; Ms. Wright-Johnson; Ms. Goff

The roll was called; a quorum was confirmed.

Dr. Frohna said that in honor of the upcoming EMS week (beginning May 17, 2026), the EMS Board thanks all of the EMS clinicians for what they do every day in caring for patients in Maryland.

Dr. Frohna called for the approval of the April 14, 2026 EMS Board minutes.

Upon the motion made by Westerband, seconded by Mr. Hobbs, the Board approve the minutes from the April 14, 2026 EMS Board meeting as written.

MIEMSS

<u>EMS Transports and Hospital Emergency Department Statistics</u>
Dr. Delbridge said approximately 211,000 patients to emergency departments by EMS, so far this year. This is consistent with 2025 data.

The five busiest hospitals receiving EMS patients continues to be: Anne Arundel Medical Center, Frederick Health, Meritus Medical Center, Baltimore Washington Medical Center, and MedStar Franklin Square Medical Center.

Monitoring of EMS-to-ED transfer times continue. The goal remains to hand-off patients in less that 35minutes from arrival of EMS to the ED acceptance of patients 90% of the time. Fewer than 50% of hospitals meet the benchmark. Performance challenges are particularly noted in Prince George's County.

MIEMSS continue to provide hospitals with weekly reports. HSCRC receives monthly data.

Emergency Department Advisory System (EDAS)

Dr. Delbridge provided a graph showing the hospitals that spend more than 50% of their time on level four which indicates an ED census that's greater than 130% of their capacity. This indicates the stress level of Maryland emergency departments on a regular basis. It also tells us is that these particular hospitals are paying attention to EDAS and using the system to keep the EMS system aware of their burden so that we can direct patients accordingly.

There are hospitals that have not engaged with EDAS as often as others. MIEMSS aspires to have all hospital ED's participating in EDAS on a regular basis. This requires hospital staff to go to a computer in emergency department and document the ED census within a 3-hour period.

Rural Health Transformation Program

Maryland allocation: ~$168 million (FY2025).
Key initiatives include the expansion of whole blood availability in rural EMS jurisdictions and Mobile Integrated Health (MIH) programs coordinated with local health departments. $969,000 has been allocated for FY2026 for blood program expansion that is expected to expand coverage to most rural areas (13 jurisdictions).

MIEMSS will be the funding pass-through between MDH and local jurisdictions for the MIH portion of the grant.

Dr. Delbridge said that there is significant interest in re-establishing the Critical Care Coordination Center (C4). MIEMSS is exploring reactivation using rural transformation funding. MIEMSS will need to demonstrate the overwhelming benefits and need for utilizing C-4 for patients in rural hospitals with strong stakeholder interest including emergency physicians. Proposal submission deadline: May 26, 2026.

National Disaster Medical System (NDMS) Pilot

Dr. Delbridge said that NDMS was established in 1984. NDMS is a collaboration of HHS, DOD, VA, and Homeland Security departments and has three parts: medical response, patient movement, and definitive care. NDMS has never been fully activated. Parts were used during Katrina and other disasters.

The NDMS pilot program is coordinated by the National Center for Disaster Medicine and Public Health at the Uniform Services University of Health Sciences in Bethesda with emphasis on civilian EMS integration into military casualty response. There are 5-nodes to the response with Washington DC as one of them. The scenario would be that C130s and KC135s loaded with wounded people would be met by civilian EMS on the tarmac to take the patients and distribute them to places throughout the National Capital Region.

Dr. Delbridge said that Maryland needs much more prep for such an event. MIEMSS has been in discussions with the military so that our expertise in standing-up systems such as C-4 is not overlooked along with the role and responsibilities MIEMSS has overseeing the EMS system, the expertise and knowledge that exists for example with the Shock Trauma Center, and maintaining Maryland's leadership role in coordination and trauma system management.

EMS Supplemental Payment Program (ESPP)

Dr. Delbridge said that the ESSP initiative was a significant undertaking by MIEMSS, MDH, Maryland Medicaid, and CMS a few years ago. CMS provides cost recovery for the federal portion of Medicaid dollars that are under-reimbursed to EMS agencies on a public expenditure basis. Medicaid reimburses EMS $150 per dispatched ambulance regardless of nature or severity of the call. If a public agency can demonstrate that it cost them $950 to actually provide care to a Medicaid beneficiary that $950 minus $150 leaves a gap of $800 unreimbursed. Under ESPP, CMS reimburses the federal share (50% of the $800) as long as the public agency can prove the $950 cost.

Medicaid contracts with the accounting firm Myers and Staffer who audits the cost report of the jurisdiction, validates the information provided, and sends back to MDH / Medicaid the final certified public expenditure number and calculated reimbursement. Maryland Medicaid reimburses the jurisdiction and in turn request reimbursement from CMS. CMS has not fully reimbursed Maryland Medicaid for prior payments (tens of millions short). CMS say it does not agree with the current contract that was confirmed by the prior administration.

CMS, Maryland Medicaid, MIEMSS, and a couple of local jurisdictions, with Baltimore City the most elaborate. CMS is trying to understand the cost report while Maryland attempts to explain the different configurations for EMS e.g. paramedics ride on fire engines and a fire engine does not only put out fires, it responds to EMS calls.

Maryland Medicaid has suspended payments pending CMS's resolution regarding upholding the contract for reimbursement. Medicaid is also investigating ways for recovering monies already paid out.

Hospital Designation

MIEMSS has redesignated University of Maryland Shore Regional Health at Cambridge Freestanding Emergency Medical Facility for 5-years.

SEMSAC Report

Chairman Haas said that SEMSAC did not meet this month. He asked if Dr. Delbridge had the opportunity to contact Dr. Fillmore regarding the question on charging students for clinical rotations and such. Dr. Delbridge said that MIEMSS just concluded the survey of all jurisdictions asking if this was an issue. All jurisdiction responded in the negative. Dr. Delbridge said he would be contacting Dr. Fillmore soon.

Chairman Haas reported that Dr. Delbridge would be providing SEMSAC with an EMSOF budget update at an upcoming meeting.

MSPAC

A written report was distributed.

Major Tagliaferri provided an operational update including vacancies (15 trooper medics), shifting of personnel due to promotional transfers, training, and helicopter maintenance. He said three helicopters are not in operation due to heavy inspections and repairs.

The aviation whole blood program continues to operate successfully. Program to-date: 422 units have been administered to 321 patients. Outcome research is underway in partnership with hospitals.

So far this year, there have been 3 hoist and 535 Medevac missions.

Major Tagliaferri highlighted a notable mission and the "Stop the Bleed" event on May 17th at Martins State Airport.

RACSTC

Dr. Snedeker said that is highlighted the June 16th Violence Prevention Summit to be held at M&T Bank Stadium featuring state and local leadership. An invitation to the event is forthcoming. The Ravens organization has generously donated $100,000 to Shock Trauma for violence prevention.

Dr. Snedeker said that the Shock Trauma gala raised over $2million dollars while celebrating the Chase Lancaster save crediting the MSPAC Whole Blood program. Video links will be shared with the Board.

MSFA

Mr. Cox said that the MSFA continues to prepare for the convention in June.

Old Business

Incorporation by Reference Trauma Data Dictionaries
Mr. Malizio said that the Trauma Data Dictionaries, approved earlier by the Board, have been published in the Maryland Register with no comments received. He asked the Board for final approval.

Upon the motion by Mr. Scheulen, seconded by Mr. Hobbs, the EMS Board unanimously approved the Trauma Data Dictionaries as published in the Maryland Register.

New Business – N/A

Dr. Frohna read the closing statement for adjourning into a closed session of the Board.

Upon the motion of Mr. Scheulen, seconded Dr. Scalea, the EMS Board adjourned the open session of the Board.